

STUDENT NON-SUICIDAL SELF-INJURY: A PROTOCOL FOR SCHOOL COUNSELORS

Schools have a demonstrated need for student non-suicidal self-injury protocols and school counselors play an important role in the development and implementation of such procedures. This article presents an overview of school counselor considerations related to developing and implementing a self-injury protocol. It provides an example of a comprehensive school counseling protocol for addressing student self-injury, including a sample safety plan. The authors present a case study application and discuss implementation considerations.

Non-suicidal self-injury (hereafter referred to as self-injury or SI) is a relatively common behavior among adolescents, with researchers suggesting that upwards of 15-30% of high school students have engaged in this behavior at least once (Muehlenkamp, Claes, Havertape, & Plener, 2012). Shapiro (2008) defined SI as an act of self-harm that occurs in the absence of suicidal intent and involves tissue damage caused by scraping, biting, burning, constricting, cutting, hitting, gouging, inhaling, picking, scalding, scratching, stabbing, and/or severing. The prevalence of SI peaks during the adolescent years and diminishes in early adulthood (Muehlenkamp et al., 2012).

Self-injury is seemingly an increasing phenomenon, and school counselors are more frequently called upon to address behaviors related to self-injury (American School Counselor Association [ASCA], 2017; Hays, Craigen, Knight, Healey, & Sikes, 2009; Shapiro, 2008; Walsh & Muehlenkamp,

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2013). In accordance with the ASCA (2017) position statement on behaviors that are harmful and place students at risk, school counselors are leaders who work to identify and prevent self-injurious behaviors. School counselors are obligated to help youth access the resources they need in order to be resilient and successful. School counselors should educate school personnel, determine key allies in the school setting, accept referrals, provide responsive services, and provide key referrals in response to self-injurious behaviors (ASCA, 2017).

DESPITE A NEED TO SYSTEMICALLY ADDRESS STUDENT SELF-INJURY, ONLY A MINORITY OF SCHOOL COUNSELING PROGRAMS HAVE A SELF-INJURY POLICY IN PLACE.

Despite a need to systemically address student self-injury, only a minority of school counseling programs have a self-injury policy in place (Roberts-Dobie & Donatelle, 2007). Roberts-Dobie and Donatelle (2007) found that only 23% of their school counseling sample reported having an established school policy or plan for addressing SI; however, nearly all respondents reported the existence of school policies for suicide attempts, alcohol use, cases of abuse, and sexual harassment.

School counselors, among other school staff members, have reported uncertainty and frustration about knowing how to proceed in addressing, supporting, and intervening with students who self-injure (Best, 2006; Duggan, Heath, Toste, & Ross, 2011; Kibler, 2009). The majority of surveyed school counselors identified a need for more information, training, and publications to contribute to their understanding of SI (Best, 2005; Simpson, Armstrong, Couch, & Bore, 2010). Many school counselors have limited knowledge of the etiology and treatment of SI (Simpson et al., 2010), and only 42% of school counselors reported that they were comfortable in educating other staff members about SI (Roberts-Dobie & Donatelle, 2007).

To address this gap in the literature, this article provides an example of a protocol for student self-injury. This protocol incorporates the strategies outlined by previous writers (e.g., Kress, Gibson, & Reynolds, 2004; Walsh & Muehlenkamp, 2013) and integrates updated research and application tools (e.g., example safety plan, case study). The model presented is unique in that it specifically focuses on the roles and responsibilities of the school counselor and provides a visual flow chart that school counselors can use to facilitate their decision making.

The SI protocol presented in this article aligns with the ASCA National Model (ASCA, 2012) and can be a part of a comprehensive school counseling program. School counselors can use this protocol to help in advocating for student needs, designating key leaders within the school, and collaborating with school personnel, parents, and referral sources. The use of such protocols can help support counselor decision making, thus facilitating ethical behavior. It can also inform direct student service delivery and detail a concrete plan which enhances counselor accountability (ASCA, 2012).

SELF-INJURY PROTOCOL FOR SCHOOL COUNSELORS

Establishing and implementing SI protocols and safety plans in schools is crucial for ensuring that students consistently receive a standard of care in accordance with a counselor's role and responsibilities (Bubrick, Goodman, & Whitlock, 2010). A school protocol

is a fixed course of action regarding the handling of a particular issue in the student population that is agreed upon and adhered to by all school staff members (Shapiro, 2008; Walsh & Muehlenkamp, 2013). Counselors should spend at least 80% of their time delivering direct and indirect student services (ASCA, 2012). As a part of direct student services, counselors should allocate time for responsive services according to their students' needs (ASCA, 2012). As such, counselors will need to adjust their self-injury protocols to effectively provide a comprehensive school counseling program.

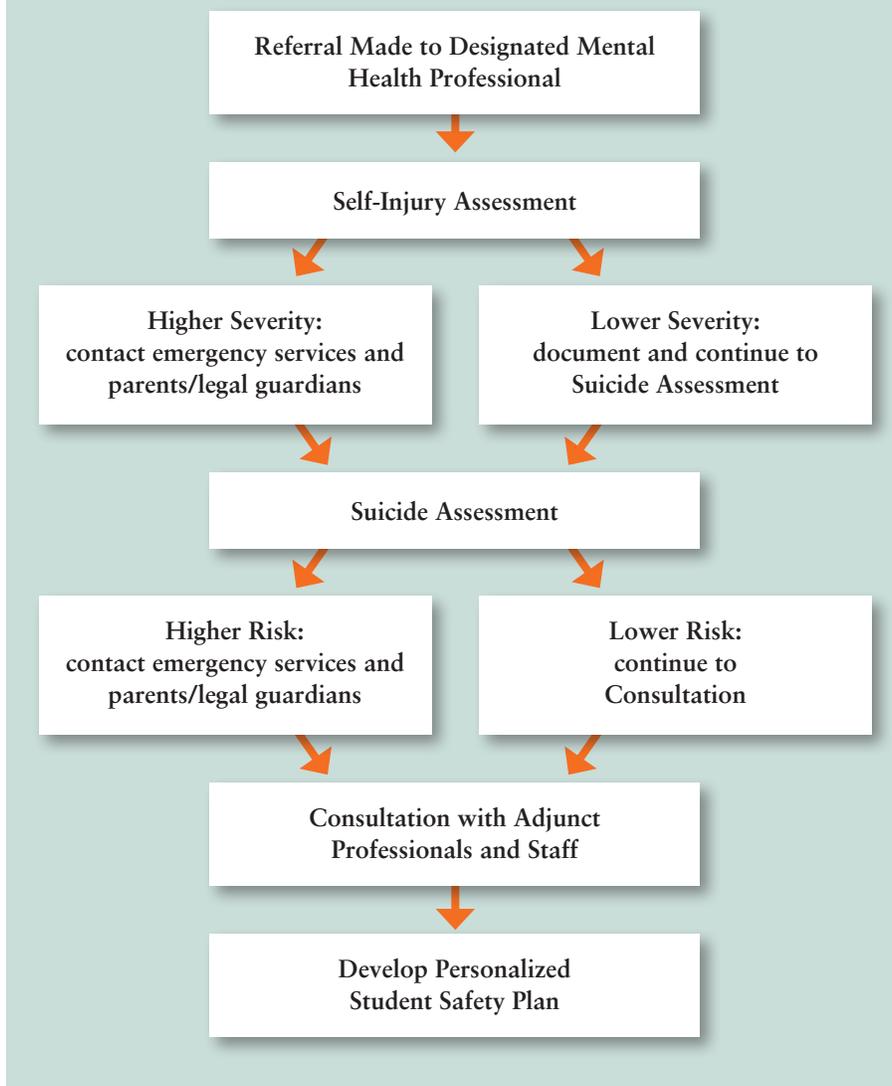
In the following sections, we present and discuss important aspects of school SI protocols, including those that involve immediate action and short- or long-term care for students who self-injure in the context of a school setting. A condensed version of the protocol is provided for ease of use (see Figure 1). Ultimately, each school counselor is responsible for knowing the implications and nuances of each step provided, and how the protocol should be modified to fit his or her unique school culture and climate.

School Counselor/Staff Roles and Responsibilities

As previously indicated, school counselors assume a primarily supportive and logistic role when working with students who self-injure. School counselors can also educate other school personnel about SI warning signs (ASCA, 2017; Duggan et al., 2011).

Upon learning about a student who self-injures, school counselors should be ready to accurately assess the student's needs and make appropriate referrals to outside services for treatment (Kress, Drouhard, & Costin, 2006). Group and individual counseling might focus on the development of alternative coping skills (e.g., verbal communication of emotions) and the use of alternative behaviors (e.g., relaxation, exercise) to replace SI (Hazell et al., 2009; Hollander, 2008; Lieberman, Toste, & Heath, 2008). School counselors should consult the most current literature to maintain an

FIGURE 1 EXAMPLE OF A SCHOOL COUNSELING PROTOCOL FOR SELF-INJURY.



SCHOOL COUNSELORS ASSUME A PRIMARILY SUPPORTIVE AND LOGISTIC ROLE WHEN WORKING WITH STUDENTS WHO SELF-INJURE.

updated understanding of the intervention strategies for students who self-injure.

When working with students who self-injure, a priority should be establishing a healthy, trusting relationship. School counselors can decrease students' discomfort by providing a safe and supportive environment; conveying a calm, supportive, and nonjudgmental demeanor; and approaching students with a respectful curiosity (Best, 2005; Shapiro, 2008). Students who have more trust in school personnel are less likely to engage in SI (Noble, Sornberger, Toste, Heath, & McLouth, 2011).

School personnel may become aware that a student is engaging in SI through personal observations or reports from other students. It is not uncommon for students who self-injure to reveal their behavior to a teacher or school staff member whom they trust and respect (Hawton, Rodham, Evans, & Harris, 2009; Lieberman et al., 2008; Noble et al., 2011). Education of staff members on SI warning signs and how to appropriately respond to young people who self-injure is important (Kress et al., 2004; Lieberman et al., 2008; Shapiro, 2008). Also important is that all school staff respond to student SI in a constructive, sensitive manner (Best, 2006).

Once it becomes apparent that a student has self-injured, the staff member should immediately report this information to the designated mental health professional (DMHP) for evaluation and assessment. Students should be assured that the situation will be kept confidential from their peers, but confidentiality cannot be guaranteed with parents (Kress et al., 2006). Whenever possible, school staff members should escort the student to the DMHP; however, if this is not possible, the school staff member can follow up with the DMHP to verify that the student was seen in a timely manner, preferably within one hour.

Education about the causes and warning signs of SI is vital for all students so that they are better empowered to report the behavior to school staff. All students should also be made aware of the DMHP and encouraged

to confide in any school personnel whom they trust if they become aware of a student who self-injures. All school personnel should know to immediately contact the DMHP with this information.

Designated Mental Health Professional

The DMHP is responsible for screening self-injury referrals. Because of a school counselor's unique position in providing early identification, inter-

vention, prevention, and advocacy, the school counselor is often designated as the person who responds to such referrals and may be the DMHP (Kress et al., 2004). A backup referral person should be available for occasions when the primary person is unavailable. The backup person might be the school nurse, school social worker, a teacher, or the principal. When in the role of DMHP, school counselors should take care to ensure that they have a backup DMHP

who is educated about SI and well equipped to address referrals if the school counselor is unavailable.

Any suspected or reported student self-injury should be referred to the DMHP. After receiving a referral, the DMHP should meet with the student within one hour of the report. Documentation is imperative when working with students who self-injure, and as such, the DMHP should document all interactions with the student (Roberts-Dobie & Donatelle, 2007). Documentation allows school counselors to keep track of their actions and demonstrate that they have followed appropriate procedures. Furthermore, to ensure best practice, the DMHP should have contact information for one or more mental health treatment providers who specialize in SI if outside consultation or a treatment resource is needed (Kress et al., 2004).

Self-Injury Assessment

Once the DMHP has received a student referral and substantiated that the student has self-injured or is engaged in regular self-injury, completing a self-injury assessment is important. Students may self-injure in a number of ways and on various parts of the body, including those that are easily covered or disguised, such as the wrists, upper arms, thighs, and stomach.

WHEN WORKING WITH STUDENTS WHO SELF-INJURE, A PRIORITY SHOULD BE ESTABLISHING A HEALTHY, TRUSTING RELATIONSHIP.

When assessing the behavior, counselors might inquire about: student's age at onset, lifetime and current frequency of self-injury, course of the behavior, changes in the behavior over time, longest period free of the behavior, emotional states when injuring, triggers leading to the self-injury, immediate and more long-term aftermath of injuring, use of substances before and after injuring, sharing cutting implements, wound care, medical complications (e.g., infections, stitches), past

attempts to stop injuring, control (i.e., success in stopping oneself), resistance (i.e., effort to stop oneself), impulsivity of self-injury, and dystonicity (i.e., a wish to stop one's self from injuring). This information can be used in a variety of ways. An open discussion about SI can increase the therapeutic relationship and be therapeutic in itself. School counselors will learn about the nature and severity of the student's SI, which will be helpful when implementing the comprehensive protocol and making referrals. School counselors also can use assessment information to inform appropriate interventions in the school.

Students who self-injure might attempt to hide their wounds because they wish to maintain the behavior without interruption (Shapiro, 2008). As such, they may be hesitant to show their injuries to anyone, particularly an adult authority figure. It is imperative that all school personnel respect the student and avoid any form of punitive inspection. Physical assessment is important so that school nurses or other medical providers can ensure students are physically well, and so that school counselors know how to personalize their interventions.

School counselors should address the topic of physical assessment with caution and make specific attempts to help maintain the student's dignity

(Kress et al., 2004; Shapiro, Heath, & Roberts, 2013). Directly assessing physical injuries is outside the scope of practice for school counselors; instead, the school counselor should refer the student to the school nurse or the student's general medical practitioner for a physical assessment. Health care professionals can provide first aid and/or immediate care, and communicate the severity of the injuries—and any related implications—to the school counselor (Shapiro, 2008).

Once the school counselor has garnered information about the student's self-injury, they can better determine which risk category the student falls into: high severity or low severity. High-severity SI tends to be more chronic and results in greater tissue damage than does low-severity SI (Whitlock, Muehlenkamp, & Ecknerode, 2008). Moreover, students whose SI is severe are more likely to use multiple means of harming themselves, have an elevated risk of an abuse history, and experience higher rates of suicidality than students whose SI is lower in severity (Whitlock et al., 2008).

Higher severity. In some cases, students may self-injure in severe ways that suggest they are at risk for serious health problems or accidental or deliberate suicide. High-risk considerations might include cutting deeply or in potentially hazardous areas, using particularly sharp objects, sharing cutting implements with others, or failing to care for their wounds (Kress et al., 2006). As such, school counselors must talk with students directly about their self-injury, gathering information such as (a) preferred methods (i.e., tools) for self-injuring, (b) frequency of self-injury, (c) depth and severity of wounds, (d) triggers for self-injury, (e) antecedents and consequential results, and (f) wound care. This information will help guide the school counselor in interpreting important dimensions of the self-injury, including (a) level of risk the self-injury tool(s) may pose (e.g., rubber eraser versus razor blade; keeping tools clean versus using contaminated tools; sharing tools with others); (b) severity of distress (i.e., higher frequency and more damaging wounds often point to elevated distress); (c) functions of the self-injury (e.g., emotion regulation, self-punishment, antidissociation, interpersonal influence, communication of distress); and (d) wound care practices and likelihood of infection (Kress et al., 2006; Walsh & Muehlenkamp, 2013).

If the school counselor identifies that students pose a marked danger to themselves, the counselor should contact the parents and provide them

with resources to help facilitate their child's safety. These resources may include information about hotlines, local mental health providers, and psychoeducational material on the subject of self-injury (Lloyd-Richardson, 2010). When students engage in severe self-injury and require urgent medical attention, parents and emergency services should be contacted immediately.

Lower severity. For students who self-injure in non-lethal and lower severity ways (e.g., delicate self-cutting and/or using relatively benign tools), practice proper wound care, and do not engage in other related risky behaviors (e.g., sharing self-injury tools; engaging in severe, impulsive self-injury during moments of acute distress), school counselors may choose to contact parents when appropriate, noting that parents will need to be notified sooner rather than later (Walsh & Muehlenkamp, 2013). Physical wounds may be monitored by the school nurse. When school counselors work with students, psychoeducational strategies may be helpful to help them identify and develop more adaptive coping strategies (Whisenhunt, 2012).

Suicide Assessment

Although self-injury and suicide are by definition separate behaviors, an emerging body of literature suggests that the two co-occur with some frequency (Hamza, Stewart, & Willoughby, 2012). Regardless of whether the self-injury is high or low severity, school counselors should always conduct a suicide risk assessment with students who self-injure (Lloyd-Richardson, 2010). Assessing for impulsivity is especially important because impulsive suicide attempts are a significant suicide risk factor when working with adolescents, some of whom may not appear particularly depressed or hopeless (Spokas, Wenzel, Brown, & Beck, 2011).

Performing the initial suicide risk assessment and screening for suicide risk on an ongoing basis is imperative when working with students who self-injure, but counselors should also avoid assuming the student is suicidal

(Brown & Kimball, 2013). School counselors should use multiple means of assessing suicidal ideation; student self-report is not always a reliable suicide risk assessment method (Toprak, Cetin, Guven, Can, & Demircan, 2011). School counselors can choose to use standardized tools to assess for suicidality, such as the Self-Injurious Thoughts and Behaviors Interview (SITBI; Nock, Holmberg, Photos, & Michel, 2007); the Suicide Attempt Self-Injury Interview (SASII; Linehan, Comtois, Brown, Heard, & Wagner, 2006); or the Columbia Suicide Severity Rating Scale (C-SSRS; Posner et al., 2010). In addition to these assessment tools, school counselors should consider talking with students about any past suicidal thoughts or attempts and monitor the use or abuse of substances; adolescents who abuse substances may be at an increased risk for suicide attempts (Toprak et al., 2011).

DIRECTLY ASSESSING PHYSICAL INJURIES IS OUTSIDE THE SCOPE OF PRACTICE FOR SCHOOL COUNSELORS; INSTEAD, REFER THE STUDENT TO THE SCHOOL NURSE OR THE STUDENT'S GENERAL MEDICAL PRACTITIONER.

Experiencing ambivalent feelings about living and dying when self-injuring is common. Such ambivalence may produce an increased risk for suicide—both intentional and unintentional. Talking with students about their perceived reasons for living may help the school counselor gauge the student's level of risk (Hawton et al., 2009; Muehlenkamp & Gutierrez, 2004), and provide useful information when identifying protective factors and strengths. Multiple protective factors may help to insulate students from suicide risk. Particularly for adolescents, having support from family can be a major insulating factor (Brausch & Gutierrez, 2010; Toprak et al., 2011).

Higher risk. A student with a higher suicide risk displays warning signs that indicate imminent threat and require

immediate intervention. Behaviors that suggest a high suicide risk include threatening to take one's life, talking or writing about suicide or death, and seeking access to means of suicide. Another factor that indicates high suicide risk is high-severity self-injury (see above) with related suicidal ideation (Rudd et al., 2006). Other warning signs may indicate that the threat of suicidality is close, but may not require immediate referral to emergency services. These signs include (a) hopelessness; (b) anger and acting out; (c) impulsivity and recklessness; (d) feeling trapped; (e) increased use of alcohol and/or drugs; (f) isolation and withdrawal; (g) anxiety and agitation; (h) difficulty sleeping or sleeping all of the time; (i) drastic changes in mood, including improvement; and (j) feeling purposeless or finding no meaning in life (Rudd et al., 2006). Intentionally and accurately assessing a student's

suicidal risk is important for school counselors.

When a student presents with high suicide risk, the school counselor should immediately contact the student's parents (Shapiro, 2008). When risk is perceived to be imminent, students should be referred to emergency services. When students do not require immediate intervention by emergency services, the school counselor should intentionally work to promote continued and improved student safety (Kress et al., 2004). The parents and student should be included in the collaborative development of a functional safety plan (discussed later in this article).

Lower risk. Suicide and SI are distinct behaviors, and not all students who self-injure are also suicidal (Shapiro et al., 2013; Walsh & Muehlen-

FIGURE 2 EXAMPLE OF A SCHOOL COUNSELING SAFETY PLAN FOR SELF-INJURY.

kamp, 2013). Some students who self-injure might not endorse any suicidal ideation. Students who self-injure and endorse some suicidal ideation would likely be classified under low risk if they deny an actual plan for killing themselves and do not display significant levels of any of the behaviors listed previously under the high risk category (Whisenhunt, 2012). When working with students who self-injure, continuously monitoring the student and reassessing at clinically relevant intervals is important.

Continuous suicide risk assessment is particularly important when working with adolescents because the factors that contribute to their emotional pain may worsen quickly, and adolescents are likely to engage in impulsive suicidal gestures (Spokas et al., 2011). When working with students who self-injure but indicate little to no risk of suicide, the school counselor should contact the student's parents or legal guardians when therapeutically appropriate and refer the student to a clinical mental health professional within a reasonable amount of time (Kress et al., 2004).

Consultation

After gathering a holistic understanding of the student's physical severity and suicide risk level, the school counselor should consult with a colleague to determine how to intervene (ASCA, 2016, A.9.a.). Consultation is imperative when working with students who self-injure because of the many complicated safety, confidentiality, and referral issues that need consideration (Hays et al., 2009; Shapiro, 2008). Before consulting, school counselors should identify the steps and considerations they plan to take. After consulting, school counselors should confirm their plans with their supervisor, principal, or the individual who oversees their work. School counselors should consult with other professionals continuously as the process unfolds.

Personalized Student Safety Plan

The personalized safety plan is the final suggested step in a SI school coun-

seling protocol. School counselors can help students create a written personalized safety plan that can be shared with parents, appropriate school staff, administration, and mental health professionals. The personalized safety plan can include the school counselor's role in supporting the student's safety and the roles of other school personnel, parents, and other mental health

professionals (Nock, Teper, & Hollander, 2007). Counselors should keep in mind that up to 30% of adolescents report self-injuring at least once (Muehlenkamp et al., 2012). In light of this, counselors may need to prioritize high-risk students and adjust their personalized safety plans in order to realistically manage a comprehensive school counseling program.

Personalized Student Safety Plan

Student Name: Lydia Frantz

Date: 12/13/17

School Counselor Completing Plan: Ashley Valenzuela, LSC, NCC

Steps Completed to Date:

1. Individual meeting with student (12/12/18; 9:00am); SI severity assessment (lower severity -based on self-report); suicide assessment (lower risk severity -based on self-report)
2. Parental Contact (left voicemail 12/12/18 9:30am; phone call with mother 1:00pm)
3. Consultation with school counseling coordinator, Loretta Ross (12/13/18 10:00am)

Referrals:

1. School nurse (met with student 12/12/18; 2:00 pm)
2. Local Adolescent Clinical Mental Health Counseling Agency (12/12/18)—contact information provided verbally to mother via telephone; written contact information given to student; follow-up weekly until release to coordinate services obtained from parents.

Proposed In-school Interventions:

1. Individual meetings; 15 minutes once per week.
2. Group meetings; 60 minutes once per month.
3. Student is encouraged to seek support from school counselor as needed.

Follow-up Plan: Reassess suicidality and SI severity at every individual meeting; consider reducing frequency of weekly individual sessions as improvements are noted. Phone call with parents and clinical counselor once per month until student is stabilized.

Reassess safety plan: 3/13/18

Student Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

While facilitating student safety and wellness, the safety plan also serves as documentation that the school counselor has followed the steps previously discussed in the comprehensive protocol and fulfilled all ethical and legal obligations to the student (Bubrick et al., 2010). See Figure 2 for an example of a self-injury safety plan.

Referrals. Although school counselors can offer supportive counseling services, students who self-injure will need referrals for additional support services including mental health treatment, and these referrals might be integrated into the student's safety plan (Kress et al., 2006). To prepare to make referrals, school counselors might use in-service days to visit local mental health facilities and gain a greater understanding of community treatment resources that can be used to support student wellness (ASCA, 2016, C.b.; Kress et al., 2004).

Referrals can be partial or complete in nature. Partial referrals are preferable in most cases because they allow the school counselor to continue to provide support to the student during school hours (Kress et al., 2004). However, the school counselor must take care to collaborate with the outside mental health professional to ensure that no interventions are contradictory to outside treatment (Nock, Teper, & Hollander, 2007).

If referrals to outside professionals are provided to parents, school counselors should attempt to obtain a written release allowing them to communicate with the outside mental health professionals. Regardless, school counselors should request confirmation of these appointments to ensure that students' needs are being met. Doing their best to ensure their students receive the proper care to remain safe is imperative for school counselors (ASCA, 2016, A.10.a.).

Interventions. According to student need, school counselors might implement time-limited mental health interventions in the school setting (ASCA, 2016; 2012), and these interventions might also be integrated into a student's safety plan. Individual

interventions in the school are likely to occur during short one-on-one meetings; counselors should focus on coping skills that help students control the urge to self-injure and help students communicate their emotions in productive, adaptive ways (Lieberman et al., 2008). School counselors should work to match their therapeutic interventions to the function the self-injury serves (i.e., emotion regulation, feeling generation, interpersonal influence, or sensation seeking). For instance, students who self-injure as a means of emotion regulation may find mindful breathing, visualization, and music to be helpful ways to self-soothe. Some students may self-injure as a means of communicating with or influencing others. In these instances, students may learn to talk assertively or express themselves through writing or art. Finally, students who self-injure as a means of seeking sensation may find physical exercise to be an effective alternative.

cus group sessions on common issues that contribute to the students' SI and consider the following group-related recommendations offered by Richardson et al. (2012): (a) teach students when and where it is appropriate to talk about SI, (b) ask students to cover injuries to avoid triggering others, (c) disallow students from talking about their SI in detail, (d) encourage healthy coping strategies, (e) ask students to focus sessions on their accomplishments and growth, and (f) talk with students about their use of websites that encourage SI, to minimize use of these sites. In-school counseling interventions should be coordinated with students' outside mental health professionals (Hazell et al., 2009). Such interventions should be documented in the safety plan, and coordination/follow-up plans should be noted (Shapiro, 2008).

Follow-up. School-based professionals should consider setting up regular meetings with the student, parents,

SCHOOL COUNSELORS SHOULD ALWAYS CONDUCT A SUICIDE RISK ASSESSMENT WITH STUDENTS WHO SELF-INJURE. ASSESSING FOR IMPULSIVITY IS ESPECIALLY IMPORTANT.

School counselors may elect to provide group interventions, with care, for SI. Researchers suggest that a social contagion effect is associated with group interventions, in which discussing the triggers, methods, and results of SI can increase youth's desires to use this unhealthy coping skill (Jarvi, Jackson, Swenson, & Crawford, 2013; Richardson, Surmitis, & Hyldahl, 2012; Walsh & Muehlenkamp, 2013). However, the degree to which SI is socially transmitted is not clear. Group interventions can help members feel a sense of bonding or belonging to their peers, as it helps them communicate their distress, highlight areas of accomplishments, and reduce feelings of isolation (Richardson et al., 2012; Walsh & Muehlenkamp, 2013).

Because of the possibility of social contagion, school counselors may fo-

school personnel, and outside professionals to discuss student progress and ensure the safety plan remains comprehensive and relevant. Meetings with the student can allow school counselors to continuously monitor the self-injury and conduct ongoing suicide assessments. Meetings with the student and school personnel can be used to identify in-school triggers for SI and supports to help minimize such triggers. Follow-up meetings with the student, parents, and outside professionals can be helpful in tracking and reviewing treatment progression and any necessary adjustments to the safety plan (Shapiro, 2008). Establishing a network of communication among school counselors, outside professionals, and parents can provide the student with the best care and support.

APPLICATION EXAMPLE

Lacey is a 14-year old, biracial, eighth-grade student who attends a public middle school. She is an honor roll student enrolled in advanced mathematics and English courses, and she excels as a member of both the school's basketball and soccer teams. For the past 10 years, Lacey and her younger brother have lived with her maternal grandmother due to her mother's substance abuse. Recently, her mother achieved one year of sobriety and requested that Lacey and her brother, age 8, return to live with her. Lacey's grandmother has been facing several health and financial challenges, and agreed to allow the children to return to live with their mother. Lacey and her brother continue to visit with their grandmother on weekends, and occasionally spend the night during the week.

CONSULTATION IS IMPERATIVE WHEN WORKING WITH STUDENTS WHO SELF-INJURE BECAUSE OF THE MANY COMPLICATED SAFETY, CONFIDENTIALITY, AND REFERRAL ISSUES THAT NEED CONSIDERATION.

After basketball practice, Michelle, one of Lacey's teammates, notices several cuts and scars on Lacey's legs and feet, and questions her about their cause. Lacey becomes upset and defensive, and tells her teammate that it is none of her business. Since moving in with her mother, Lacey's teachers have noticed a change in her academic performance and that she seems to be disengaged from her peers. Michelle reports her concerns about Lacey's cuts to her coach, who then informs the school's designated mental health professional (DMHP) and school counselor, Ms. Davis.

Ms. Davis requests that Lacey come to her office. Prior to their meeting, Ms. Davis consults with some of

Lacey's teachers to inquire about any recent changes in her behavior. Lacey arrives, puzzled about the meeting, and Ms. Davis explains that some of the school staff have shared concerns about her wellbeing. Ms. Davis continues to build trust and rapport with Lacey by demonstrating warmth, empathy, and unconditional positive regard, and maintains a nonjudgmental demeanor. Lacey begins to express the difficulties she is experiencing secondary to her return to her mother's custody, and she also shares that she is experiencing struggles related to her transition to high school and her racial identity. Lacey states, "I don't know where I fit in, or who I want to be."

Ms. Davis then asks Lacey about the incident with Michelle, and she inquires about both abuse and self-injury. Lacey reports that she has been using razor blades to self-injure on her upper thighs and feet, areas that she is able to hide with clothing. The onset of the self-injury coincides with her move to her mother, and she reports

that cutting helps her to alleviate her "stress." Ms. Davis provides brief psychoeducation on self-injury and the school's policy related to self-injury, and she talks with Lacey about the school nurse providing a physical evaluation of her wounds. Lacey's wounds do not appear to be infected or life threatening and the nurse discusses safety issues related to self-injury.

Ms. Davis then assesses Lacey for suicide risk, and Lacey discloses that while she has thought about "what it would be like if I wasn't here," she has no suicide-related plans or intent. Lacey shares several suicide protective factors, including concerns about who will care for her younger brother if she is not around. Ms. Davis consults with

a local mental health counselor affiliated with the school, as well as some of Lacey's teachers and her coach. Lacey and Ms. Davis collaboratively develop a safety plan. With Lacey's permission, Ms. Davis contacts Lacey's mother and invites her to a session to discuss safety planning and the self-injurious behavior. At the meeting, Ms. Davis provides Lacey and her mother with a referral for mental health counseling to further address her self-injury and other associated issues.

DISCUSSION

School counselors are in a unique position to provide support to students who self-injure. School counselors must be aware of multiple ethical considerations, such as maximizing student privacy, determining the timing and degree of parental involvement, helping to minimize risk to students, adhering to school policies, and maintaining current knowledge and professional competence in the area of self-injury intervention (ASCA, 2016). To fulfill these professional responsibilities, school counselors should work with administrators to develop a comprehensive school protocol to address student SI (Bubrick et al., 2010). At minimum, this protocol should include the following elements: (a) the appointment of a designated mental health professional (DMHP) within the school who can serve as a point of contact for students who self-injure and assign roles and responsibilities to all involved school staff, faculty, and administrators; (b) a physical assessment of the wounds to acquire any necessary physical care and aid in the risk assessment process; (c) a comprehensive suicide risk assessment with identified levels of risk; (d) a process for professional consultation; and (e) a personalized safety plan including referral sources within the community, in-school support, and follow-up.

Educating school personnel and students on the warning signs of SI is an important part of a comprehensive school strategy for addressing self-

injury (Bubrick et al., 2010; Duggan et al., 2011). Students are most likely to tell a trusted peer or teacher when they self-injure, and only a portion of students may confide in a mental health professional (Lieberman et al., 2008). Because fellow students and teachers are in the position to identify SI and respond in supportive ways, providing them with accurate information about SI and how to respond when a student discloses self-injury is imperative.

When working with students who self-injure, a school counselor's primary focus should be on establishing and maintaining a strong relationship. Because of the secretiveness and stigma associated with SI, this population requires a nonjudgmental stance (Shapiro, 2008; Shapiro et al., 2013). Once the school counselor has established rapport, exploring the functions of self-injury is important because these will differ between students and may change over time. Student self-report is unlikely to be entirely accurate but may provide helpful information regarding treatment needs and risk assessment. Follow-up should include not only communication with other mental health professionals and parents, but also ongoing support and connection with the students.

Future research on the topic of SI in the schools is warranted. Specifically, research on the types of policies and protocol components schools use and find helpful would add to the existing literature base. A review of policies that are demonstrated to be less helpful may also inform school counselor practice (Bubrick et al., 2010).

School counselors must consider multiple factors when creating a comprehensive school counseling SI protocol. This article provides important elements of an SI protocol, but school counselors should explore additional resources that may best assist them in providing support in their distinct school settings (e.g., the Cornell Research Program Guides, Bubrick et al., 2010). Just as each student and each school setting is unique, a school self-injury protocol must also be unique. A well-tailored self-injury protocol can

help ensure that each student receives the individualized, ethical support they require. ■

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