



Cornell Research Program on Self-Injury and Recovery

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Non-Suicidal Self-Injury in Schools: Developing & Implementing School Protocol

Who is this for?

School staff and faculty, specifically for school administrators, counselors, nurses and other support personnel

What is included?

- How to develop a protocol
- How to implement a protocol
- Questions and issues that might come up
- Flowchart to aid in decision-making

Non-suicidal self-injury is an increasingly common behavior among school-aged youth and occurs with regularity in secondary school and college settings. It is uncommon, however, for schools to have well-articulated protocols for detecting, intervening in, and preventing self-injury. Although specific protocols and practices are likely to vary considerably from school to school, this report provides an overview of best practices for detecting and responding to self-injury in secondary school settings.

The information presented here has been adapted from the work of Barent Walsh, Matthew Selekman, Nancy Heath and Mary K. Nixon, in addition to our Program's own research.

Non-suicidal self-injury (NSSI) is defined as: the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned.¹

Why is a self-injury protocol important?

Protocols are useful in guiding school personnel responses to situations that many find uncomfortable or unable to manage. Additionally, they provide a means of assuring that a school's legal responsibilities and liabilities are addressed even in situations where personnel may not have this as their primary concern. In his discussion of self-injury protocols, Walsh (2006) explains that "the advantage of having a written protocol is that staff know how to respond to self-injury systematically and strategically."² It is essential to note that although a self-injury protocol may be similar to one used to manage suicide-related behavior, it is not the same. The two types of protocols may, however, share common elements and suicide-related protocols are often a good starting point for development of non-suicidal self-injury protocols.

What is included in the school protocol?

A functional school protocol for addressing self-injury incidents should include steps for the following processes:

- Identifying self-injury
- Assessing self-injury
- Designating individuals to serve as the point person or people at the school for managing self-injury cases and next steps
- Determining under what circumstances parents should be contacted
- Managing active student self-injury (with self-injurious student, peers, parents, and external referrals)
- Determining when and how to issue an outside referral
- Identifying external referral sources and contact information
- Educating staff and students about self-injury

Developing a Protocol

What is the first step?

Responsibility for developing a self-injury protocol most often resides with the school crisis team. If a school does not have a crisis team in place, the first step would be to assemble a team of diverse individuals (typically some combination of guidance counselors, nurses, school social workers, school psychologists, administrators and/or teachers) best positioned to address issues related to detecting and managing self-injurious students. It is also important to identify a point person from this team to serve as the main liaison between the student, his/her parents, and the school. The crisis team should seek in-depth training from local self-injury or mental health experts. If this training is unavailable locally, the crisis team should look to national organizations such as S.A.F.E. Alternatives (selfinjury.com), The Bridge (<http://www.thebridgetraininginstitute.org>) or our project (<http://selfinjury.bctr.cornell.edu>) for more information. They should also be tasked with the development of strategies for providing general education about self-injury for school staff and faculty.

What does the crisis team/point person do?

The crisis team/point person (or both) is responsible for:

- Responding to any disclosures of self-injury. They also serve as a resource for faculty or staff who may suspect a student is injuring but do not know for sure.
- Making contact with the student and directing him or her to the nurse for an assessment and care of wounds.
- Assuring that a self-injurious student is assessed for suicidality at the point of identification and later as indicated by symptom changes.
- Acting as a liaison between the student, parents, affected faculty/staff and peers, and outside referral agents associated with the student as a result of the disclosure.
- Establishing a productive and supportive relationship with the self-injurious student or finding someone else who can be in this role.

In order for the crisis team or point person to operate effectively, it is important for faculty and staff to refer all suspected or confirmed self-injury cases directly to the crisis team or point person.

Who should be trained in self-injury protocol?

All teachers and members of the school staff, from janitors to administrators, should be trained in self-injury protocol. Students should **not** be included in this education session (unless schools have designated student mental health teams composed of students not at risk for self-injury or related behaviors).

What should be part of the staff training?

The most important part of staff training is learning how to identify signs and symptoms of self-injury. Staff must be able to recognize the full range of self-injury behaviors. They also need to know what is **not** self-injury, such as body modification like tattoos and piercings. (Note: Individuals practicing extreme body modification may well be doing so with self-injurious intent. While subtle assessment can be useful in these cases, it would not be appropriate to pull them aside for formal assessment without additional cause for concern.) It is also imperative that staff members are trained to recognize the difference between self-injury and suicidal behavior, and to be aware of the conditions under which self-injury requires immediate attention, such as severe wounds that need stitches or other medical care. Staff should be aware of the designated point person for managing self-injury on campus. Although the designated point person may well be the individual to first initiate conversation with the student, all staff should be trained to comfortably respond to students who disclose self-injury. Learning how to respond with what Dr. Barent Walsh calls “respectful curiosity” and how to keep the door open for conversation with a student who denies or shuts down conversation is an important skill for anyone who may be in contact with self-injurious students. For more general information about self-injury, please see the factsheet “What is self-injury?” (<http://selfinjury.bctr.cornell.edu/perch/resources/what-is-self-injury-10.pdf>)



A person who engages in self-injury has a DIFFERENT INTENT than a person engaging in suicide-related behaviors. While self-injury is a symptom of distress, it is in and of itself not a suicidal act, as it is most often used as a means of coping with stress, not ending life. For more information on the differences between self-injury and suicidal behavior, please see the “About Self-Injury” section on the Cornell Research Program on Self-Injurious Behavior website at: <http://selfinjury.bctr.cornell.edu/about-self-injury.html>

Someone who displays respectful curiosity is not just concerned about making a problem go away but rather with understanding the problem.³ Examples of questions showing respectful curiosity include:

- *“How does self-injuring make you feel better?”*
- *“What kinds of situations or types of things make you want to injure?”*
- *“When did you begin injuring and why?”*
- *“What role does self-injury play in your life right now?”*

Protocol in Action

Identifying self-injury

How is self-injury detected?

There are several means through which a school staff person might discover that a student is self-injuring. A student could self-disclose that he or she is self-injuring. Or, a peer might notify a staff member of another student’s self-injurious behavior. In other cases, a teacher, counselor or staff member might first notice signs and symptoms suggesting that a student is self-injuring.

Signs and symptoms of self-injury are sometimes absent or easy to miss. Arms, hands, and forearms opposite the dominant hand are common areas for injury and often bear the tell-tale signs of self-injury history (e.g., a right-handed person will often injure his/her left arm). However, evidence of self-injurious acts can and do appear anywhere on the body. Other signs include:

- Inappropriate dress for season (consistently wearing long sleeves or pants in warm weather)
- Constant use of wrist bands/coverings, unwillingness to participate in events/activities which require less body coverage (such as swimming or gym class)
- Frequent bandages, odd/unexplainable paraphernalia (e.g., razor blades or other implements which could be used to cut or pound)
- Heightened signs of depression or anxiety
- Unexplained burns, cuts, scars, or other clusters of similar markings on the skin⁴

It is not uncommon for individuals who self-injure to offer stories which seem implausible or which may explain one, but not all, physical indicators such as “It happened while I was playing with my kitten.” If the individual says that he or she is not self-injuring or evades the question, do not push – it is important to respect someone’s right to privacy. You can, however, keep the door open, by saying, “Okay, well if you ever want to talk about anything, I am available.” Stay connected and look for other opportunities to ask – particularly if there is continuing evidence that your suspicion is correct.

Staff should recognize that self-injury is not confined to certain groups of students, such as “goths” or “emos.” Self-injury is not limited to a particular look or appearance nor is it confined to membership in a particular social group. See our “15 misconceptions about self-injury” factsheet (<http://selfinjury.bctr.cornell.edu/perch/resources/15-misconceptionsenglish-1.pdf>) for more information.⁵



What should happen once we know or suspect a student is self-injuring?

If a staff member learns or suspects that a student is self-injuring, he or she should contact the designated crisis team or point person specifically trained to deal with self-injury. In some cases, someone other than the point person or crisis team member will be faced with responding directly to a self-injury disclosure or incident. Regardless of the individual, it is critical that the first response to self-injury disclosure be emotionally calm, kind, and non-judgmental (see the use of "I statements" below). It is also important that first responders be honest with the student about the school protocol requiring them to share their knowledge of self-injury with the designated point person. They should assure the student, however, that although it is likely that the designated point person will be in touch with the student, all information shared about the student's self-injury is strictly confidential. In schools with protocols which include the self-injurious student as a collaborator in deciding a course of action once self-injury is disclosed, students will also benefit from knowing that they will have a say in what happens after the designated point person is notified.

Use of "I" statements such as "I'm concerned about you and want to be sure you have the support you need," or "I'm worried about you. I've seen these scars on your arms and I think you might be hurting yourself. If you are, I want you to know that you can talk to me about it. If you can't talk to me about it, I hope you will find someone else you trust to talk to" demonstrate concern without judgment and may help to put a self-injurious student at greater ease.

Assessing self-injury

Who should assess?

Assessment of student needs and next steps will require input from the designated point person/team as well as from the nurse if there are open wounds that require attention. Unless the student is in obvious emotional crisis, kind and calm attention to assuring that all physical wounds are treated should precede additional conversation with the student about the non-physical aspects of self-injury. The wound severity, implements used, location of the injury and observed number of scars from old wounds can all be noted during treatment and discussed with the designated point person/team when triaging next steps. Asking straightforward medically-focused questions at this stage may also be appropriate if student is calm and willing to share. Questions of value in assessing severity and next steps include:

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

In addition to informing the nurse about the student's capacity for self-care, responses to these questions will be useful to the designated point person/team when assessing next steps related to parental notification and involvement, school responses and management, and engagement of external referral sources.

Should a suicide assessment be conducted?

Some students who self-injure may also be suicidal, either during the period in which they are injuring or later in their development. While it is uncommon for actively self-injurious students to be suicidal, suicide assessment is warranted – particularly if there is any reason to believe that the student might be actively suicidal. In this case, suicide assessment should occur immediately and, if suicidality is detected, suicide protocols should be followed from this point forward. Note that while a self-injurious student may not be or have ever been suicidal at the point at which self-injury was detected, the behavior does serve as a warning sign for some students that suicide may become an option later, especially if the distress underlying self-injury is not adequately addressed.



Research suggests that not all self-injury is equally severe. One study documented 3 self-injury classes⁶:

Superficial

- Low lifetime frequency (fewer than 11 episodes of self-injury)
- Use forms capable of resulting in largely superficial tissue damage (e.g., scratching or wound interference)
- Tend to use relatively few forms of self-injury behaviors
- This is the least severe level of lethality, however, people falling in this class might be at an increased risk for suicidal ideation compared to students who do not self-injure

Battery/light tissue damage

- Low lifetime frequency of self-injury (fewer than 11 episodes of self-injury)
- Use forms capable of resulting in light tissue damage (e.g., small punctures and bruising)
- Tend to use several forms over time (most serious form used results in light tissue damage)
- Members of this class are at a higher risk for suicidality, a history of trauma, and disordered eating in comparison to the superficial class and those who do not self-injure

Chronic/High severity

- High lifetime frequency of self-injury (greater than 11 incidents)
- Use forms capable of resulting in high tissue damage (e.g., cutting, ingesting caustic substances, bone breaking, etc.)
- Tend to use several forms over time (most serious form used results in high tissue damage)
- Members of this class are at the highest risk for suicidality, a history of trauma, and disordered eating in comparison to other self-injury classes and non-self-injurers.
- Members of this group are most likely to fulfill the classic “cutter” stereotype (e.g., they have self-injury routines, report some degree of perceived dependence on self-injury, report hurting themselves more than intended, and report life interference as a result of their self-injury)

What next?

Ideally, someone from the designated team will have the opportunity to talk to the self-injurious student immediately following the physical assessment or soon after. In general, response to self-injury, like many student behaviors at school, is heavily context-dependent. Immediate responses to students should be honest and respectful. Collecting basic information about a student’s self-injury practices and history will be important in determining the need for parental involvement and engagement of outside resources.

Overall, questions should aim to assess a) history, b) frequency, c) types of methods used, d) triggers, e) psychological purpose, f) disclosure, g) help seeking and support, and h) past history and current presence of suicidal ideation and/or behaviors. Decisions about next steps can be made based on the outcome of this assessment. In general, students are likely to fall into one of two risk categories:

Low risk students

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



Higher risk students

Students with more complicated profiles – those who report frequent or long-standing self-injury practices, who use high lethality methods, and/or who are experiencing chronic internal and external stress with few positive supports or coping skills – are likely to require more aggressive intervention and management. Unless there exists a high likelihood that it will pose an additional risk to the student, parental involvement will likely be indicated in these cases. It is important to note that students should be engaged as active participants in each step – even in cases where the next obvious step elicits resistance. Unless the student is in severe crisis and unable to function (in which case parents need to be contacted immediately) the decision to make parental contact should be discussed honestly and respectfully with the student.

Engaging parents

Ideally, the student should be encouraged to call his or her parents to talk about what occurred. The point person should also talk to the parent about the need for a meeting to talk about next steps. The meeting should include the student, parents, and the point person or crisis team and should be scheduled as soon after the event as possible. In the event that a student is reluctant to contact his or her parents, the crisis team must take responsibility and alert parents that their child might be in danger of harming him or herself in the future.

Since state and local laws surrounding student confidentiality and parent disclosure may vary, each school's policy about parental contact will need to be crafted in accordance with these regulations.

Parent meetings provide an opportunity for the crisis team to answer questions, address parental concerns and dispel any myths about self-injury that the parents might have.

It is also recommended that the team provide parents with both community and web-based resources for understanding and effectively addressing self-injury. Another important goal of the meeting is for the crisis team, parents and student to discuss how to create and maintain a supportive, appropriate environment for the student. Helping parents understand the difference between constructive and unhelpful responses to self-injury and related issues will be very important when it is obvious that parent-child dynamics may be contributing to the behavior.

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

Scheduling a follow-up meeting with parents and student before leaving the initial meeting is also useful. This typically occurs 1-2 weeks and no later than 1 month after the school detects a self-injury incident.

What are the legal issues surrounding parent notification and self-injury?

When the situation is deemed by the point person to require additional intervention, the point person should contact the student's parents or guardians. The American School Counselor Association requires confidentiality between students and counselors except in event that the student is at risk for harm.⁷ The literature surrounding self-injury suggests that elementary or secondary school staff should inform parents about their child's self-injuring behavior even if it is deemed that the child is not an immediate threat to himself or herself. In making this decision, the point person should account for all factors surrounding the student's situation, not just the severity of the injury. The student should be advised in advance of this and allowed to be present during the conversation.

It is the legal responsibility of the school to notify parents of their child's self-injury. If a parent of a student who is self-injuring does not make any effort to seek outside counseling or help for their child, their behavior may be seen as neglectful. The school does have the responsibility to report parental neglect to the local child protection agency.



What may parents be asked to do?

The purpose of involving parents is to ensure that the student will receive care and so that outside referrals to services can be made. Depending on the circumstances, the parent may be asked to:

- Initiate outpatient counseling for the child and/or family
- Agree to having the child receive enhanced academic and/or counseling supports within the school itself
- Provide releases of information to the school so that the crisis team/point person may communicate with any outside professionals who are assisting the student⁸

How might parents react and what kind of support can be provided?

Counselors should expect to see a wide range of reactions from parents. Some parents will respond quickly and favorably, but others may need more time and help in coping with their own thoughts and feelings.

What if parents feel guilty? Parents may think that their child is self-injuring because of something that they did or did not do as a parent. If the parent seems to be struggling with guilt or frustration, it may be helpful to remind them that they can also get counseling for themselves during this difficult time.

What if parents are dismissive about a student's problem? The school's role is to encourage the parents to be more responsive to their child's needs.

What if parents are enraged about a student's problem? The school's role is to encourage the parents to try and understand what their child might be going through, recognize that their child is suffering, and approach their child from a nonjudgmental stance.

How should we deal with parents that have extreme reactions? The school's job is to gently suggest that the parents seek outside counseling for dealing with their adolescent.

How can we encourage collaboration? Schools must encourage parents and students to use teachers and staff as resources.

What if the parents are absent, lack the financial capital to seek outside help or are unable to act as a resource and advocate for their child? The school must take initiative and act as an advocate for the student. Here, the crisis team may seek outside resources for the child. The crisis team may seek solutions to financial barriers preventing the student or family from seeking help.

While it is important to validate parent's reactions, certain parental attitudes towards self-injury can promote, trigger or maintain the behavior.⁹

Helping parents react with a calm, empathetic and comforting demeanor can ease the recovery process.

Identifying External Referrals

Finding local therapists and counselors to treat adolescents who are self-injuring is a challenge.

- The S.A.F.E. Alternatives website provides a listing of local therapists (by state) that are trained in self-injury treatment. This information may be found at http://www.selfinjury.com/referrals_therapistreferrals.html
- If there are not therapists trained in self-injury that are nearby, general guidelines on how to find a therapist can be found at http://www.selfinjury.com/referrals_findatherapist.html
- Another good resource for finding a local therapist is the listing of State and Provincial Psychological Associations, available from the American Psychological Association. This information can be found at <http://www.apa.org/practice/refer.html>
- The crisis team or point person can refer parents to the preface of Matthew Selekman's book *Working With Self-Harming Adolescents: A Collaborative, Strengths-Based Approach* for help in coping with a child's self-injury.



Social Contagion

What is social contagion? How can we identify a social contagion problem in our school?

Social contagion refers to the way in which a behavior such as self-injury can spread among members of a group. Social contagion is a possibility any time that other students become aware that someone among them is injuring. Dr. Barent Walsh notes that certain behaviors are susceptible to social contagion both because of their power to communicate as well as the provocative nature of their stigma.¹⁰ Sometimes, behaviors can be unintentionally reinforced by people outside of the group, including adults.

How can we prevent social contagion and self-injury in schools?

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

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

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

The example below provides reference to how a self-injury protocol may work in a real-life school setting:

Amanda is a 15 year old sophomore at City Y’s High School. One day, Tom, her gym teacher, notices both older and more recent scratches and scars on Amanda’s forearms and thighs that look like a sign of self-injury he learned about in school training sessions.

Tom is concerned that Amanda could be putting herself in danger by self-injuring. He contacts Barbara, the school social worker and designated self-injury crisis team point person, about his concerns.

Barbara and Tom talk about the scars Amanda has and together determine that she might be self-injuring. Barbara assures Tom that she will not reveal him as her source of the referral and will keep him updated on the course of action with Amanda. Since Amanda’s self-injury does not require immediate

care, the nurse need not be contacted immediately.

Soon after their discussion, Barbara asks to speak with Amanda and lets her know that she’s not in trouble. In their one-on-one meeting, Barbara tells Amanda that it has been brought to her attention that she may be injuring herself. Amanda denies it at first but eventually discloses that she has been injuring her forearms and thighs on and off for 8 months. Amanda says that she cuts herself when she’s angry with her mother, who recently divorced her

father and that her cutting makes her feel less angry. Barbara asks whether or not Amanda’s parents know about her self-injury, if anyone else knows, and about other resources Amanda has available for helping her cope with her feelings. Based on what Amanda has told her, Barbara believes that Amanda is not in immediate danger but does bring the case to the crisis team to decide the course of action. Barbara tells Amanda that she would like to have the nurse take a look at her scars so that she can be sure that none of



her injuries become infected and help her treat her older scars. Amanda concedes but asks that no one else know about her behavior. Barbara tells Amanda that she can promise not to talk to any of her peers and will share information with other adults in the school on a “need to know” basis only. Barbara does tell Amanda that she will need to consult with the school crisis team about how to best support her, but reassures Amanda that they will both be involved in any decisions that are made about what to do next.

The crisis team meets with Amanda present and decides, based on the information available, that Amanda will best be helped by treatment with a local psychotherapist who specializes in helping individuals who self-injure. Then Barbara contacts Amanda’s parents, with Amanda present, to make them aware of the situation and provide a referral for treatment. Amanda’s mother reacts with shock when Barbara tells her that her daughter has been cutting herself for 8 months. Barbara assures Amanda’s mother that Amanda is not trying to commit suicide, but rather that Amanda is having issues with her parents’

divorce that are manifesting in her cutting behavior. Barbara requests that Amanda’s mother come in for a meeting with the crisis team so they can discuss treatment options and how best to support Amanda while she deals with her self-injury. Barbara also gives Amanda’s mother the name of a psychotherapist in the area that specializes in treating self-injury that she should contact as soon as possible.

Despite the crisis team’s best efforts, Amanda’s mother refuses to come in for a meeting at the school. Barbara calls her mother again to ask her to send Amanda to the psychotherapist. In their follow-up phone call, Amanda’s mother explains that her work schedule and child care needs make it difficult for her to come into school and that is why she could not make a meeting. Barbara lets Amanda’s mother know that a meeting will not be necessary at the school, but that she must make an appointment for Amanda with the psychotherapist. She also gives Amanda’s mother some basic information about self-injury and how to remain supportive while her daughter is in treatment. She asks that

Amanda’s mother call her back when she has made an appointment with the psychotherapist and reminds her that she will be calling to get an update on Amanda’s progress each week and the mother agrees. Amanda’s mother does call for an appointment within the week and does eventually consent to a meeting with the school team.

Barbara assures Amanda that she can come to her at any time if she has any issues and that she will be meeting with her periodically to see how she is doing. Barbara follows up in two weeks and finds out that Amanda has started treatment with the psychotherapist and is actively working on other ways to deal with her feelings and stress. Although Amanda has not stopped self-injuring, she has slowed down and does agree to use the techniques the nurse gave her to treat her wounds as well as to limit the number of peers with whom she talks about her self-injury and to whom she shows her scars at school. Finally, Barbara talks with Tom, who originally disclosed Amanda’s self-injury, to let him know that Amanda has made progress in her treatment.

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School Protocol Process

The flowchart below can help school staff decide what action(s) to take after discovering that a student may be engaging in self-injury.

