Outcomes First Group

SELF-INJURIOUS BEHAVIOUR POLICY

Children's & Adults Care

SELF-INJURIOUS BEHAVIOUR POLICY

Contents **Page**

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 INTRODUCTION

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

Self-injurious behaviour is the result of an attempt to self-regulate, express pain or discomfort or communicate whereas self-harm is when people deliberately hurt their bodies intentionally causing physical pain or harm to themselves. However, there is not always a clear distinction between self-injury and self-harm and it can be difficult to identify which type of behaviour the individual is displaying. The accompanying Self-Harm Policy may be more applicable for some people we support.

The appropriate policy should be used in response to the individual’s needs, with support from the Clinical Team and in discussion with senior leaders. This policy for self-injurious behaviour will usually be followed for individuals who have neurodivergence as their primary need, however, some may display self-harming behaviour in which case the Self-Harm Policy should be followed. Self-harm is more likely to occur in individuals who have Social, Emotional, Mental Health (SEMH) as their primary need.

This policy should be read alongside the:

- Care Support Planning Policy (Adults)/ Care Planning & Risk Assessment Policy (Children)
- Ligature Management Policy and Ligature/ Ligature Point Audit Guidance.
- Risk Assessment Templates (Health & Safety)
- Behaviour Policies and Information (Schools)
- Person-centred Behaviour Policy (Children's Homes)
- Positive Behaviour Policy (Adult Care & Education)
- Restraint Reduction and Terms of Reference Policy
- Notifiable Events Policy - Children's Residential / Notifiable Events Policy (Adult Care)
- Serious Incident Escalation Policy & Forms
- Group Supervision Policy.docx
- Team Member Support – Post Incident
- the setting's Safeguarding Policy

Team members should also be familiar with:

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

2.0 LEGISLATIVE & NATIONAL GUIDANCE FRAMEWORK

This policy complies with all relevant regulations and legislation. 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

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 or self-injury. For example, in recent NCISH annual reports, 80% of patients who died by suicide were rated as 'low risk', demonstrating that the tools have poor predictive value and should not be used to exclude individuals from care and treatment. **Risk assessment tools should, therefore, not be used as a basis for deciding whether or not to make care and intervention available for an individual.**

3.0 WHAT IS SELF-INJURIOUS BEHAVIOUR

Self-injurious behaviour is where a person physically hurts themselves an attempt to self-regulate, express pain or discomfort, or communicate. This can include head banging on floors, walls or other surfaces, hand/arm or other body part biting, hair pulling, eye gouging, face or head slapping, skin picking, scratching or pinching, forceful head shaking.

The National Autistic Society states that around half of autistic people engage in self-injurious behaviour at some point in their life.

Child maltreatment and trauma are also known risk factors for non-suicidal self-injury.

4.0 DEFINITION OF SELF-INJURY

The terms self-harm and self-injury are sometimes used interchangeably, however they are different. **Self-injury** - is the destruction or alteration of one's body tissue without conscious suicidal intent in an attempt to self-regulate, express pain or discomfort or communicate. This term is used to distinguish these actions from common socially accepted harmful behaviours such as drug use, smoking, excessive alcohol use. Body modification for aesthetic purposes is not included.

Self-harm is when people deliberately hurt their bodies, intentionally causing physical pain or harm to themselves. It is any kind of action or behaviour that can be harmful to the body or mind, 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. It includes drug use, excessive alcohol use and smoking. **Please see the accompanying** Self-Harm Policy

5.0 UNDERSTANDING SELF-INJURIOUS BEHAVIOUR

There can be many reasons and factors behind why a person self-injures. It is often a means of communication or expression where the individual is trying to convey a feeling or idea, they may not be able to express in words. Biting, headbanging or other self-injurious behaviours can be a means of getting their needs met. It could be that they are hungry, or thirsty, or there may be an urgent need to express pain, fear, displeasure, or anxiety.

Some individuals may self-injure to obtain relief from a particular emotional state or overwhelming situation. They may also self-injure to end a feeling of emotional or physical numbness. Other individuals may self-injure as a way of punishing themselves and/or to get their needs met by another.

6.0 FUNCTIONS OF BEHAVIOUR

A behaviour that a person engages in repeatedly will serve some kind of purpose or function for them otherwise it would not typically continue to occur. Understanding the function is essential to finding out why the individual is injuring themselves and to providing the most effective way to support them. The functions could be sensory stimulation, pain attenuation, escape or avoidance, attention and/or tangibles/activities.

The common functions are:

Sensory Stimulation - This behaviour refers to stimulating the senses, or self-stimulating. This behaviour functions to give the person some kind of internal sensation that pleases them or removes an internal sensation they do not like.

Pain Attenuation – The behaviour alleviates some type of pain, such as pain from an ear infection or rea headache. There is growing evidence that pain associated with gastrointestinal problems, such as acid reflux and gas, may be associated with self-injury. For autistic people, pain can sometimes be caused by sounds such as a vacuum cleaner or alarm, which may lead to self-injurious behavior. For individuals who have experienced trauma, they may self-injury to distract from, lessen or end emotional pain.

Escape or Avoidance - Not all behaviours occur so the person can "obtain" something; many behaviours occur because the person wants to get away from something or avoid something altogether. These are most frequently escape from social situations and demand avoidance. For example, an individual who injuries themselves in a busy supermarket as an expression of communicating that they wish to leave.

Attention – All humans require attention and engagement from others. A person may engage in a certain behaviour to gain some form of attention or a reaction from other people. The individual may feel that it is better to obtain negative attention than no attention at all, especially if they are bored. Some individuals who have experienced neglect, may feel the only way they can receive care and attention is

by demonstrating their level of distress through self-injury. This can be related to their disrupted attachments and therefore the terms ‘attachment seeking’ or ‘attention needing’ can be less pejorative.

Tangibles or Activities - Some behaviour occurs so the person can obtain a tangible item or gain access to a desired or preferred item or activity. Often these individuals will have complex needs, specifically this could be limited communication, so they do not have a range of skills in order to meet their needs or effectively ask for the thing they want. For example, spending time with specific member of their team.

6.1 Multiple Functions

The behaviour may serve more than one function. For example, an individual with a Learning Disability may injure themselves to avoid a task they do not like and injure themselves to get attention from a carer.

An individual who has experienced trauma may self-injure after a good day as a punishment because they do not feel worthy of a positive experience and as a way for them to communicate their distress to their care team.

A person who self-injures repeatedly may not always do it for the same reason each time. Whilst it is helpful to understand the individual’s history, assumptions based on previous incidents should not be made and each act must be assessed separately to determine the motivation behind it. Misunderstanding the reason/s for the behaviour can cause further frustration and distress to the individual.

Some forms of self-injury might be part of a repetitive behaviour, an obsession or a routine and related to other mental health issues. Some self-injurious behaviour can indicate mental health issues, such as depression or anxiety. This should be considered by the Clinical Team.

The person might still do some things that most people stop doing as children, such as hand mouthing putting their fingers or hand into their mouth, but as an adult they are causing injury to themselves. This could be for development reasons or regressing to childhood behaviour to comfort themselves.

The person might learn that self-injurious behaviour can be a very powerful way of controlling the environment. A behaviour, e.g., head slapping, which they did at first because of physical pain, could eventually become a way of avoiding or ending a situation they do not like, e.g. turning the television off, or interrupting an argument taking place nearby.

7.0 METHODS OF SELF-INJURIOUS BEHAVIOR

There are many different methods of self-injury used including but not limited to tying ligatures, cutting, headbanging, biting, skin picking, swallowing poisonous substances, or eating inedible objects, inserting objects into the body or under the skin and jumping from heights. Witnessing self-injury can be very distressing for team members, and support can be sought in supervisions, as well as from clinical well-being teams and reflective practice sessions.

7.1 Head injuries and head banging

Some individuals bang their heads; this can cause them to incur significant and serious head injuries. Headbanging can also cause accumulative damage over time. Head banging can present team members with challenges in terms of preventing the individual from injuring themselves. Placing a softer object between their head and the hard service can be an effective way to prevent significant injury. This will be set out in their Support Plan if appropriate.

Team members must undertake checks of the individual’s health and wellbeing following an episode of head banging. Attached to this policy at appendix C and D are a head injury checklist and protocol which must be implemented for any individual involved in any incident where they have been self- injuring by banging their head.

8.0 USE OF LIGATURES

Teams members should be familiar with the Health & Safety:

- Ligature Management Policy
- Ligature and Ligature Point Audit Guidance and Ligature and Ligature Point Audit Form
- Safe use of Hook Ligature Cutters Procedure

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

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

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

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

9.0 PHYSICAL INTERVENTION AND RESTRAINT

Please also see Restraint Reduction and Terms of Reference Policy

Some self-injurious behaviour may require team members to physically intervene using prescribed physical interventions using Crisis Prevention Institute (CPI) intervention, which team members are trained in.

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

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

All team members involved, as well as the individual, must have an appropriate debrief. These will be recorded on the setting's electronic recording system (e.g. Access/Sleuth). The service's clinical team must be kept informed of the incidents and regularly review the individual's Support Plan.

10.0 ASSESSMENTS

The Initial Assessment Tool should include details of any previous incidents of self-injury, including details of previous management or support. Where possible, the school and clinical team will engage family members to gain their views and experience about any self-injurious behaviour and how it can most effectively be managed. This will we be used in the development of the individual's Support Plan.

At least one of the following functional analysis tools must be completed for anyone who has self-injured:

- Functional Assessment Screening Tool (FAST)
- Motivation Assessment Scale
- Questions About Behavioural Function (QABF)

- Brief Behavioural Assessment Tool (BBAT) - Expanded
- Behaviour Chain Analysis

This information will inform a detailed risk assessment that must be regularly reviewed by the multi-disciplinary team, including members of the Clinical Team. The risk assessment should identify the preferred methods of managing the self-injurious behaviour and what post-incident support should be provided.

There is clear evidence that risk assessment tools are **not an effective basis** on which to predict future incidents of self-harm or self-injury 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 or self-injury***. 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).

11.0 CARE SUPPORT PLANNING

The assessment and management of self-injurious behaviour is an on-going part of the care support planning process and is carried out in line with the Group's Care Support Planning Policy (Adults)/ Care Planning & Risk Assessment Policy (Children)

For those who have been assessed as at risk of self-injurious behaviour there will be an agreed plan in place as to how this behaviour is to be managed in both the short and long term.
The individual's care plan should be reviewed with them, including the aims of support and at a minimum interval of every 12 months.

12.0 REDUCING THE RISK OF SELF-INJURY

The risk of self-injurious behaviour may be reduced by using some preventative strategies and measures as described below.
Check for other medical causes - Contact the GP and/or dentist and give details of the behaviour, including what time of day it happens, in which situations, how often it happens, when it first started and how long it lasts.

Check for mental health causes – Has there been any changes to their wellbeing and mental health status; are they sleeping more or less, eating more or less and/or are there any other significant behavioural changes? Seek advice from the Clinical and Wellbeing Team.

Review the team member supp**ort of the individual**- The SLT in the service can consider and review the individual's team member ratio; for example, it might be appropriate to increase from a 1:1 to a 2:1. The Clinical and Wellbeing Team can support these decisions as required.

Review the individual's environment - Check whether there have been any changes to the individual's environment or whether the environment is overly restrictive and/or overwhelming. Ensure the environment is tidy, organized and clean. Seek advice from the Clinical and Wellbeing Team.

Think about the function of the behaviour - Include in daily recordings what is occurring before, during and after the behaviour. This could help you and other professionals to understand the purpose of the behaviour. Make notes on the environment, including who was there, any changes e.g., sounds, smells, and how you think the person was feeling. Where possible and appropriate discuss with the individual to facilitate increased 2 way understanding of the self-injury; meaning for the individual to help their team understand how they view their self-injury and for the team to help the individual increase their own understanding.

Review the structure and routine set out in the individual's Support Plan - There may be things

that can be done to make things more predictable to reduce anxiety, boredom, being alone, and therefore reduce the likelihood of the person engaging in self-injurious behaviour. If the self-injury usually happens at the same times of day, consider what can be done at this time e.g., providing more supervision and support at these times.

Provide sensory alternatives - Build alternative sensory experiences into the daily routine. Appropriate alternatives will be included in the individual's Support Plan following risk assessment and consideration by the Multidisciplinary Team (MDT) and Clinical and Wellbeing Team.

Use communication tools - Support the person to use other ways of communicating their wants, needs and physical pain or discomfort. Visual supports, pictures of body parts or symbols for symptoms can help for some people with learning or communication needs; signals such as a red zone of regulation card could be used with an individual who recognises their urges to engage in self-injurious behaviours.

Reward positive behaviours - Where it is helpful give encouragement for positive behaviour and for periods when they do not engage in self-injurious behaviour. This can help them learn that other behaviours bring positive outcomes. For example, if an individual has sought support from a team member rather than self-injuring, this should receive high levels of support and care from team members. The reward must be tailored to the individual.

Medication - is sometimes used where the behaviour is very severe or lasts a long time. Medication should only be used under the direction of a suitable medical practitioner and in agreement with the MDT.

13.0 WHAT MUST YOU DO WHEN SELF-INJURIOUS BEHAVIOUR HAPPENS

Respond quickly and consistently when the person self-injures. Even if you think the person is doing it to get attention, it is never appropriate to ignore self-injurious behaviour. If you find that an individual has engaged secretly in self-injurious behaviours, it is important the level of injury is assessed and recorded. If they are seriously injured or at risk of serious injury, ring 999.

Keep responses low key - Limit verbal comments, facial expressions and other displays of emotion. Try to speak calmly and clearly, in a neutral and steady tone of voice.

Reduce demands - The person might be finding a task too difficult or overwhelming. If the task needs to be completed, come back to it later when the person is feeling calmer.

Remove physical and sensory discomforts - Smells, sounds or tastes might be causing the person distress. If there is something bothering them remove it if possible or them to another room. If their clothes are uncomfortable, prompt them to change. If it is noisy outside, close the window or offer ear defenders. Provide relief for physical discomfort (e.g., pain killers) in line with the Medication Policy.

Redirect - Tell them what they need to do instead of the self-injurious behavior; for an individual with a learning disability give them a clear instruction, for example "hands down". You can use visual cues, such as picture symbols to back up instructions. Redirect to another activity that cannot be done at the same time as the self-injurious behaviour, e.g., an activity that needs both hands. Give praise when they switch to the activity.

Distracting activities can include but are not limited to:-

- Physical- going for a run, throwing socks at the wall, dancing
- Creative – singing, drawing, writing
- Comforting – cuddling a soft toy, having a bath, having their favorite food
- Constructive – baking a cake, cleaning, painting their nails
- Fun – play a computer game, watch TV show, listen to music
- With others – talk to someone, sit in the living room
- Inspiring – Yoga, meditation, mindfulness

Use barriers – for some people it may be appropriate to place a barrier between the person and the object that is causing injury. Appropriate barriers must be agreed by the MDT, risk assessed and set out in the individual's Support Plan.

Physical restraints - where there is risk of severe injury, the use of physical restraints may be considered; this will always be within the Mental Capacity Act best interests' principle and in line with Restraint Reduction and Terms of Reference Policy

This will be set out in the individual's Support Plan and have been risk assessed.

These methods should help to stop or reduce the behaviour but do not address the cause of the behaviour, so they must never be used in isolation without understanding and supporting the person.

14.0 SUPPORTING TEAM MEMBERS AND PEER GROUP

Please also see Team Member Support – Post Incident Policy

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

Reflective practice sessions, debrief meetings, regular team meetings and individual 'safe space' support sessions will help below deal with what they observe, learn from the incident and help to minimise future risk of injury to the individual.
Team members should take into account how the individual's self-injurious behaviour may affect their close friends and peer groups and provide appropriate support to reduce distress to them as well as the individual. The service should contact the Clinical and Wellbeing Team if advice is required around how best to support peers.

15.0 REPORTING AND RECORDING

All incidents of self-injurious behavior must be recorded in the individual's notes, reported in the weekly reports and on the settings electronic reporting system e.g. Access, Sleuth etc.

The SLT and Clinical Team in each service should collectively agree when and how an incident of self-injury should be reported to the service's Clinical Team e.g. which named clinician to be informed and how. These decisions can be made at a site-specific level but also can be made in relation to a specific individual depending on their needs.

Incidents may also require reporting to a regulatory body as appropriate. Adult and Children's Care should refer to their service's Notifiable Events Policy.

16.0 SUPPORT FROM CLINICAL PROFESSIONALS

Please see appendices detailing the process of seeking professional support. If there is no in house clinical team and professional support is required, refer to the Community Learning Disability Team or Mental Health Team for assessment. Those supporting children and young people may need to refer to CAMHs.

The service's in house Clinical Team (where available) must be involved when an individual is referred to a service within the Group in order to assess and understand their risk of actual or potential self-injury. The Clinical Team must also be informed when an individual, who has not previously, starts to engage in self-injurious behaviours.

All occurrences of self-injury must be discussed with the Clinical Team at the regular multi-disciplinary team meeting/ other clinical-based meetings. If an individual's self-injury is increasing in frequency, intensity, duration or the method has changed, the Clinical Team should be informed at the time of the concern rather than waiting for the next MDT or Clinical meeting.

It is the role of the Clinical Team to work as part of the services' SLT to review the individual's current self-injury plan, team member protocol and risk assessment, to provide additional support to the individual when appropriate, to consider what team member support/reflective practice might be required and consider what specialist intervention could be offered.

The Clinical Team may be involved in the following ways:

- providing consultation/training/reflective practice to team members
- work collaboratively with the setting to develop a support plan for the individual
- developing a risk formulation, including a shared understanding of why the individual has self-injured
- reviewing the individual's current risk assessment, ensuring that the individual receives the care they need
- supporting with giving the individual and their family members or carers information about their actions and findings
- providing additional and/or direct support to the individual where appropriate

Further assessment of the self-injurious behaviour may be required by the clinical team to support the above work. This involves a collaborative process between the individual who has self-injured and the clinician that aims to summarise the individual's current risks and difficulties and understand why they are happening in order to inform a support plan. Formulation typically includes taking into consideration historical factors and experiences, more recent problems, and existing strengths and resources.

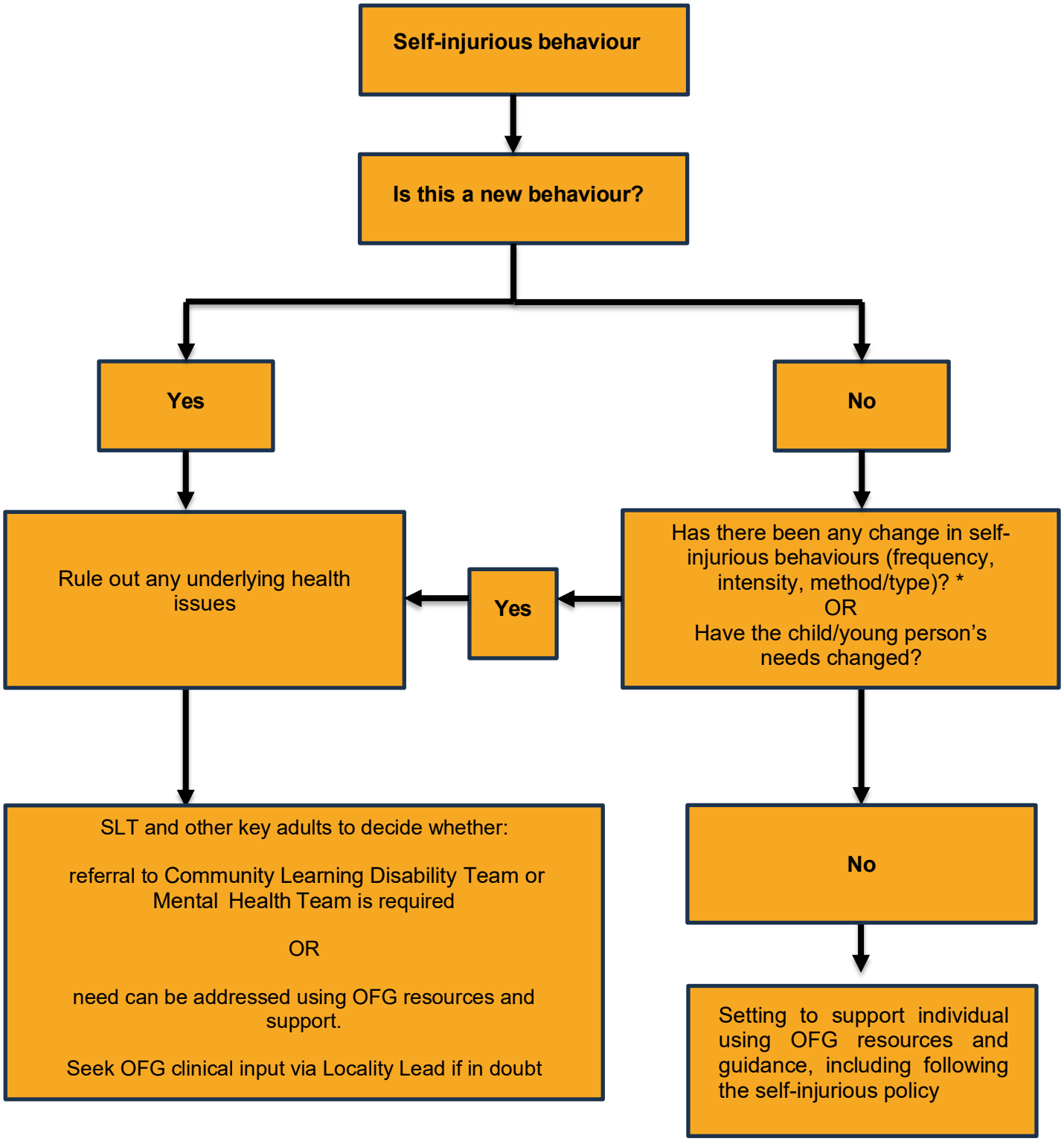
17.0 HELPFUL RESOURCES

National Autistic Society: Self-injurious-behaviour

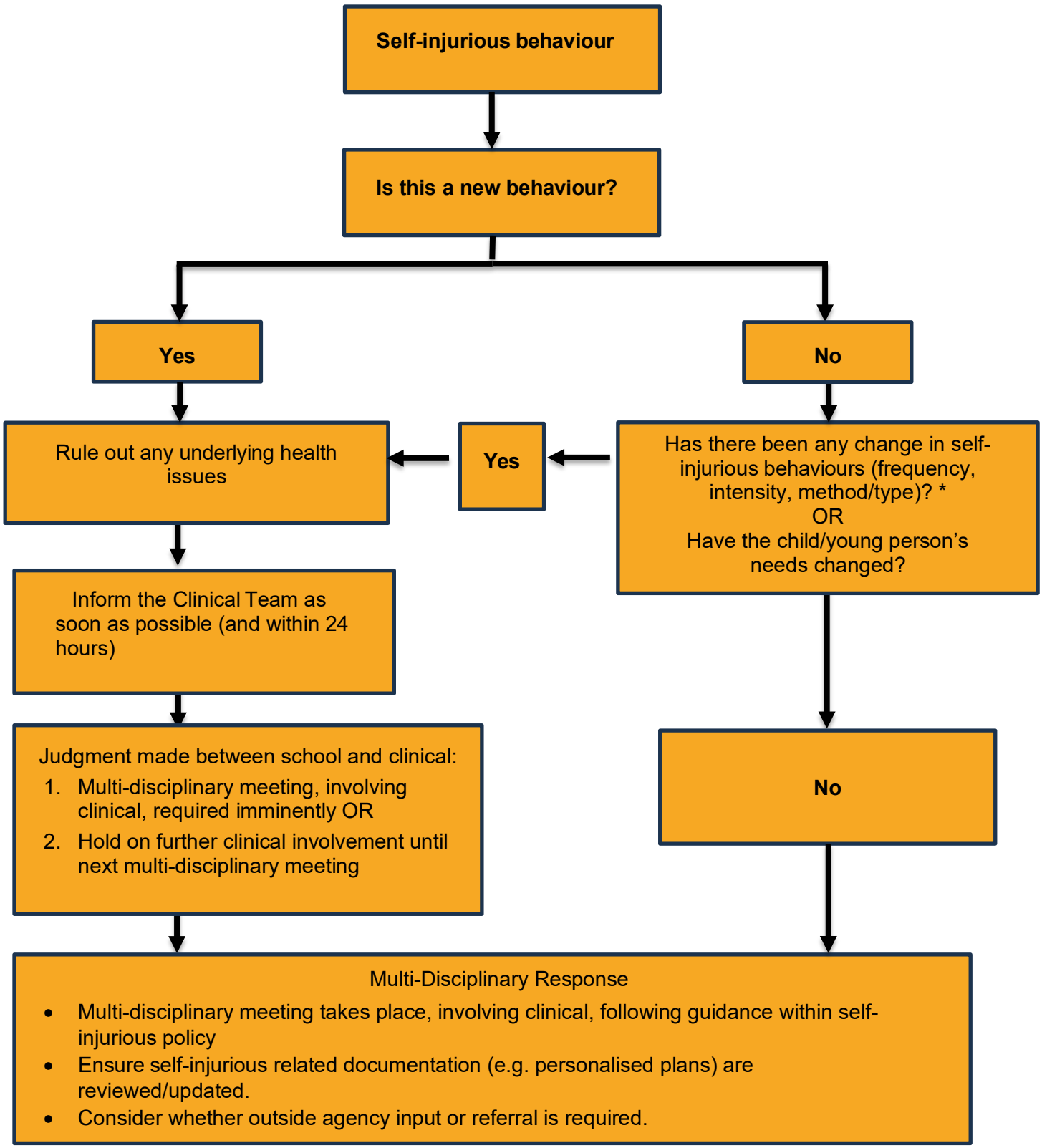
National Autistic Society: Self-harm

Autism Research Institute: Self-Injury

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



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



APPENDIX C - HEAD INJURY PROTOCOL

All team members should follow the head injury protocol to ensure the safety of all individuals. When XX's anxieties increase he may engage in head-hitting. XX may also engage in this behaviour whilst at baseline as a form of self-stimulatory behaviour. XX may hit his head with his hands, as well as on the walls, doors, windows and other hard surfaces. XX has a wound on his forehead from engaging in this behaviour in the past and this may re-open when he is engaging in head-hitting behaviours.

If XX hits his head, team members should monitor him for 24 hours to look for any symptoms of concern (see below).

If XX has hit his head, team members should look for the following symptoms of head injury and concussion and seek appropriate medical advice (e.g., 111).

- Difficulties staying awake or keeping their eyes open
- Vomiting since the injury
- Headache that does not go away with pain relief
- Dizziness or difficulties with balance
- A change in behaviour, e.g., more irritable
- Any signs of confusion
- If XX re-opens an old wound
- Problems understanding or speaking when compared with usual presentation
- Problems with their eyesight

Call 999 immediately if the following symptoms are observed:

- Unconsciousness
- Clear fluid coming from the ears or nose
- Seizure activity
- Bleeding from the ears or bruising behind the ears
- Numbness or weakness in part of their body
- Prolonged signs of dizziness/unsteadiness on their feet

Please note this is not an exhaustive list and please seek advice if you are unsure or concerned about XX's presentation.

Review date:

Signed:

Information around signs and symptoms gathered from the NHS website and NICE guidelines

APPENDIX D - CHECKLIST AFTER HEAD-BANGING/HITTING INCIDENT

Following a head-banging/hitting incident, please complete the following checklist:

Person's name: _____ **Date:** _____

Symptoms/ Person's Presentation:	Yes	No	Actions Taken
Unconsciousness, or lack of full consciousness (for example, problems keeping eyes open)			
Drowsiness (feeling sleepy) that goes on for longer than 1 hour when they would normally be wide awake			
Difficulty waking the person up			
Problems understanding or speaking			
Loss of balance or problems walking			
Weakness in one or more arms or legs			
Problems with their eyesight			
Painful headache that won't go away			
Vomiting (being sick)			
Dizziness			

Clear fluid coming out of their ear or nose bleeding from one or both ears			
Symptoms/ Service User Presentation:	**Yes**	**No**	**Actions Taken**
Any signs of confusion			
Seizures (also known as convulsions or fits)			
Did the Service User suffer a high-energy head injury (e.g., a fall from a height of 1.2 m (4 ft); hitting head during car crashes; hitting the head after falling from a fast-moving bicycle)			
Was there suspicion of a skull fracture or penetrating head injury (when injury involves an open wound to the head from any object or outside force)			
A change in behaviour (please describe)			
Any other comments/observations and actions taken:			

Form completed by: _____

Sign: _____

Outcomes
First Group