GW4-AF4-003

GW4 Children and Young People's Self-harm and Suicide Research Collaboration: Report

Rhiannon Evans, Abigail Russell, Frances Mathews, Rachel Parker, the Self-harm and Suicide in Schools GW4 Research Collaboration, and Astrid Janssens.

GW4 Self-harm and Suicide in Schools research collaboration: Lucy Biddle, Tamsin Ford, David Gunnell, Nina Jacob, Ann John, Judi Kidger, Becky Mars, Christabel Owens, Jonathan Scourfield and Paul Stallard.

Acknowledgements and funding

We would like to thank the schools that participated in our study, our colleagues at the University of Swansea, and GW4 who funded this collaboration (ref GW4-AF4-003)

Author affiliations
University of Bath: Prof Paul Stallard
University of Bristol: Dr Lucy Biddle, Prof David Gunnell, Dr Judi Kidger, Dr Becky Mars
Cardiff University: Dr Rhiannon Evans (PI Cardiff), Dr Nina Jacob, Rachel Parker, Prof Jonathan Scourfield
University of Exeter: Dr Astrid Janssens (PI Exeter), Prof Tamsin Ford, Frances Mathews, Dr Christabel Owens, Dr Abigail Russell
Swansea University: Dr Ann John

How to cite this report: Evans, R., Russell, A.E., Mathews, F., Parker, R., the Self-Harm and Suicide in Schools GW4 Research Collaboration and Janssens A. 2016. **GW4 Children and Young People's Self-harm and Suicide Research Collaboration: Report**. Available from: http://medicine.exeter.ac.uk/research/healthresearch/childhealth/child-mental-health/

Further information

If you would like further information about this project, please contact either:

Dr Astrid Janssens
University of Exeter
A.Janssens@exeter.ac.uk
01392 726 002

Dr Rhiannon Evans
Cardiff University
EvansRE8@cardiff.ac.uk
02920 870 099

Table of Contents

1. Introduction 7
2. Methods 9
2.1 Sample and recruitment 9
2.1.1 Wales 9
2.1.1.1 Survey 9
2.1.1.1.1 Sample and recruitment 9
Figure 1: Study sample and recruitment 10
Table 1. Difference in survey response rates Wales 11
Table 2. Professional role of respondents in Wales (n=94) 11
Table 3. Socio-demographic profile of schools participating in qualitative consultation Wales 12
2.1.2 South-West England 13
2.1.2.1 Survey 13
2.1.2.1.1 Sample and recruitment 13
2.1.2.1.2 Response rates and respondents 13
Table 4. Difference in survey response rates South-West England 13
Table 5. Professional role of respondent South-West England (n=59) 14
Table 6. Socio-demographic profile of schools participating in qualitative consultation South-West England 15
2.2 Data Collection 15
2.2.1 Survey 15
2.2.2 Qualitative consultation 16
2.3 Analysis 16
2.3.1 Survey analysis 16
2.3.2 Qualitative analysis 16
3. Results 18
3.1 Survey 18
3.1.1 Health priorities of schools 18
Table 7. School health priorities in Wales (n=96) 18
Table 8. School health priorities in South–West England (n=59) 19
3.1.2 Usefulness of health promotion and intervention provisions 19

Figure 2. Usefulness of health promotion and intervention provision (All schools n=153) 20

Table 9. Usefulness of health promotion and intervention provision (Wales n= 94).....21

Table 10. Usefulness of health promotion and intervention provision (South-West England n=59) 21

3.1.3 Prevalence of student self-harm.....22

Figure 3. Prevalence of student self-harm (All schools n=153) 22

Table 11. Prevalence of student self-harm (Wales n=94).....23

Table 12. Prevalence of student self-harm (South-West England n=59).....23

3.1.4 Self-harm prevention and intervention provision 23

Figure 4. Self-harm prevention and intervention provision (All schools n=153).....24

Table 13. Self-harm prevention and intervention provision (Wales n=94) 25

Table 14. Self-harm prevention and intervention provision (South-West England n=59) ..26

3.1.5 Usefulness of self-harm prevention and intervention provision.....26

Figure 5: Usefulness of self-harm prevention and intervention provision (All schools n=153) 27

Table 15. Usefulness of self-harm preventions and intervention provision (Wales n=94) .29

Table 16. Usefulness of self-harm preventions and intervention provision (South-West England n=59).....27

3.1.6 Delivery agents of self-harm prevention and intervention provision 28

Figure 6: Delivery agents of self-harm prevention and intervention provision (All schools n=153) 28

Table 17. Delivery agents of self-harm prevention and intervention provision (Wales n=94) 29

Table 18. Delivery agents of self-harm prevention and intervention provision (South-West England n=59).....30

3.1.7 School staff training on self-harm.....31

Table 19. Receipt of training for school staff 31

Table 20. Training provider for school staff training for student self-harm 32

3.1.8 Barriers to self-harm prevention and intervention 34

3.1.9 Participation in future research on self-harm prevention and intervention development 38

3.2 Qualitative consultation.....40

3.2.1 Perception of self-harm 40

3.2.1.1 Self-harm typologies....40
3.2.1.2 The emotive nature of self-harm....42
3.2.1.3 Self-harm as a coping strategy....42
3.2.1.4 Managing self-harm: *'doing the right thing'*....42
3.2.1.5 Pressure of the school context....43
3.2.1.6 Part of mental health....43
3.2.2 Prevention....44
3.2.2.1 Promotion of mental health and wellbeing....44
3.2.2.1.1 Promotion of student mental health and wellbeing....44
3.2.2.1.2 Physical location of mental health support in schools....45
3.2.2.2 Raising awareness....46
3.2.2.2.1 Self-harm awareness for students and staff....46
3.2.2.2.2 School website and newsletter....47
3.2.2.2.3 Signposting....47
3.2.2.2.4 Contagion of self-harm....48
3.2.3 School Processes for self-harm intervention and management....49
3.2.3.1 Responsibility....49
3.2.3.2 Disclosure and detection of self-harm....50
3.2.3.3 Safeguarding procedures....51
3.2.3.4 Risk assessment, classification of harm and triaging....51
3.2.3.5 The containment of self-harm....52
3.2.3.6 Harm minimisation....53
3.2.3.7 Promotion of alternative coping strategies....53
3.2.4 Key people involved....54
3.2.4.1 Parents....54
3.2.4.1.1 Informing parents about self-harm....54
3.2.4.1.2 Family functioning and parenting style....55
3.2.4.1.3 School as a place for advice and consultation for parents....55
3.2.4.2 Peers....56
3.2.4.2.1 Peer mentoring....57
3.2.4.2.2 Social media: Peer culture around self-harm....58
3.2.4.2.3 Social media intervention and management of self-harm....59

3.2.5 Future aspirations and unmet needs....59
3.2.5.1 Early identification....59
3.2.5.2 Awareness and prevention....60
3.2.5.3 Improved links with external services....61
2.2.5.4 Toolkits of strategies....61
4. Discussion....62
5. References....68
6. Appendices....70
Appendix A: Survey administered to secondary schools in Wales....70
Appendix B: Survey administered to secondary schools in South-West England....74
Appendix C: School research agreement....83
Appendix D: Participant information sheet....86
Appendix E: Participant consent form....88
Appendix F: Focus group and interview topic guide....89
Appendix G: School survey data....92
Table S1. Usefulness of health promotion and intervention provisions (All schools n=153)....92
Table S2. Prevalence of student self-harm (All schools n=153)....92
Table S3. Self-harm prevention and intervention provision (All schools n=153)....93
Table S4: Usefulness of self-harm prevention and intervention provisions (All schools n=153)....94
Table S5: Delivery agents of self-harm prevention and intervention provisions (All schools n=153)....95
Table S6. Barriers to self-harm prevention and intervention (All schools n=153)....96

1. Introduction

Self-harm refers to any act with a non-fatal outcome where an individual engages in a behaviour or ingests a substance with the intention of causing harm to themselves (1). The definition of self-harm is contentious, with increased differentiation between non-suicidal self-injury (NSSI) and acts that have an associated suicidal intent (2-4). However, both behaviours share a number of risk factors (5), suggesting that they may be conceived as lying along the same continuum. Self-harm is an established risk factor for suicidal ideation (6) and completed suicide (7,8). It is a growing concern amongst young people. Hospital admissions for self-harm amongst young people aged under 25 increased 68% between 2001-2011. Community samples of UK adolescent populations estimate that prevalence ranges from 6.9% to 18.8% (6, 9-11).

The effectiveness of interventions for children and young people who engage in self-harm remains limited, with a recent Cochrane review commenting on the paucity of evidence (12). Furthermore, whilst school-based interventions have demonstrated impact for suicidal ideation, suicide attempt and suicide, there is a dearth of approaches addressing self-harm within this context. Some professional support tools are increasingly being made available, such as "Signs of Self-Injury" (SoSI) (13), which is informed by the evidence-based Signs of Suicide prevention programme. However, the effectiveness of this approach has not been established. A recent meta-ethnography, which systematically reviewed qualitative evidence, theorised how schools' existing structures may prevent the effective management of self-harm, and may even exacerbate such behaviours (14). The review highlighted how self-harm is often rendered invisible within schools, due to a limited conceptualisation of self-harming behaviours and the lack of time to identify them. As a consequence, self-harm is often not prioritised, and structures and support systems to equip staff in prevention and intervention are rarely provided. Rather, staff escalate instances of self-harm through the hierarchical structures of the school in the effort to locate 'expertise', which often comes from an external source. This approach sits in sharp contrast to the stated needs of students, who value communication with staff, whilst recognising the importance of being listened to.

The present study aims to ascertain the existing provision of student self-harm prevention and intervention activities, along with future needs, in secondary schools in Wales and South-West England. Data are generated through a cross-sectional survey with a convenience sample of schools complete with an embedded qualitative consultation with case-study schools. The study addresses the following research questions:

1. What student self-harm prevention and intervention activities are currently delivered by secondary schools in England and Wales?
2. What prevention or intervention needs do secondary schools in England and Wales have in regard to student self-harm?
3. What would be key to an acceptable and feasible prevention or intervention approach for addressing student self-harm in secondary schools in England and Wales?

2. Methods

A cross-sectional survey was conducted with a convenience sample of secondary schools in Wales and South-West England, with an embedded qualitative consultation.

2.1 Sample and recruitment

Sampling and recruitment processes differed across the two sites, and the narrative is presented separately. Site-specific samples are presented in Figure 1.

2.1.1 Wales

2.1.1.1 Survey

2.1.1.1.1 Sample and recruitment

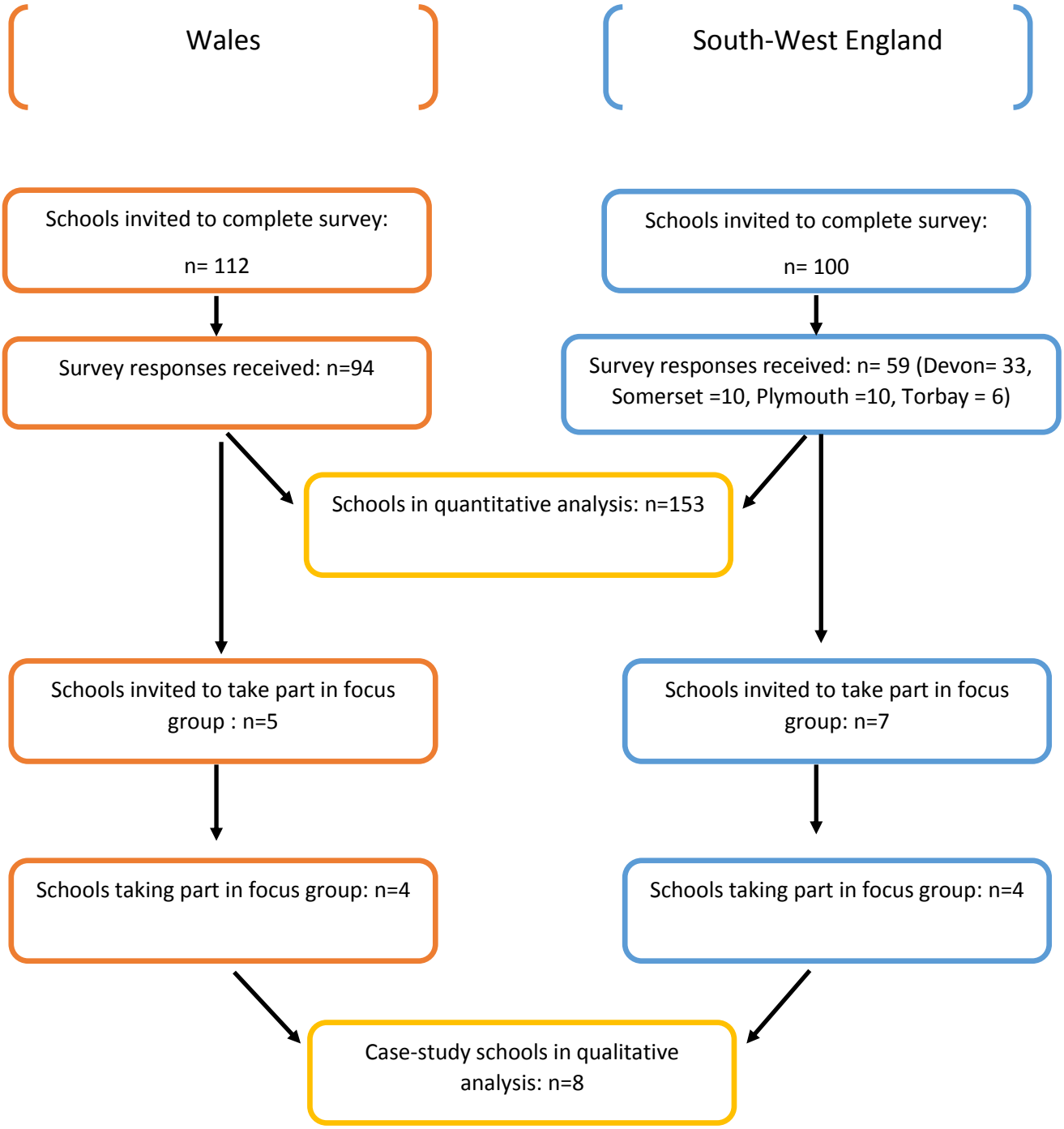
The survey sample in Wales comprised all secondary schools enlisted in the School Health Research Network (SHRN). The network is funded by Cancer Research UK, Public Health Wales and Welsh Government. It is administered by the DECIPHer research centre at Cardiff University. Participating schools complete a bi-annual student survey, which is based on the Health Behaviour in School Children (HSBC) survey to permit integration of data every four years. Bi-annual school environment surveys are also undertaken by a member of school staff. Each school environment survey contains a supplementary set of questions on a priority substantive health topic, and following a GW4 Initiator Grant funded consultation with secondary schools, self-harm was identified as the priority area for inclusion in the 2015 survey.

In 2015 there were 115 schools enrolled in the SHRN. Schools were independent or state funded (i.e. non-fee paying). The three-year average proportion of students eligible for free school meals was 16.8%, which is slightly lower than the national average of 17.5% for Wales (15). For the purposes of the present study, and in anticipation of the feasibility of future intervention development and evaluation research, the inclusion criteria was limited to state funded schools regardless of whether they have a selective intake procedure. Three independent schools were excluded. There were 112 schools in Wales eligible for participation.

Initial newsletters and emails were sent to schools in the Autumn term of 2015 indicating that the school would be invited to complete the school environment survey from January-April 2016. Each school in the SHRN network has an appointed contact. Survey information and paper versions of the survey were posted to the named contact at each school. The contact was asked to pass the survey to the relevant member of staff if they were unable to provide the requested information. Schools that

had not completed the survey within four weeks were followed up with reminder emails and a telephone call. Schools that completed the survey by the end of July 2016 were included in the study.

Figure 1. Study sample and recruitment



2.1.1.1.2 Response rates and respondents

The survey had an 84% (n=94) response rate. Responding and non-responding schools were compared on dimensions that were hypothesised to affect self-harm prevention and intervention provision in schools: free school meal (FSM) eligibility, Key Stage 3 academic attainment; and religious affiliation. Responding schools were similar on FSM eligibility and religious affiliation, but 80% of responding schools had above average Key Stage 3 academic attainment compared to 50% of non-responding schools (Table 1). One school who did not respond to the survey was excluded from reporting on differences in socio-demographic characteristics for responders and non-responders due to being a recent amalgamation of two secondary schools, and so no routine data was available.

Table 1. Difference in survey response rates Wales

	Responders N (%)	Non-responders N (%)
Below average free school meal eligibility[a]	56 (61)	11(61)
Above average Key Stage 3 academic attainment[b]	77(80)	9(50)
Religious affiliation	11 (11)	2 (11)

[a] Average free school meal eligibility based on national average for Wales, [b] Average Key Stage 3 academic attainment based on national average for Wales.

A phone survey was conducted with a random 10% subset of non-responders to ascertain the reasons for non-response. Cited reasons were: forgot to complete the survey; didn't know the answers; and lack of time to complete. On completion of the survey, the respondent was asked to indicate their professional role (Table 2). The most frequent professional role was assistant head teacher (76%).

Table 2. Professional role of respondents in Wales (n=94)

Profession	N (%)
Head teacher	2 (2)
Assistant Head teacher	71 (76)
Healthy School Coordinator	2 (2)
PSE Coordinator	3 (3)
Wellbeing Coordinator	2 (2)
Student Support	-
CPO/Safeguarding Lead	-
Other School Professional	12 14)

2.1.1.2 Qualitative consultation

2.1.1.2.1 Sample and recruitment

Schools were sampled for the qualitative consultation from the schools that completed the survey. School selection commenced following completion of surveys. One survey question asked schools to indicate if they would participate in further research. Respondents providing a positive response were considered. Supplementary recruitment activities were undertaken through attendance at two annual SHRN conferences, held in both North and South Wales. One member of the research team delivered a short presentation on the study and attendees were invited to provide contact details if they would like to participate in the consultation. Potential schools were stratified according to the following variables: free school meal eligibility; existing provision of self-harm prevention and intervention activities, as indicated by the survey data (high/low); and region within Wales, in order to ensure a geographical spread. As per the study protocol, the research intended to undertake qualitative consultation with two schools at each study site. Due to unanticipated additional research capacity, we were able to invite more schools to participate. Four schools were purposively sampled to take part in the consultation in Wales. One school withdrew from the study due to an impending inspection, and were replaced within the strata. The final sample for Wales is presented in Table 3.

Table 3. Socio-demographic profile of schools participating in qualitative consultation Wales

	FSM Eligibility	Self-harm Provision	Region
School W01	High	Low	South Wales
School W02	High	High	South Wales
School W03	Low	Low	North Wales
School W04	Low	High	North Wales

[a] Average free school meal eligibility based on national average for Wales, [b] Average Key Stage 3 academic attainment based on national average for Wales.

The SHRN school contact was responsible for circulating information about the consultation to school staff and recruiting participants. Three of the focus groups comprised five or six staff members. In the fourth focus group, the school encountered some organisational problems and following the rearranging of the focus group only two staff members were able to attend. The professional roles of staff included: assistant head teacher; Special Educational Needs Co-ordinator (SENCo); school counsellor; head of house/year; teacher; teaching assistant; safeguarding officers; and pastoral or support.

2.1.2 South-West England

2.1.2.1 Survey

2.1.2.1.1 Sample and recruitment

The survey sample in South-West England comprised all secondary schools in the counties of Devon and Somerset, coming under the auspices of four local authorities (Devon, Plymouth, Torbay and Somerset). Schools were included if they were state-funded (i.e. non-fee paying) regardless of whether they had a selective intake procedure. There were 100 schools eligible for the study.

Initial telephone contact was made with schools by a member of the research team to identify the appropriate member of staff to complete the survey (e.g. those with knowledge of self-harm prevention and intervention within the school). This member of staff served as the appointed contact. Survey information and a link to the survey was emailed to the contact. Paper questionnaires were provided on request. Surveys were distributed to schools between May and June 2016. Schools that had not completed the survey within two weeks were followed up with reminder emails, a telephone call and postal questionnaires. Schools that completed the survey by the end of September 2016 were included in the study.

2.1.2.1.2 Response rates and respondents

The survey had a 59% response rate (n=59). Responding and non-responding schools were compared on the dimensions of: free school meal eligibility, Key Stage 3 academic attainment; and religious affiliation. Differences between responding and non-responding schools were found across these dimensions (Table 4). A higher proportion of responders had above average free school meal eligibility. A higher proportion of non-respondents had above average Key Stage 3 academic attainment. The number of schools indicating a religious affiliation were so small as to make the characterisation of differences meaningless.

Table 4. Difference in survey response rates South-West England

	Responders N (%)	Non-responders N (%)
Above average free school meal eligibility[a]	15(29)	5(14)
Above average Key Stage 3 academic attainment[b]	24(46)	15(50)
Religious affiliation	2(4)	3(8)

[a] Average free school meal eligibility based on national average for England, [b] Average Key Stage 3 academic attainment based on national average for England.

A phone survey was conducted with a random 10% subset of the non-responders to ascertain reasons for non-response. Reasons were: they did not want their school to be included in the study; they would have responded if an appointment had been made with the appropriate lead to go in and talk through the project; the school receives a huge amount of requests to participate in studies so they only participate in studies that are relevant to the school at that time; the school had recently participated in an large study that they perceived to incorporate self-harm, so they were unable to allocate additional time to complete the questionnaire.

On completion of the survey the respondents were asked to indicate their professional role (Table 5). The most frequent professional roles were assistant head teacher (36%) and student support (37%).

Table 5. Professional role of respondent South-West England (n=59)

Profession	N (%)
Head teacher	-
Assistant Head teacher	21 (36)
Healthy School Coordinator	-
PSE Coordinator	-
Wellbeing Coordinator	-
Student Support	22 (37)
CPO/Safeguarding Lead	10 (17)
Other School Professional	6 (10)

2.1.2.2 Qualitative Consultation

2.1.2.2.1 Sample and recruitment

Schools for the qualitative consultation were sampled from the schools that completed the survey. School selection commenced following completion of 85% (n=50) of the surveys to ensure sufficient time for recruitment. Respondents who indicated they would participate in future research in the survey were considered. Schools were stratified according to: free school meal eligibility; existing provision of self-harm prevention and intervention activities, as indicated by the survey data (high/low); and region. Seven schools were purposively sampled to take part in the consultation. Three schools were eventually unable to participate, with four schools taking part in the consultation. The final sample for South-West England is presented in Table 6.

Table 6. Socio-demographic profile of schools participating in qualitative consultation South-West England

	FSM Eligibility	Self-harm Provision	Region
School SWE01	Low	High	Plymouth and Torbay
School SWE02	High	Low	Plymouth and Torbay
School SWE03	Low	High	Devon
School SWE04	High	Low	Devon

The school contact was responsible for circulating information about the consultation to school staff and recruiting participants. Three of the focus groups comprised eight staff members. The fourth focus group comprised four staff members. The professional roles of staff included: assistant head teacher; SENCo; school counsellor; head of house/ year; teacher; teaching assistant; safeguarding officer; pastoral support; and other (e.g. receptionist).

2.2 Data Collection

2.2.1 Survey

The survey administered to schools addressed the following topic areas: schools' health priorities; the usefulness of different school-based approaches to health promotion and intervention; the prevalence and forms of self-harm observed in school; existing self-harm provisions, and barriers and facilitators to self-harm prevention and intervention provision. Questions were informed through consultation at a stakeholder event in January 2014, as part of the GW4 Initiator Grant funded *Children and Young People Self-harm and Suicide Research Collaboration.* Further question refinement was conducted through discussion with grant co-applicants and consultation of existing research evidence. The survey provided in Wales was included in Appendix A and the survey provided in South-West England is included in Appendix B. The formatting of some questions were different due to the functionality of platforms utilised. However, with the exception of the question asking schools to rank their health priorities, the construct of variables was the same across sites and the data are comparable. The majority of the survey questions were multiple choice, but with available space for free text comments.

The survey was trialled for readability and sense-checked with a sample of schools within the SHRN before being made available to participating schools. In Wales the survey was translated into Welsh so additional checking was undertaken to ensure the meaning of the questions were retained. Surveys took approximately 15-20 mins to complete.

In Wales, the survey was included as a supplement in the bi-annual School Health Research Network (SHRN) school environment survey, which was completed in paper format. In South-West England, the survey was hosted by the Surveymonkey platform. Forty-three schools completed the survey online. Schools were provided with the option of a paper format survey. Sixteen completed the paper copy and return it by post.

2.2.2 Qualitative consultation

Each school invited to participate in the qualitative consultation was asked to sign a research agreement outlining the commitment of the school and the research team (Appendix C). The school contact was responsible for recruiting staff for the focus group as well as arranging a convenient time and place for the group. All focus groups were undertaken at the school site. Prior to the commencement of the focus group, participants were provided with information sheets (Appendix D) and consent forms (Appendix E). The focus groups followed a semi-structured topic guide covering schools current practices regarding student self-harm, future prevention and intervention needs, and recommendations for the development of new effective practices (Appendix F). Focus groups were audio-recorded with a Dictaphone, and transcribed verbatim. Two researchers attended each group in England (AER/FM). One researcher attended each group in Wales (RP). Schools were provided with £200 reimbursement for staff to attend the focus groups.

2.3 Analysis

2.3.1 Survey analysis

Data from surveys were analysed descriptively with SPSS version 23. Analysis was conducted per individual site and for the total sample. For the question regarding school's health priorities, variables differed across sites due to variances in the functionality of data collection methods used, and thus descriptive analysis for the total sample could not be undertaken. Data are summarised as n values and percentages. Due to rounding, not all percentages total 100%. Further analysis was considered to assess differences in responses across key socio-demographic variables. However, due to consistently low expected cell values this analysis was not appropriate.

2.3.2 Qualitative analysis

Focus group transcripts were checked for accuracy. Names and identifying features (e.g. local place names) were removed from the transcripts and pseudonyms were inserted. Thematic analysis (16) was used to analyse the qualitative data from each case-study school using the framework method (17).

Two transcripts were indexed each by two researchers (AR/ FM /AJ). These indexes were compared and a coding tree derived. All transcripts from both sites were coded (each by one researcher) using the coding tree structure in NVivo version 11. Following coding, codes determined as being of most relevance to the research questions were identified. These primarily pertained to understanding existing self-harm prevention and intervention provisions and future needs.

Codes were summarised using Framework analysis. Framework analysis is a system for structuring and summarising qualitative data in order to aid the theoretical analysis approach (in this case thematic analysis, based on themes emerging from the data). In short, each code of interest forms a column of a spreadsheet and each row one focus group. For each cell (focus group/code combination), summaries of data are constructed along with illustrative quotes and researcher notes. Reading down the column for the code then allows for themes within the data to be drawn out from the framework. These themes were then reviewed as in traditional thematic analysis in order to ensure that they fit with the overarching data collected and made sense in relation to the wider context of the focus group data.

Ethical approval for the study was provided by Cardiff University's School of Social Sciences Ethics Committee

3. Results

The results report on schools' existing student self-harm prevention and intervention provisions, in addition to future needs and recommendations for the development of effective practices. They commence with the presentation of survey data before thematically exploring data generated during the qualitative consultation.

3.1 Survey

3.1.1 Health priorities of schools

Respondents indicated the health priorities of their respective school. The method of ascertaining this data differed across study sites, although the health priorities considered were identical. In Wales, nine health outcomes were ranked, with 1 indicating that it is the highest priority for schools and 9 indicating that it is the lowest priority. The response rate for individual health outcomes ranged from 86%-88%. Respondents endorsed emotional health and wellbeing as the highest priority, with 60% ranking it as the number one priority (Table 7). For self-harm, 5% of respondents ranked it as the highest priority in the school, with 20% and 17% ranking is as the 2nd and 3rd priority respectively. Meanwhile 27% ranked it as the 8th most important priority.

Table 7. School health priorities in Wales (n=96)

	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
Sex and relationships (n=83)	5	14	22	25	11	10	12	1	-
Suicide (n=82)	13	10	9	9	4	4	2	10	40
Smoking (n=81)	2	10	6	6	17	19	21	12	6
EHWB (n=82)	60	10	5	6	5	1	10	1	2
Alcohol (n=81)	1	4	11	10	15	27	12	11	9
Healthy eating (n=82)	2	11	12	9	7	22	11	13	12
Self-harm (n=82)	5	20	17	10	7	2	10	27	2
Physical health (n=81)	7	16	9	10	15	7	10	9	17
Drugs (n=81)	4	10	9	16	25	11	9	12	5

In South-West England, respondents were invited to endorse how much of a priority each of the nine health outcomes are. Ratings ranged from very high to very low. The response rate for individual health outcomes was 100%. The findings were similar to those from Wales, respondents indicated that emotional health and wellbeing was a very high priority for their school (61%) (Table 8). For self-harm, 37% of respondents ranked it as a very high priority, with 36% indicating it is a high priority.

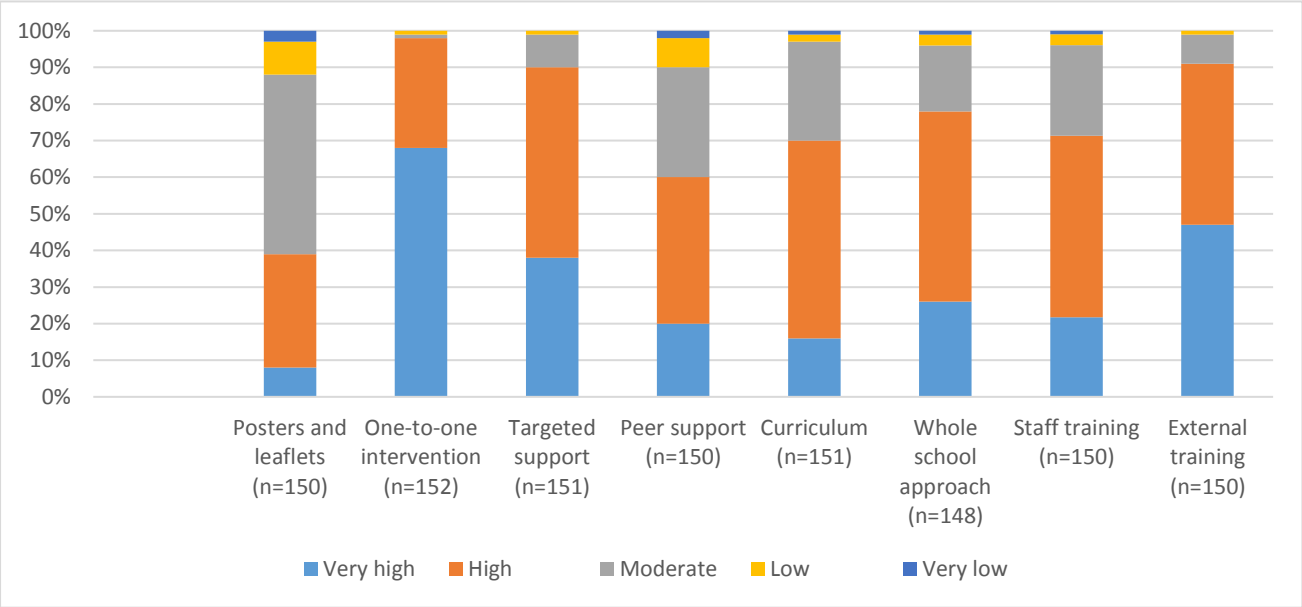
Table 8. School health priorities in South–West England (n=59)

	Very high (%)	High (%)	Moderate (%)	Low (%)	Very Low (%)
Sex and relationships (n=59)	39	39	17	3	2
Suicide (n=59)	32	27	24	14	3
Smoking (n=59)	17	46	34	34	3
EHWB (n=59)	61	32	3	-	3
Alcohol (n=59)	22	44	32	2	-
Healthy eating (n=59)	20	46	32	-	2
Self-harm (n=59)	37	36	20	3	3
Physical health (n=59)	36	39	24	-	-
Drugs (n=59)	31	51	15	-	

3.1.2 Usefulness of health promotion and intervention provisions

Respondents were provided with a range of different health promotion and intervention approaches that schools may utilise. They were asked to indicate the perceived usefulness of each approach and to list additional activities that they find to be of use. The response rate for individual items for all schools ranged from 97%-99%. The range in Wales was 97%-99% and in South-West England was 97%-100%. For all schools, respondents most frequently endorsed one-to-one intervention (68%), external training (47%), and targeted approaches (38%) as having very high utility. Poster and leaflets were rated lower than the other approaches, with 49% of respondents stating they were of moderate utility. All school results are presented in Figure 2. The corresponding data is presented in Appendix G (Table S1).

Figure 2. Usefulness of health promotion and intervention provision (All schools n=153)



Site specific data are presented in Tables 9 and 10. In Wales, respondents most frequently cited one-to-one intervention (65%), external training (49%), whole school approaches (49%) and targeted approaches (35%) as having very high utility. Poster and leaflets were rated lower than the other approaches, with 52% of respondents endorsing them as having moderate utility. In South-West England, one-to-one intervention was also indicated as being the highest rated approach, with 73% of respondents stating it has very high utility. Other provisions cited as having very high utility were targeted support (44%) and external training (42%). Rating of whole school approaches as having very high utility was 19% points lower than in Wales, with 30% of respondents rating it as such. Again posters and leaflets were amongst the least highly rated options.

Other activities respondents stated as useful were: an annual staff wellbeing week and health education day for sixth form and Year 10 students (n=1); assemblies and tutorial activities (n=1); mental health wellbeing project funded by DFES (n=1); PSE days (n=1); parental involvement (n=1); resilience/general mental and emotional health (n=1); some excellent staff who deal daily with student welfare and wellbeing issues (n=1); themed weeks with assemblies and PowerPoints (n=1); working with externally funded agencies (n=1); whole staff training, inset days, external visitors and drama groups (n=1): and youth workers (n=1).

Table 9. Usefulness of health promotion and intervention provision (Wales n= 94)

	Very high (%)	High (%)	Moderate (%)	Low (%)	Very low (%)
Posters and leaflets (n=91)	7	31	52	9	2
One-to-one intervention (n=93)	65	34	1	-	-
Targeted support (n=92)	35	57	9	-	-
Peer support (n=92)	17	46	26	10	1
Curriculum (n=92)	17	52	28	2	-
Whole school approach (n=91)	49	45	5	-	-
Staff training (n=92)	17	52	28	2	-
External training (n=91)	49	45	5	-	-

Table 10. Usefulness of health promotion and intervention provision (South-West England n=59)

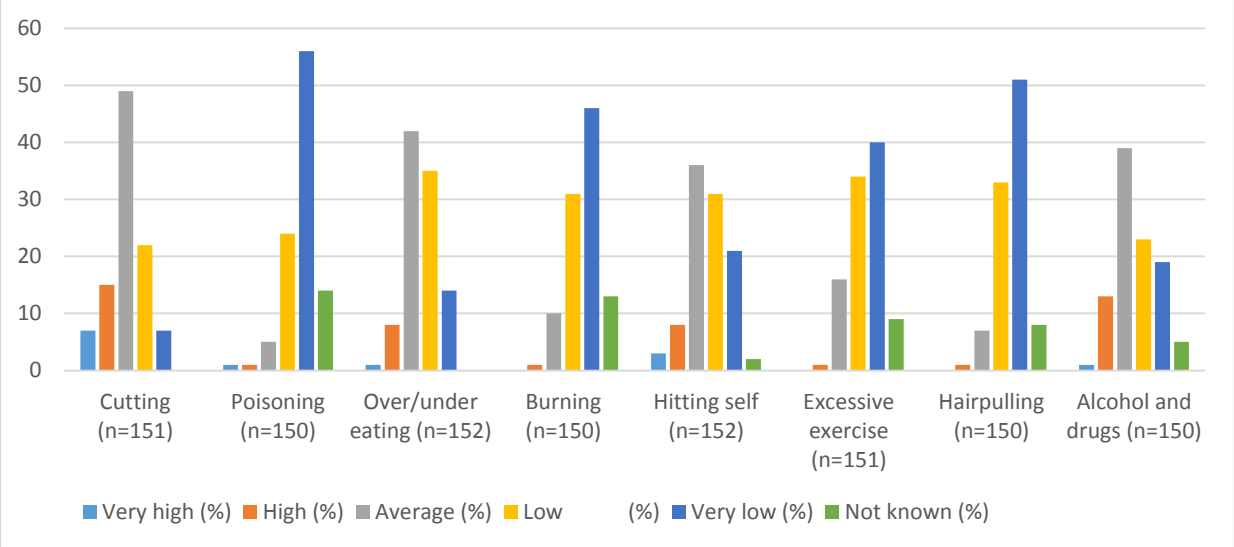
	Very high (%)	High (%)	Moderate (%)	Low (%)	Very low (%)
Posters and leaflets (n=59)	10	32	44	10	3
One-to-one intervention (n=59)	73	24	2	2	-
Targeted support (n=59)	44	46	8	2	-
Peer support (n=59)	24	31	36	5	3
Curriculum (n=59)	14	58	25	2	2
Whole school approach (n=57)	30	47	18	4	2
Staff training (n=59)	14	58	25	2	2
External training (n=59)	42	42	12	3	-

3.1.3 Prevalence of student self-harm

Respondents provided data estimating the prevalence of a range of self-harming behaviours that students may engage in. Drawing on data from community-prevalence studies of self-harm amongst secondary school students in the UK, respondents were offered guidance determining 'average' prevalence of self-harm as being 10% of the student population. The response rate for individual items for all schools ranged from 98%-99%, whilst the range in Wales was 97%-99% and in South-West England was 100%.

For all schools cutting was indicated as the most prevalent self-harming behaviour, with 22% of respondents stating prevalence was very high or high, and 49% stating prevalence was average. A number of behaviours were cited as having a low prevalence rate, where the rating for low and very low was combined: poisoning (80%); burning (77%); excessive exercise (74%); hair pulling (84%). Respondents were provided with the space to state additional self-harming behaviours that the student population might engage in. Indicated behaviours were: overdose (n=1); risk-taking behaviours (n=1); sexual risk taking (n=1); and sleep deprivation (n=1). One respondent stated that self-harm in school is unlikely as it often takes place outside of school. All school results are presented in Figure 3. The corresponding data is presented in Appendix G (Table S2).

Figure 3. Prevalence of student self-harm (All schools n=153)



Site-specific prevalence rates of self-harm behaviours are presented in Tables 11 and Table 12. Both sites rated the highest prevalence behaviour as cutting. In Wales 13% of respondents stated that cutting is very high or high. In South-West England 36% of respondents stated that cutting is high or very high.

Table 11. Prevalence of student self-harm (Wales n=94)

	Very high (%)	High (%)	Average (%)	Low (%)	Very low (%)	Not known (%)
Cutting (n=92)	3	10	54	25	8	-
Poisoning (n=92)	1	-	1	27	71	-
Over/under eating (n=93)	-	3	43	40	14	-
Burning (n=91)	-	-	9	33	58	-
Hitting self (n=93)	2	5	37	39	17	-
Excessive exercise (n=92)	-	-	13	38	49	-
Hairpulling (n=91)	-	-	3	35	62	-
Alcohol and drugs (n=91)	-	8	43	26	23	-

Table 12. Prevalence of student self-harm (South-West England n=59)

	Very high (%)	High (%)	Average (%)	Low (%)	Very low (%)	Not known (%)
Cutting (n=59)	12	24	44	17	7	-
Poisoning (n=59)	-	2	10	19	32	-
Over/under eating (n=59)	3	15	41	27	14	-
Burning (n=59)	-	2	12	27	27	32
Hitting self (n=59)	3	12	34	19	27	1
Excessive exercise (n=59)	-	2	20	29	27	24
Hairpulling (n=59)	-	2	12	31	36	20
Alcohol and drugs (n=59)	2	22	32	19	14	12

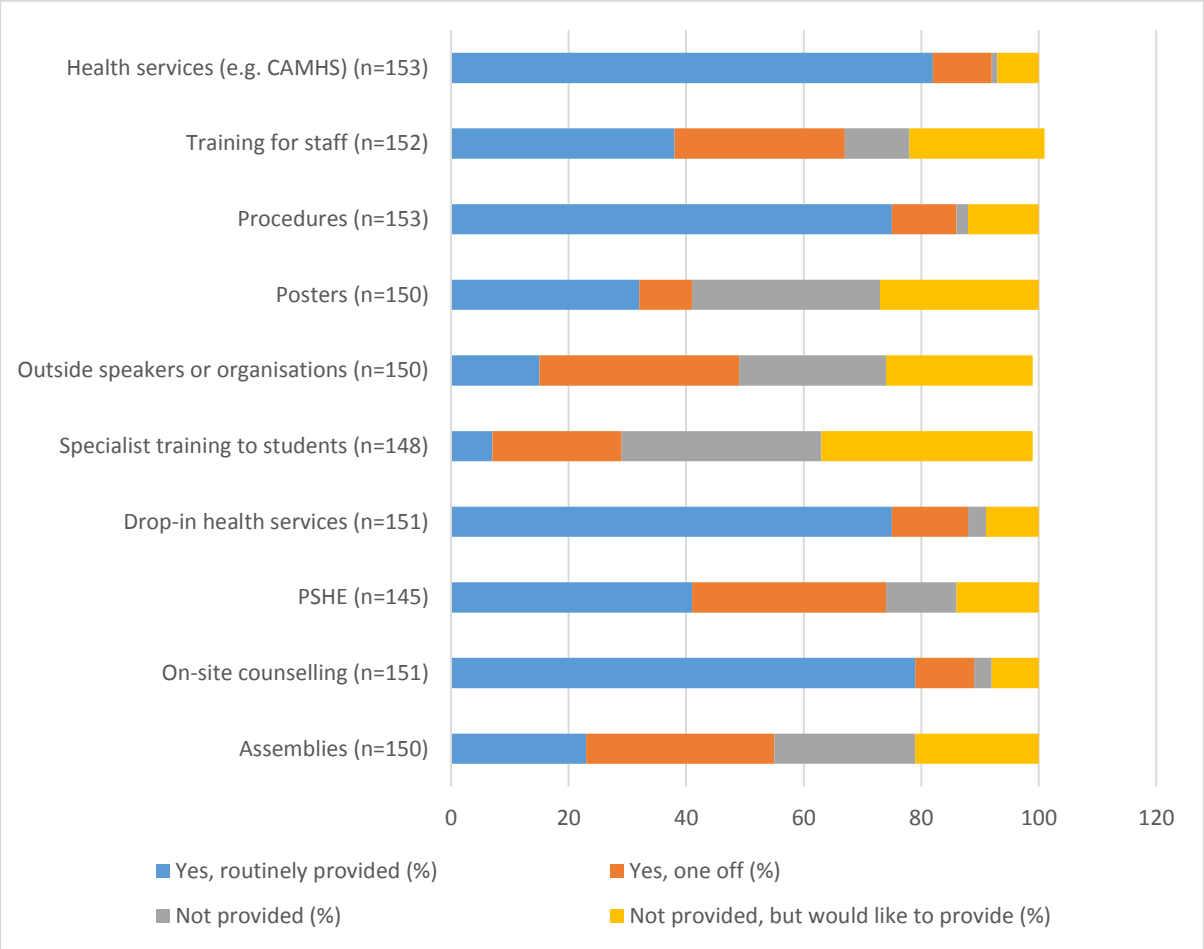
3.1.4 Self-harm prevention and intervention provision

Respondents were requested to list the self-harm prevention and intervention activities provided within the school setting. For the purpose of the survey self-harm was defined as 'any behaviour that is intended to intentionally hurt oneself. It may or may not be associated with suicidal intent.' For all

schools, the response rate across individual options ranged from 97%-100%. In Wales the response rate ranged from 91%-100%, and in South-West England was 100%.

Health services, such as Child and Adolescent Mental Health Services (CAMHS), were one of the main provisions utilised as part of self-harm prevention and intervention, and was routinely provided in 82% of cases. Other approaches that were routinely provided include: on-site counselling (79%); school policies and procedures (75%); and drop-in health services (75%). Schools identified areas where they would like additional provision. This included specialist training to students (36%); and to a lesser extent posters (27%); outside speakers or organizations (25%); training for staff (23%); and assemblies (21%). All school results are presented in Figure 4. The corresponding data is presented in Appendix G (Table S3).

Figure 4. Self-harm prevention and intervention provision (All schools n=153)



Site specific data is presented in Tables 13 and 14. In Wales, health services were the most frequently utilised provision (81%) along with onsite counselling (76%). To a lesser extent schools routinely provided school policies and procedures (69%) and drop-in health services (66%). Schools identified additional provisions they would like to offer: specialist training to students (37%); posters (27%);

outside speakers or organisations (23%); training for staff (23%); and assemblies (21%). In South-West England, drop-in health services were the most frequent approach to be routinely provided (90%). Meanwhile, 85% of respondents stated routine provision of on-site counselling, school policies and procedures, and health services. Additional provisions schools would like to offer include: specialist training to students (36%); outside speakers or organisations (29%); posters (27%); training for staff (24%); and assemblies (22%).

Table 13. Self-harm prevention and intervention provision (Wales n=94)

	Yes, routinely provided (%)	Yes, one off (%)	Not provided (%)	Not provided, but would like to provide (%)
Assemblies (n=91)	14	37	27	21
On-site counselling (n=92)	76	13	3	8
PSHE (n=86)	31	42	14	13
Drop-in health services (n=92)	66	18	4	11
Specialist training to students (n=89)	4	26	33	37
Outside speakers or organisations (n=91)	16	32	29	23
Posters (n=91)	27	13	32	27
Procedures (n=94)	69	15	3	13
Training for staff (n=93)	39	26	13	23
Health services (e.g. CAMHS) (n=94)	81	13	1	5

Table 14. Self-harm prevention and intervention provision (South-West England n=59)

	Yes, routinely provided (%)	Yes, one off (%)	Not provided (%)	Not provided, but would like to provide (%)
Assemblies (n=59)	36	24	17	22
On-site counselling (n=59)	85	3	3	8
PSHE (n=59)	54	20	10	15
Drop-in health services (n=59)	90	5	-	5
Specialist training to students (n=59)	12	17	36	36
Outside speakers or organisations (n=59)	14	37	20	29
Posters (n=59)	39	2	32	27
Procedures (n=59)	85	5	-	10
Training for staff (n=59)	36	34	7	24
Health services (e.g. CAMHS) (n=59)	85	7	0	8

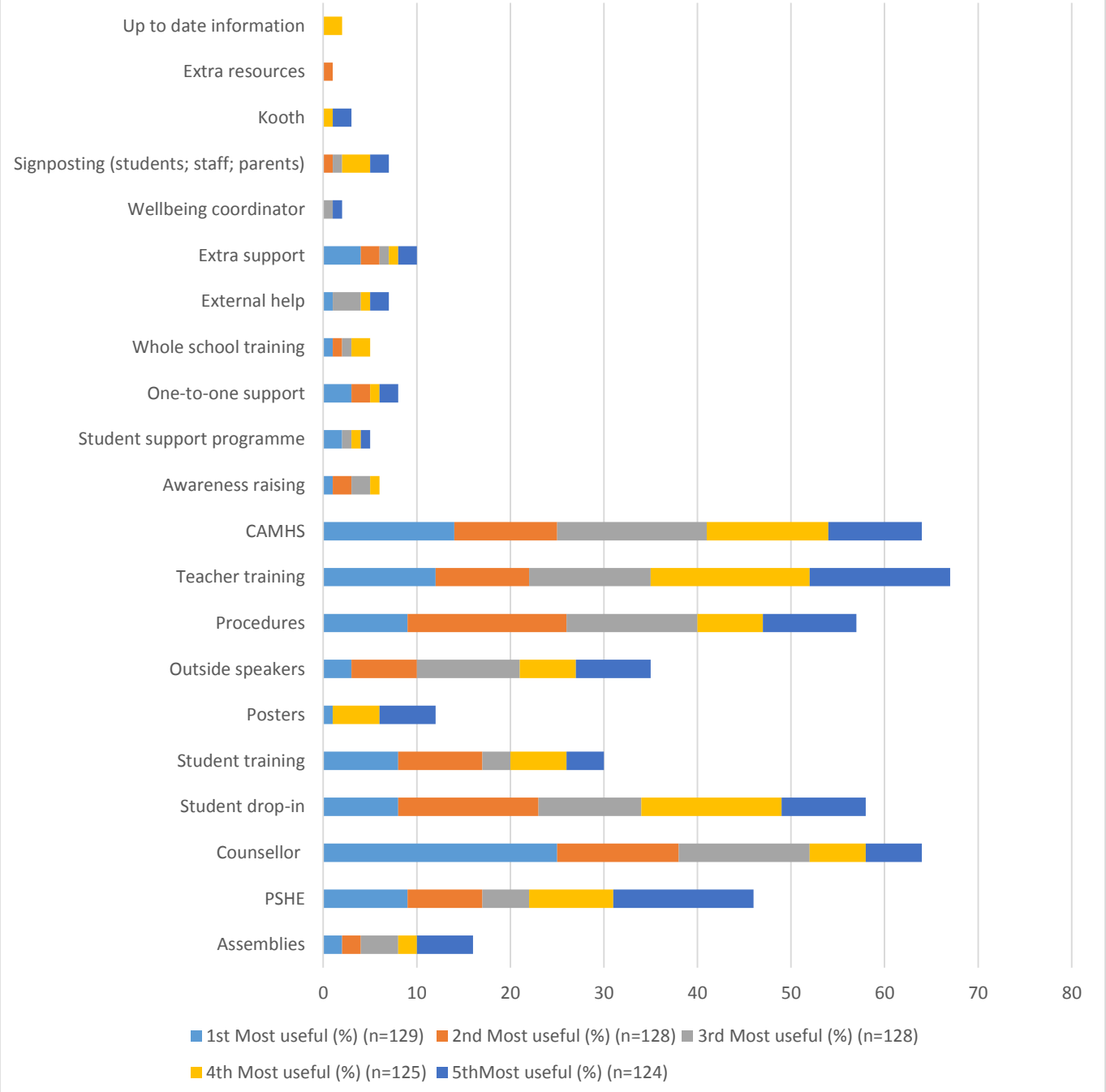
3.1.5 Usefulness of self-harm prevention and intervention provision

Respondents ranked the usefulness of a range of potential prevention and intervention provisions that schools may utilise to address student self-harm. Respondents were requested to indicate the five most useful approaches. For all schools, the response rate across individual ranking options ranged from 81%-84%. In Wales the response rate ranged from 77%-78%, and in South-West England was 88%-97%. A range of options were pre-specified (e.g. assemblies through to whole school approaches), with respondents being provided with the opportunity to add additional provisions. The most commonly cited provisions (i.e. external help through to up-to-date information) are also included in Tables S4, 15 and 16.

Across all schools, counsellors were ranked as the most useful approach to addressing student self-harm, and accounted for 25% of all provisions ranked first. This was followed by CAMHS (14%) and teacher training (12%). Amongst the pre-specified options, provisions that were least frequently cited

as the most useful were awareness raising; student support programmes; one-to-one support; and whole school approaches. All school results are presented in Figure 5. The corresponding data is presented in Appendix G (Table S4).

Figure 5. Usefulness of self-harm prevention and intervention provision (All schools n=153)



Site specific data is presented in Table 15 and Table 16. In Wales, there was a smaller concentration of provision cited as useful compared to South-West England. Counsellors were indicated as the most useful approach (28%); followed by CAMHS (15%); school policies and procedures (11%); and teacher training (10%). There was limited endorsement of one-to-one support and whole school training. No respondents claimed to find awareness training or student support programmes useful. In South-West England, outside speakers were cited as the most useful provision (22%); followed by counsellors (21%); teacher training (14%); and CAMHS (12%). Of the pre-specified items, posters, awareness raising, student support programmes, one-to-one support, and whole school training were the least frequently ranked as being useful provisions. The majority of additionally coded items were derived from the South-West England data. Some schools found the following provisions useful: external help; extra support; wellbeing coordinator; signposting for students, staff and parents; Kooth, which is a free online service offering emotional and mental health support for children and young people aged 11-19 years; extra resources; and up to date information.

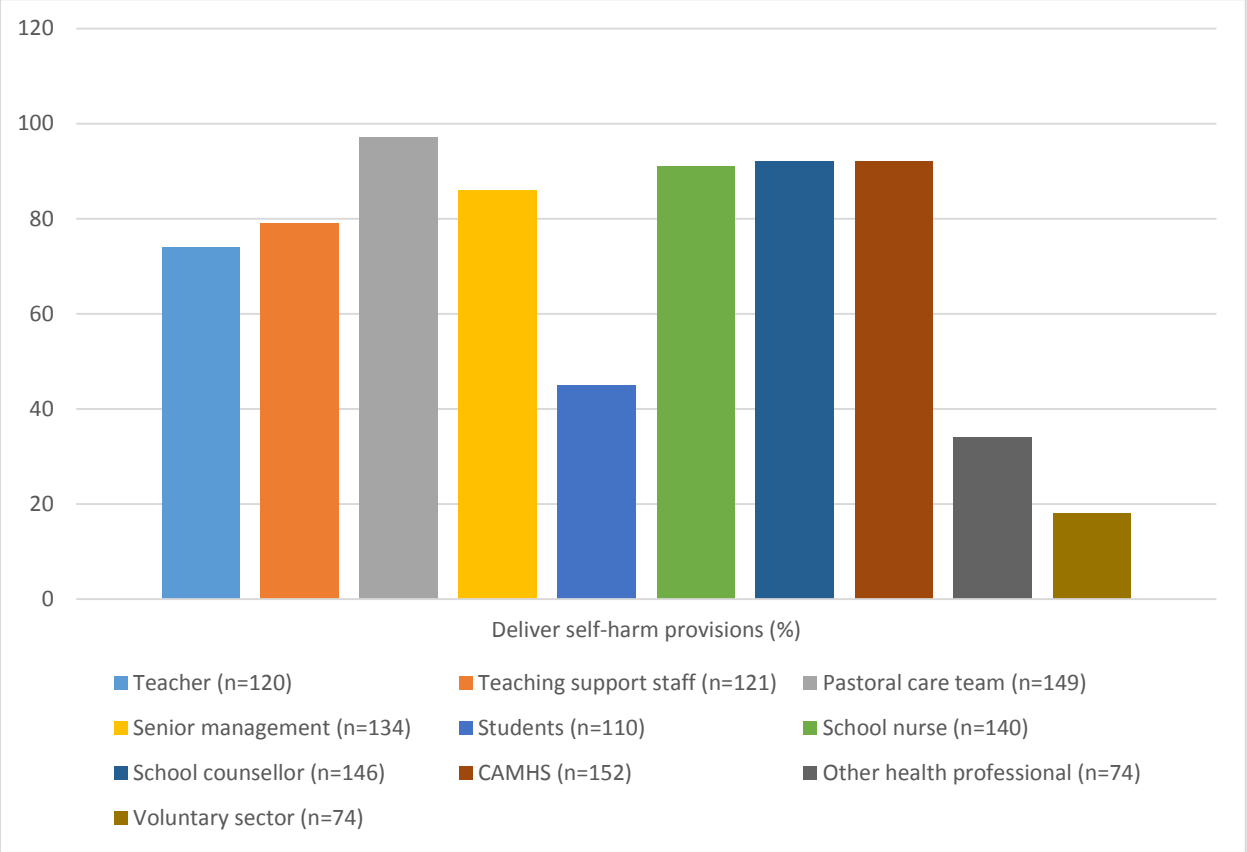
Table 15. Usefulness of self-harm preventions and intervention provision (Wales n=94)

	1st Most useful (%) (n=72)	2nd Most useful (%) (n=73)	3rd Most useful (%) (n=73)	4th Most useful (%) (n=72)	5thMost useful (%) (n=72)
Assemblies	3	1	4	3	8
PSHE	8	10	4	10	19
Counsellor	28	10	14	8	11
Student drop-in	4	12	12	15	10
Student training	7	14	3	10	4
Posters	1	-	-	7	6
Outside speakers	4	8	15	6	8
Procedures	11	21	18	13	11
Teacher training	10	11	8	19	15
CAMHS	15	14	22	14	7
Awareness raising	-	-	-	-	-
Student support programme	-	-	-	-	-
One-to-one support	1	-	-	-	-
Whole school approaches	-	-	-	1	-
External help	-	-	-	-	
Extra support	1	-	-	-	
Wellbeing coordinator	-	-	-	-	-
Signposting (students; staff; parents)	-	-	-	-	-
Kooth	-	-	-	-	-
Extra resources	-	-	-	-	-
Up to date information	-	-	-	-	-

Table 16. Usefulness of self-harm preventions and intervention provision (South-West England n=59)

	1st Most useful (%) (n=57)	2nd Most useful (%) (n=55)	3rd Most useful (%) (n=55)	4th Most useful (%) (n=53)	5thMost useful (%) (n=52)
Assemblies	2	2	4	2	4
PSHE	9	5	7	2	8
Counsellor	21	18	15	4	-
Student drop-in	5	18	9	15	8
Student training	9	4	4	2	4
Posters	-	-	-	2	6
Outside speakers	22	5	5	8	8
Procedures	5	13	9	8	8
Teacher training	14	9	18	13	15
CAMHS	12	7	7	11	13
Awareness raising	2	4	4	-	-
Student support programme	4	-	2	2	2
One-to-one support	5	4	-	2	4
Whole school approaches	2	2	2	4	-
External help	2	-	2	2	4
Extra support	7	5	7	2	6
Wellbeing coordinator	-	-	2	-	2
Signposting (students; staff; parents)	-	2	2	8	4
Kooth	-	-	-	2	4
Extra resources	-	2	-	-	-
Up to date information	-	-	-	4	-

3.1.6 Delivery agents of self-harm prevention and intervention provision



Data were analysed to ascertain the delivery agents for existing self-harm prevention and intervention provisions within schools. Respondents were requested to indicate whether a range of professionals were involved in delivery, and were provided with opportunity to list additional delivery agents. The response rate for stating if individual professional roles were involved in provision ranged from 48%-99% for all schools. For Wales the range was 16%-96% and for South-West England was 95%-100%.

The results for all schools are provided in Figure 6, with the data being presented in Table S5 (Appendix G). The professional roles most involved with the delivery of self-harm prevention and intervention were: pastoral care teams (97%); school counsellors (92%); school nurses (92%); and CAMHS (92%). Teaching staff were involved in 74% of schools, with a slightly higher proportion of teaching support staff engaged in such activity (79%). Students were cited as being the group of school-based individuals that were least frequently involved with prevention and intervention delivery (45%).

Figure 6. Delivery agents of self-harm prevention and intervention provision (All schools n=153)

The site-specific data are presented in Table 17 and Table 18. Schools at each site indicated that pastoral staff were most frequently involved in the delivery of prevention and intervention activities (97%). Schools in Wales tended to state a higher rate of involvement than schools in South-West England across a range of professionals. Seventy-nine percent (79%) of schools stated teachers are delivery agents compared to 69% in South-West England. The respective data for senior management was 92% and 78%, for school counsellors 99% and 83%, and for CAMHS 96% and 86%. Both sites reported equally low rates of involvement for students (43% in Wales and 46% in South-West England). Respondents in Wales indicated much higher involvement of the voluntary sector, but this item only had a 16% response rate and so should be interpreted with caution.

Table 17. Delivery agents of self-harm prevention and intervention provision (Wales n=94)

	Yes (%)	No (%)
Teacher (n=61)	79	21
Teaching support staff (n=62)	81	19
Pastoral care team (n=90)	97	3
Senior management (n=75)	92	8
Students (n=51)	43	57
School nurse (n=81)	90	10
School counsellor (n=87)	99	1
CAMHS (n=83)	96	4
Other health professional (n=18)	61	39
Voluntary sector (n=15)	40	60

Table 18. Delivery agents of self-harm prevention and intervention provision (South-West England n=59)

	Yes (%)	No (%)
Teacher (n=59)	69	31
Teaching support staff (n=59)	78	22
Pastoral care team (n=59)	97	3
Senior management (n=59)	78	22
Students (n=59)	46	54
School nurse (n=59)	92	8
School counsellor (n=59)	83	17
CAMHS (n=59)	86	14
Other health professional (n=56)	25	75
Voluntary sector (n=59)	12	88

The other health professionals that respondents cited that their schools utilise were: emergency services (n=1); the Amber Project, which offers counselling, workshops and support to young people aged 14-25 who have experience of self-harm (n=1); School nurse (n=4); NHS outreach nurse (n=1); Counselling service (n=1); GP (n=7); Young Minds (n=1); Educational psychologist (n=1); Emotional

wellbeing officer (n=1); Welfare officer (n=2); School-based social worker (n=1); Social services (n=1); Children's services (n=1); Family-centred team (n=1); Virgin Care Young Devon, which is a dedicated team of nurses supporting the mental health and wellbeing of children and young people in care (n=1).

Respondents were further asked to document the voluntary sector services that they utilise. These were: BASE, Harbour (n=1); Barnardo's (n=1); Bounce Back service. As part of Barnardo's, this service offers mental health and therapeutic support to individuals at risk of homelessness and other potential harms (n=1); Changing Minds (n=1); Governors (n=1); Head Above the Waves, which raises awareness and coping strategies for depression and self-harm (n=1); ICE team, which provides support for friends and family supporting someone with a mental health issue (n=1); Parent and Family Support Advisor (PFSA) or Parent Support Advisor (PSA), which provides advice and guidance to schools, parents and families to improve the learning opportunities for children and young people (n=2); Posters around school for Kooth, ChildLine, Samaritans, and other charities. Kooth is a free online service offering emotional and mental health support for children and young people aged 11-19 years (n=1); Safeguarding officers (n=1); Safer Merthyr Tydfil, which is a crime prevention charity (n=1); Samaritan's Young Carers (n=1).

3.1.7 School staff training on self-harm

Data were provided on the extent of training that school staff have received on student self-harm, in addition to training delivery agents and the funding agency. Respondents were further asked to indicate the perceived adequacy of existing training provisions. The response rate for this survey question was 98% for all schools, and at both study sites (Table 19). Of all schools, 54% had received some staff training on self-harm, with 23% receiving mandatory training and 31% receiving voluntary training. A slightly higher percentage of schools in Wales were in receipt of mandatory staff training (25%) compared to schools in South-West England (17%). Across all schools, 39% stated they had not received staff training. In Wales this was 43% compared to 33% in South-West England.

Table 19. Receipt of training for school staff

	Wales (%) (n=92)	South West England (%) (n=58)	All Schools (%) (n=150)
Yes. Mandatory training	25	17	22
Yes. Voluntary training	25	41	31
No	43	33	39

Don't know	7	9	7

Where respondents indicated receipt of either mandatory or voluntary training for self-harm, they were requested to stipulate the training provider (Table 20). For all schools, 85% of respondents who indicated receipt of some training stated the training provided. This response rate was 80% in Wales and 91% in South-West England. CAMHS was the most frequently cited training organisation across all schools (31%), and for respondents in both Wales (35%) and South-West England (26%). However, most schools stated receipt of training from 'other' organisations.

Table 20. Training provider for school staff training for student self-harm

	Wales (%) (n=37)	South West England (%) (n=31)	All Schools (%) (n=68)
In house training	13	16	12
Primary mental health team	2	19	12
CAMHS	35	26	31
Charity	-	23	10
Other	51	16	35

Respondents indicated the funding agent for staff training on self-harm (Table 21). For all schools, 56% of respondents who indicated receipt of some training stated the funding agency. This response rate was 50% in Wales and 65% in South-West England. Schools were cited as the most common funder for staff training across all schools (49%), and in South-West England (68%). In Wales, 57% of respondents stated that they received funding from a different source. The majority of training incurs a cost. Only 4% of schools stating they receive free training, with all schools in Wales incurring some financial cost.

Table 21. Funder for school staff training for student self-harm

	Wales (%) (n=23)	South West England (%) (n=22)	All Schools (%) (n=45)
NHS	9	23	16
Education Improvement	4	-	2

Grant/Grant Gwella Addysg			
School	30	68	49
No cost	-	9	4
Other	57	0	29

Respondents endorsed a rating for the perceived adequacy of existing school staff training (Table 22). Ratings were not limited to schools that stated receipt of training, with respondents indicating adequacy even where they earlier stated not having training within the school. For all schools, 50% of respondents indicated that the adequacy of training is moderate. This rating was provided in 52% of schools in Wales and 47% in South-West England. Meanwhile, 22% of all schools endorsed the current adequacy of provision as being very high or high, with this figure standing at 20% in Wales and 22% in South-West England. Conversely, 23% of all schools stated that adequacy was low or very low. In Wales this was 28% and in South-West England it was 19%.

Table 22. Adequacy of school staff training for student self-harm

	Wales(%) (n=89)	South West England (%) (n=59)	All Schools (%) (n=148)
Very high	7	0	4
High	13	22	18
Moderate	52	47	50
Low	19	7	14
Very low	9	12	9
None provided	-	12	5

Data were abstracted to elicit the reasons for respondents' adequacy ratings. Fifty-one respondents in Wales and 52 in South-West England provided an explanation. Examples of explanations for ratings of high adequacy were:

'very much at the forefront and have clear strategy to address the issue.'

'staff are vigilant.'

Examples of explanations for ratings of moderate adequacy are:

'we respond to need and could be more proactive.'

'Strong individual support, but few proactive strategies.'

Examples of explanations for ratings of low adequacy were:

'little support available from school nurse/health service since we lost our allocated school nurse. It is now a team which we rarely see and they do not engage with our students. Rarely get support from CAMHS unless serious case – need advice on prevention.'

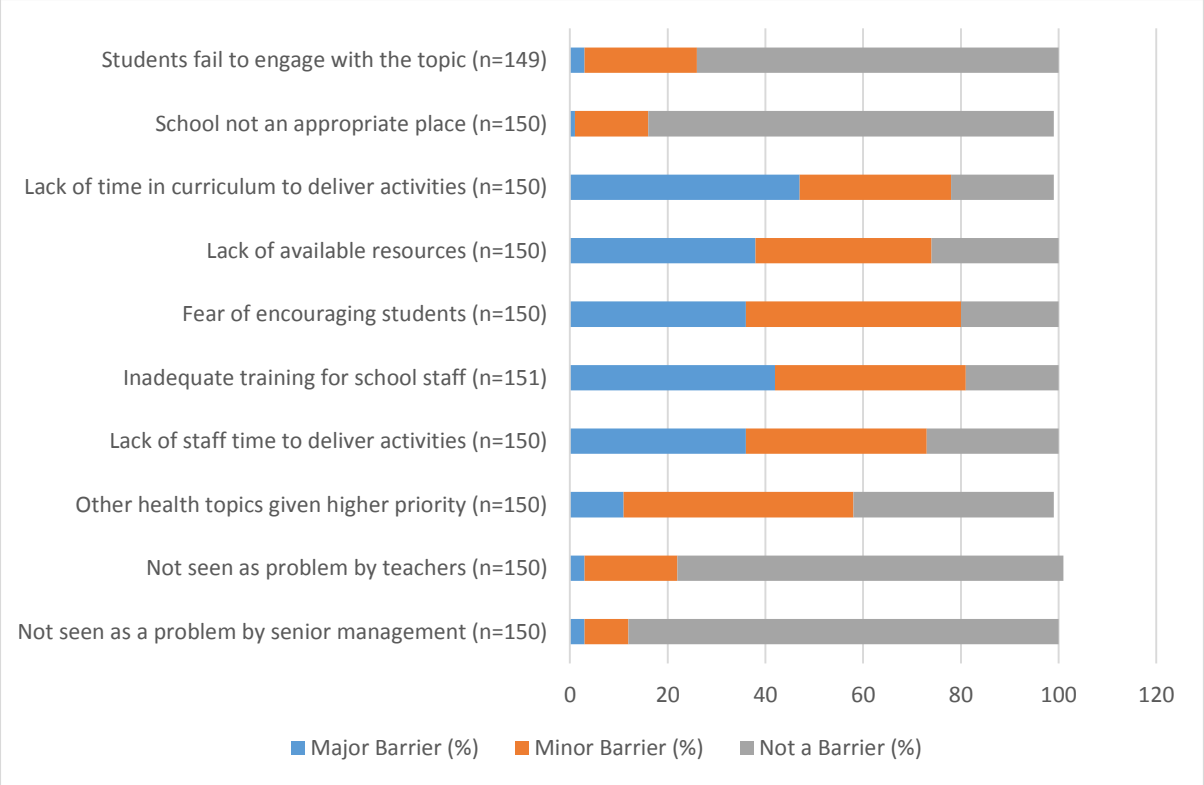
'staff are not sufficiently trained to deal with self-harm. A school's core business is to educate young people. We refer to specialists e.g., CAMHS/counsellor to deal with specific cases.'

3.1.8 Barriers to self-harm prevention and intervention

Data were analysed to identify key school-level barriers to preventing or intervening with self-harm in students (Figure 7). The corresponding data are presented in Appendix G (Table S6). The response rate for individual items in this question ranged from 97% to 99%. Across all schools a lack of time and resources were cited as a major barrier, with 47% stating there was inadequate time in the curriculum, 38% stated there was a lack of available resources, and 36% stated there was a lack of time to deliver activities. Inadequate training for school staff was also frequently cited as a major barrier (42%), with only 19% indicating that it was not a barrier to prevention or intervention. As reflected in the qualitative consultation data, respondents maintained that the fear of encouraging students to engage in self-harm is a key barrier to prevention and intervention. It was cited as a major barrier by 36% of respondents, a minor barrier by 44%, and not a barrier by 20%. Attitudinal responses to addressing self-harm within the school context were the least endorsed barriers. Self-harm not being seen as a problem by senior management or teachers was not a barrier in 88% and 79% of schools respectively. Meanwhile, 74% stated that students' failure to engage in the topic is not a problem and 83% of schools rated school not being an appropriate place as not a barrier.

Schools were provided with the option of listing additional barriers. These were: teachers do not have expertise in this area (n=1); parents may not wish their child to be involved (n=1); pressure to deliver academic results at expense of student wellbeing (n=1); students keen to engage and often request subjects but parents may not be happy (n=1); lack of consistency in the current thinking surrounding self-harm (n=1).

Figure 7. Barriers to self-harm prevention and intervention (All schools n=153)



Site-specific data are provided in Table 23 and Table 24. At both sites, lack of time in the curriculum to deliver activities was the most frequently endorsed major barrier, being cited by 51% of respondents in Wales and 42% of respondents in South-West England. One key difference to emerge across sites was the relative importance of inadequate training for school staff. It was cited as a major barrier by 49% of respondents in Wales and 32% of respondents in England.

Table 23. Barriers to self-harm prevention and intervention (Wales n= 94)

	Major Barrier (%)	Minor Barrier (%)	Not a Barrier (%)
Not seen as a problem by senior management (n=91)	-	12	88
Not seen as problem by teachers (n=91)	-	21	79
Other health topics given higher priority (n=91)	13	53	34
Lack of staff time to deliver activities (n=91)	38	30	32
Inadequate training for school staff (n=92)	49	32	20
Fear of encouraging students (n=91)	34	47	17
Lack of available resources (n=91)	41	33	26
Lack of time in curriculum to deliver activities (n=91)	51	29	21
School not an appropriate place (n=91)	1	16	82

Students fail to engage with the topic (n=90)	2	21	77

Table 24. Barriers to self-harm prevention and intervention (South-West England n=59)

	Major Barrier (%)	Minor Barrier (%)	Not a Barrier (%)
Not seen as a problem by senior management (n=59)	7	7	86
Not seen as problem by teachers (n=59)	5	15	78
Other health topics given higher priority (n=59)	8	39	53
Lack of staff time to deliver activities (n=59)	32	47	20
Inadequate training for school staff (n=59)	32	51	17
Fear of encouraging students (n=59)	39	39	22
Lack of available resources (n=59)	34	41	25
Lack of time in curriculum to deliver activities (n=59)	42	36	22
School not an appropriate place (n=59)	2	15	83
Students fail to engage with the topic (n=59)	2	15	83

3.1.9 Participation in future research on self-harm prevention and intervention development

Respondents were asked to indicate if their school would be prepared to participate in future research to develop student self-harm prevention and intervention activities for schools (Table 25). There was a 98% response rate for this question for all schools, with a 96% response rate in Wales and a 98% response rate in South-West England. Seventy-seven percent (77%) of schools said they would be prepared to participate in future research. This response was slightly higher in South-West England (79%) than in Wales (76%). Nine percent of all schools were disinclined to partake in future research, and 13% said they did not know.

Table 25. Prepared to participate in future research on self-harm prevention and intervention development

	Wales (n=92)	South-West England (n=58)	All Schools (%) (n=150)
Yes	76	79	77
No	11	7	9
Don't Know	13	14	13

3.2 Qualitative consultation

Five key themes related to the study research aims emerged from the data generated through the qualitative consultation. First, perceptions of self-harm, which influence schools reaction and responses. Second, is prevention, which encompasses the activities carried out by schools relevant to preventing self-harm. In actuality, the focus in schools is the promotion of students' positive mental health and raising awareness of key staff in safeguarding and pastoral roles. Schools express concern that overt discussions around self-harm will lead to contagion and behavioural amplification. Third, is school processes for self-harm intervention and management, which encompass the process of self-harm disclosure and schools response. Fourth, is key individuals beyond school professionals involved in the disclosure and management of self-harm. These key individuals mainly comprise parents and peers. Finally, is future aspirations and unmet needs, which collates themes around the perceived prevention and intervention provisions schools require in order to improve their management of self-harm.

3.2.1 Perception of self-harm

Schools have perceptions and interpretations of self-harm that determine how they understand the behaviour within the context. These perceptions influence schools' prevention and intervention provision, as well as their needs for future support. The theme of perception comprises six subthemes: self-harm typologies, the emotive nature of self-harm, self-harm as a coping strategy, managing self-harm or wanting to '*do the right thing (…)*' pressures of the school context; and self-harm as part of mental health.

3.2.1.1 Self-harm typologies

Self-harm is considered to occur along a continuum '*from minor to quite extreme*', with most instances of self-harm falling at one end or the other of the spectrum:

> *'I think there's two distinctive groups. There's the ones that follow the crowd and it's quite minor in nature, and then you have the other ones that there is the significant underlying issue or concern, and that manifests it's way in a slightly more sinister sort of method.'*

These two types of self-harm are perceived to differ on motivation, severity of harm, and appropriate intervention. Superficial or minor self-harm is described by participants as being '*fashionable*' and thought to be linked to social trends. Superficial self-harmers are also characterised as being willing to display marks of their behaviour as *'a badge of honour.'* This type of self-harm is noted as a *'cry for help'* rather than representing an underlying mental health problem, and is thought to often be manageable within school: *'I think there's enough information out there at the kind of soft end, but*

not at the real extreme end.' School counsellors and provision of alternate coping strategies are often implemented for this level of self-harm, as there is a belief among participants that superficial self-harm is related to poor coping skills rather than a deeper underlying mental health problem*: 'If it is just low level or in its infancy then generally we will try and deal with it in house with our school counsellors before escalating it up.'*

Severe self-harm is thought to need external expertise in order to manage it: '*straight away go through CAMHS* (…)' It is described as severe wounding where emergency medical treatment is needed, or clear suicidal behaviour such as taking of overdoses and can result in staff accompanying a student to accident and emergency (A&E).Participants felt that severe self-harmers are characterised by their attempts to keep their self-harm secret: '*then you have got those who hide the fact that they self-harm and I think we look on them as in different categories (…)'* Students engaged in severe self-harm are thought to have *'very complex'* reasons for this and are also noted as potentially having underlying mental health problems. Schools feel less able to manage what they classify as severe self-harm. However, they experience that their conceptualisation of self-harm does not necessarily fit with the eligibility threshold that determines access to external services:

> *'In our mind they were the high end cases but when they got to diagnoses they weren't deemed as being high end (…)'*
>
> *'Obviously she had done it quite a lot and it wasn't an attention thing. So it should have gone to CAMHS and everything.'*

Participants discussed cases where superficial self-harm *'escalates'* into more serious self-harm: *'it was experimental at first, but then she did have quite a deep cut.'* These cases demonstrate awareness by participants that self-harm can become worse if intervention is not put in place: '*If it isn't nipped in the bud when they're not supported, right from the early days, what it might lead to (...)'*

In addition to the two types of self-harm, participants report a patterning in the incidence and prevalence across time. They described self-harm as occurring in *'peaks and troughs.'* Onset of self-harm is thought to be around year eight or nine in most cases. This is when students are often identified as '*vulnerable*' although this vulnerability may emerge as early the transition to secondary school or during primary school. Other young people's self-harm onsets during year 10 or 11, when exam stresses and other pressures are thought to contribute to their anxiety. These are the students schools fear they cannot identify as being at an elevated risk of self-harm early on:

> *'The ones we've missed or tended not to get as early as we could would be those high-level students, you know those kind of bright people that suddenly become very anxious and very*

concerned, particularly getting into years 10 and 11 exam pressures and destinations and everything kind of builds up.'

3.2.1.2 The emotive nature of self-harm

Participants discussed how self-harm and experiencing self-harm in the school setting can be emotionally-charged: *'It does have quite an impact, doesn't it, self-harm (…)'* They considered how school staff can react to witnessing or disclosures of self-harm with *'fear'* and *'panic.'* This reaction to self-harm in the classroom is described as a *'knee jerk reaction'* and participants indicate that they believe this reaction by staff is due to lack of knowledge and information. However in some cases schools actively try to address this: *'we have tried to create an ethos of don't panic about it.'*

3.2.1.3 Self-harm as a coping strategy

Participants understand self-harm as one of a range of coping strategies: *'how one particular student expresses it may be different as to how another student is, but the reasons are the same.'* They consider it alongside experimenting with alcohol or drugs as a method of coping with pressure that young people may turn to, and link being able to cope effectively to good mental health.

'We come out with strategies as well, about keeping them safe and about their own mental health and their own wellbeing; because actually you know sometimes days are really tough. And they need that.'

Self-harm is perceived by staff as a negative coping strategy used by students who lack healthy coping skills:

'Let's have positive strategies of coping and not go down the self-destruction path (…)'

'We need to give them something else to do, some other way of coping without hurting themselves.'

3.2.1.4 Managing self-harm: *'doing the right thing'*

Participants discussed concerns that they are not equipped with enough knowledge to know that they are managing self-harm *'the right way in school'.* This concern, described as *'worry'* is related to the perceived consequences of self-harm being potentially lethal: *'In this job you make a mistake and it could be absolutely devastating and that is the big worry (…)'* Training and supervision are discussed in the same terms, with participants feeling that external supervision may be helpful in order to ascertain *'that we've done everything correctly.'* Even in cases where schools use a variety of strategies with students, concerns about the pervasive nature of self-harm remain: *'I think that's the worry for us, even with strategies...we've still got kids coming in, cutting themselves (…)'*

3.2.1.5 Pressure of the school context

The school context and the pressures it puts upon all staff and students are discussed by participants. This is described as a '*vicious circle'* where staff are under pressure to appropriately support those who self-harm. Subject teachers are considered to be under enough pressure with delivering the curriculum and seeing a large volume of students without needing the additional pressure of being informed of every individual who may need additional consideration.

The changing pressures of the school context are considered by participants when they discuss when activities are delivered to students *'so I always do one before exam season and cover stress and anxiety, and just before mocks.'* Participants also empathise how the pressure of the school context may impact on individual children: '*if you are a child in a class of 30 moving through five different teachers, fourteen teachers through the course of a week, school is quite a scary, high pressured, lonely place.'* Participants frame this as a causal attribution for self-harm: *'so the pressure builds up and that's what triggers that self*-harm.'

3.2.1.6 Part of mental health

Self-harm is perceived and understood by participants to be part of the wider area of mental health. There are various facets to this subtheme that allow participants to understand self-harm in the context of the school and access prevention strategies around promoting good mental health as opposed to focussing on self-harm specifically:

> *'So I think it'd be something about understanding what is, you know what is good mental health and what's not.'*

Participants see self-harm as '*an indicator of an underlying concern or problem*' and acknowledge that the causes of self-harm can be '*very complex'* although on occasion individual problems are simplified as due to attention seeking: ''*One young person does it for attention, a cry for help.'* Participants discuss the underlying reasons for self-harm and that these are not evident, and consider a deeper understanding of the individual's reasons for self-harm to be important: '*work with them to find out why they are self-harming… I think that's really important.'*

Participants conceptualise self-harm as a coping strategy used when mental health is deteriorating:

> '*It's about enjoying life you know, and about managing your mental health…managing how you feel, how to cope with it if you don't.'*

Mental health awareness is something that schools tend to cover, either through staff training or delivered to students through safeguarding assemblies and Personal, Social and Health Education

(PSHE) activities: '*the mental health stuff we do is very generic (…)'* This mental health approach and awareness appears to be used in order to do preventative work while allaying fears about contagion of self-harm:

> '*And I'm not sure it's the self-harm that needs the bigger boost, rather…about the positive thinking, and these things come up, but this is where you can go for the help*.'

3.2.2 Prevention

Self-harm prevention provisions across schools fall into two broad domains:

- Promotion of mental health and wellbeing
- Raising awareness of self-harm and associated risk factors

Evident throughout discussion was a need to focus resources on preventative approaches so that students would not reach the point of engaging in self-harm. This particularly entails activities to promote mental wellbeing and the early identification of students who may be at an elevated risk:

> *'And then identify the kids early, identify who your vulnerable are so I think girls groups and things like that and boys groups have been a big influence on keeping it down. And being open.'*

Identification strategies were discussed in general terms and schools do not have a consistent or specified approach. Schools do not provide many activities that might be considered as specifically preventing self-harm.

3.2.2.1 Promotion of mental health and wellbeing

3.2.2.1.1 Promotion of student mental health and wellbeing

Participants suggested that improving overall mental health and wellbeing would prevent onset of self-harm. The majority of health promotion activities are delivered as part of PSHE curriculum. These activities are universal and primarily address social and emotional competencies and coping strategies:

> *'We have now got PSHE days coming up for year 10 where we are going to deliver mindfulness and counselling and it gives them coping mechanisms but that is whole cohorts.'*

Delivery agents for these activities vary across schools. Some employ specialist PSHE staff members, whilst others draw more upon external agencies (e.g. nurses, charities) to deliver presentations, workshops and theatre productions. Participants noted that having dedicated subject teachers of external experts to deliver mental health promotion activities has a range of benefits:

'*It instils more confidence because I know when I was a tutor and having to deliver PCRE*[1] [Personal Careers and Religious Education] *to a sixth form that was the worst lesson of the week for me [laughter]. It really was, it was like completely out of comfort zone.'*

Schools offer more targeted support to students they understand as *'vulnerable.'* Vulnerability largely comprises social and emotional difficulties or young people at risk. The identification processes for this vulnerable group often entails recommendation from school staff or screening with tools such as those provided in the Thrive[2] programme. Thrive provides online screening for children and young people against age-related expectations of their emotional and social skills.

'We identify them quite early as far as the Thrive program goes and even if they are not formally assessed on the Thrive program if we know that they have got emotional difficulties…we'll set up programmes straight away for when they come in, and I think that maybe gets things before something could go down the route of self-harm.'

Targeted support work is then delivered to these identified students, with the content depending on their perceived vulnerabilities.

3.2.2.1.2 Physical location of mental health support in schools

Participants discussed the role of nurture rooms and student hubs in centralising pastoral support, improving the accessibility and availability of provision, and enhancing staff-student relationships by increasing informal interactions. Within these spaces students receive social and emotional support from a range of pastoral care staff, with some schools co-locating the counselling service within the same space:

'They can come in there, they can sit, they can colour, they can do whatever they want…We've got somebody to talk to and they know if I can't do anything we'll put them in the right direction of somewhere to go.'

Having pastoral and support facilities in a designated physical location was felt by participants to aid students' understanding of where to go for support if required: *'That's one place where you go to for any support.'*

[1] The PCRE curriculum is very similar to the national PSHE curriculum.

[2] Thrive: The Thrive Approach helps adults prepare children and young people for life's emotional ups and downs (www.thriveapproach.com)

3.2.2.2 Raising awareness

3.2.2.2.1 Self-harm awareness for students and staff

Participants discussed schools' existing activities to explicitly raise awareness about self-harm amongst both students and staff. Participants tend to conflate self-harm and cutting, and thus often delineate 'self-harm' from other types of harm that may be self-inflicted, such as alcohol abuse and substance misuse. Discussions also extended to explore additional harms that fall within schools' safeguarding remit (e.g. domestic violence, child sexual exploitation and female genital mutilation [FGM]).

Provision of self-harm awareness for students is variable, with numerous barriers to delivery. Schools undertake a range of assemblies, but these tend to focus on alternative forms of harm:

> *'Member of staff: We do have people come in and deliver workshops for alcohol and drugs and stuff like that.*
> *Interviewer: So they are useful?*
> *Member of staff: They are useful. We got a group last year who came in about FGM they did one on that to raise awareness which is not self-harm but it is harm.'*

Across the schools there was tentativeness about discussing self-harm with the whole school population, amidst fear of contagion or amplification. Student and parent assemblies were discussed with a similar outcome: participants would not feel comfortable addressing the issue in groups – mostly out of '*putting ideas in their head*' or giving too much information when parents do not need to know. With regards to a parent assembly, they mention that there could be a potential link between the home situation and self-harm and that '*every family and every case of self-harm is different, so they will ask for personal advice anyway*.'

Participants mention they will go with expert advice on how to deal with self-harm as they feel less knowledgeable: they consider themselves *'by no means experts'* in areas such as mental health, and fear giving the wrong advice:

> *'We asked [a consultant at a CAMHS] about children, could they be spoken to in assemblies about things, but they've, CAMHS advised us at the time not to do that.'*

One school does include self-harm as part of more general safeguarding assemblies that are delivered to students three times throughout the academic year.

'Well the kind of focus of the assemblies is keeping you safe, so I touch on PREVENT, female genital mutilation, sexual exploitation and then other things such as anxiety, stress, self-harm.'

Participants did state that self-harm awareness is in some cases addressed within the PSHE curriculum, as part of the broader range of safeguarding issues. This primarily centres on signposting to relevant support services in the event that they experience emotional distress:

'It's also covered within the [PSHE] curriculum and so again the awareness side. This year we have put in every student planner help numbers… relating to anything from self-harm through to PREVENT so the students all have those numbers with them whether they are in school or out of school.'

Participants vary in their views of the appropriate age at which awareness of self-harm should be addressed. Some consider that this is something best left until sixth form or the end of school, as this group are perceived to be less susceptible to contagion.

Alongside discussions pertaining to the fear and panic that school staff often experience when encountering students who self-harm, participants considered there was often limited awareness training offered to school staff beyond safeguarding. Where training had been provided, it was primarily around generic mental health:

'I also think that we don't have the expertise within us to be able to talk about self-harm… the idea is that CAMHS will come in and do training with staff about mental health in general.'

3.2.2.2.2 School website and newsletter

Participants discussed the potential of using websites and newsletters to communicate information to parents in order to raise awareness and signpost to relevant resources. However, these discussions were couched in concerns about explicitly mentioning self-harm:

'So it, you could almost slot something in, just discretely, but you know be careful around our wording and just be something to be mindful of.'

3.2.2.2.3 Signposting

Schools may signpost students to additional services or provisions that may be of use. This includes charity or community organisations that may offer advice and assistance for self-harm, but can encompass websites, classes and clubs '*like yoga, boxing whatever they can do to get their anxiety out.*'

3.2.2.2.4 Contagion of self-harm

Participants expressed apprehension about undertaking awareness raising activities, due to concern that self-harm may be contagious and that open discussion of the behaviour will encourage or amplify engagement in the behaviour; '*We could be making people think, ah, actually, I'm gonna do that.'* This theme was pervasive throughout the focus groups:

> *'I don't know whether we're, cause its quite a delicate subject, I mean, it's something that awareness, you know, I wouldn't necessarily want to be putting loads of information up on boards because it could be a double edge sword in a way, couldn't it?*'

This fear of contagion underpins schools tendency to react to instances of self-harm rather than actively promote awareness. As participants have experienced self-harm being a trend or clustering in groups, they are reluctant to reinforce this group identity. There was also expressed concern that discussion of methods of self-harm would provide students with knowledge and ideas that they previously did not have:

> *'We had a conversation with CAMHS about whether they should come in and speak to all of them about the perils of taking medication. I feel really uneasy about that because most of the kids in year 11 aren't doing that, I don't want to put that idea into their heads.'*

The balance between awareness and promotion is considered carefully by schools: '*you want to do enough to say that we are here without promoting it.'* On occasion participants considered that the benefits of promoting awareness of self-harm may outweigh the detrimental impacts it may have:

> '*You're gonna have the number that self-harm regardless, and the ones that are going to want to try it. And I think by highlighting it, they are going to try it, but…the gain will outweigh the risk… without identifying the problem you can't solve it. So you just need to be aware, staff need to be aware and you know, you have to raise it as a problem.'*

In addition, participants reflect that contagion can be reduced by the departure of pupils who are deemed to be influential in promoting self-harm or seen to exacerbate the social desirability component of self-harm. They also believe that having policies to keep marks of self-harm covered may reduce contagion:

> *'We got some advice from another school after we had a spate of it …and one of the things that the school had adopted they said that made a difference was this, covering of the marks to stop that kind of drawing in and the fascination by other children of what they are seeing and doing.'*

3.2.3 School Processes for self-harm intervention and management

Schools employ a variety of approaches for intervening when presented with a case of self-harm. These procedures are largely informal although schools cite clear examples of how they make both pupils and parents aware of who they should talk to about safeguarding and related concerns that included self-harm: '*They were given like a credit size card, with pictures [of] who they could go to, to, feel safe.'* Another school had different coloured lanyards for staff with safeguarding responsibilities and informed students regularly of who these key people were. School-based responses tend to be reactionary rather than pre-determined. Decisions on the course of action is generally undertaken on *a 'case-by-case basis'* with the approach being tailored to the needs of the individual student, and being dependent on the severity and history of harm, plus the home environment. The process that schools have in common is that core safeguarding and pastoral individuals assumed responsibility for intervening when self-harm is disclosed.

3.2.3.1 Responsibility

Self-harm is viewed as being within the remit of schools' responsibility, falling under the *'safeguarding umbrella'.* By conceptualising self-harm as a safeguarding issue, schools have a clear process of for dealing with disclosures. Incidents are passed to a designated safeguarding lead. This approach is enacted in an informal school policy of '*do not go home if you are concerned about a child; pass it on.*' Teaching staff, parents and students are made aware of disclosure and referral procedures through a variety of methods including assemblies, induction sessions for new staff, generic staff training, and notice boards displaying the roles and responsibilities of key individuals. Participants expressed the view that designation of safeguarding leads allows schools to be clear on who is responsible for self-harm. Schools vary on how much training subject teachers, other staff and pupils have around self-harm. Including self-harm under the safeguarding policy allows the creation of clear guidelines and procedures around informing parents.

Participants with a pastoral or support role indicated that teachers should not be expected to be directly involved in the management of self-harm. They frame this in terms of the emotive impact that self-harm can have and the lack of appropriate training. Views included that it should be '*being dealt with by somebody that's trained in that area rather than expecting a maths teacher to do it.*' There was further consideration of the extensive responsibilities already being managed. However, participating subject teachers and teaching assistants expressed an interest in being more involved in self-harm prevention and management: '*you know some would happily take more [responsibility]. I know it's easy to pass on (…)'*

3.2.3.2 Disclosure and detection of self-harm

There are four main mechanisms through which student self-harm is detected or disclosed within the school context. Firstly, students will inform a staff member that a peer is engaging in harmful behaviours:

> *'… sometimes the children will come in and say well you need to talk my friends as well because they're doing it… so then we encourage them then …the friend to come in and talk.'*

Secondly, students will themselves disclose to a member of school staff that they are self-harming. Participants stated that students know who they can go to, though there is sometimes a lack of procedure for informing students on how they might seek help: *'I think the students do probably know where to go, if there is a problem.'* Indeed, participants generally stated that if a student was to seek help within the school context they would approach a member of the pastoral team, but that there was not necessarily a designated source of assistance for self-harm:

> *'Cause they know they can come up and disclose to us and we do have a large number of students who are happy to disclose to us [the pastoral team](…)'*

However, participants were clear that all students are made aware of the role of safeguarding leads and pastoral team members.

Thirdly, staff may detect self-harm amongst students. This is thought to be particularly apparent in the case of physical education (PE) teachers who may notice cuts or scars that are otherwise covered. In some schools staff are advised about how to identify someone who may be self-harming as part of safeguarding training:

> *'They will know to look out for suddenly someone who was wearing a short-sleeve will be coming in with long-sleeves, not want to get changed for PE or drama, so all those signs, symptoms staff and students are told to look out for.'*

However, participants felt that teachers would benefit from more training or support with regards to identifying a student who was engaging in self-harm, or having a conversation where the subject is broached in a supportive and caring manner in order to address the fear that they may *'say the wrong thing'*:

> *'there are some that probably could do with some form of, of identifying of self-harm or prevention …so it's just a little bit of knowledge about how you can manage it…just that initial response I think is what they need.'*

Where training had been provided it was deemed effective and helpful to the staff: *'…we had some self-harm training, last week. And it was wonderful training.'* Meanwhile other participants continued to express that training is not adequately targeted to secondary school students or there is a focus on generic mental health without specific consideration of self-harm.

Fourthly, schools may be also informed by a student's parents that their child is self-harming. This process was variable, with participants stating a complex relationship with parents, especially if they did not see the school as having a role in intervention and management:

> *'I think some parents stand back from maybe coming forward to us because they see most of the role of the school still as academic, they might maybe go to a doctor first, and then they might maybe contact us to say you know, I've taken her to the doctor. Just to make you aware, I have taken him or her to the doctor.'*

3.2.3.3 Safeguarding procedures

Following the disclosure or detection of self-harm, schools transition into the process of management. Across schools the response is structured by safeguarding procedures, with reporting and escalation through the system being similar to other risks and harms. School staff that become aware of a student engaging in self-harming behaviours escalate the incident to the safeguarding lead. This procedure is undertaken in accordance with safeguarding protocols. Adherence to this process reflects a concern amongst school staff about having the knowledge needed to manage the incident themselves:

> *'At the moment [named person] is our safeguarding member of staff so I would report anything I am concerned about to him and then we deal with it as we see fit*.'

> *'Now I'm quite scared to get involved, because I just, I literally just pass it on, pass it on, pass it on. It's hard when you've got that child in front of you, it's alright to follow the procedure, but when that child is front of you it's hard.'*

However, there are perceived barriers to effectively managing self-harm through this process, as there may be a lack of communication or joined-up working with the school.

3.2.3.4 Risk assessment, classification of harm and triaging

On the referral of a case of self-harm to the safeguarding lead, informal and formal risk management and assessment tools are put in place. Management strategies are intended to

be sensitive to the needs of the individual, and include involvement of a range of internal and external service provisions:

> *'In each meeting there would have been the head of house, pastoral support manager, senior link, myself, [named safeguarding lead], so 6 people. For each hour discussing the kids that we are worried about…so we can grade what our concerns are and where we've got CAMHS and where we've got counselling.'*

In some instances other school staff will be made aware of the student's history and needs:

> *'If they're at risk of overdosing for example, we would put severe and very stringent things in place, so their teachers are aware, the pastoral teams [are] aware.'*

Where the risk assessment process and categorisation of harm indicates that a student requires external support, the school triages the student and makes a referral to the appropriate services following consultation with the student and their parents, where appropriate. This includes: CAMHS; social services; accident and emergency; the GP or a child psychologist. Participants expressed concern about having to hold more serious instances of self-harm within the school until appropriate external services such as CAMHS could be accessed: '*almost like a sticking plaster until they get to CAMHS'* which was problematic due to delays in waiting times and high eligibility thresholds:

> *'Regular self-harmers that aren't being picked up because they've not taken it to the extremes…we've not got the expertise but they are not being picked up by CAMHS.'*

Participants discussed that having more support from CAMHS during the time between a referral and treatment may alleviate some of their concerns about managing a student within the school: *'It's that bridge we are missing.'* Others reported already having strong working relationships with CAMHS and other external professionals. Variance in experience seems contingent on individual relationships and the coverage of services at different geographical locations.

3.2.3.5 The containment of self-harm

A key process to emerge following the disclosure or detection of self-harm amongst students is to contain the incident. This approach is largely informed by assumptions pertaining to the risk of contagion or behaviour amplification. As part of the containment effort a number of schools actively limit the number of staff dealing with self-harm to a small and dedicated team:

'She would go into a lesson and do it [self-harm], and so all teachers were jumping on board then and everybody was giving her a little bit of advice… so it was getting a bit out of hand… because it was starting to affect a lot of people so a smaller team worked well.'

3.2.3.6 Harm minimisation

Participants stated that they aim to promote alternative coping strategies, but will equally employ harm minimisation strategies for students that continue to self-harm:

'It got to the stage where they are doing it, safely, and able to talk about it, is that better than them doing it and it going wrong or taking it to that next level?'

Participants also commented that students occasionally use implements that they find within school to self-harm (e.g. in food technology classes, taking the blades out of pencil sharpeners), so will aim to minimise access to these implements or on occasion check that students are not in possession of them.

3.2.3.7 Promotion of alternative coping strategies

Schools aim to provide students who self-harm with what they deem to be more adaptive ways of coping with their emotions: *'giving students… knowing what they could do in that situation and giving them kind of ways out and support as well.'* These strategies can be sourced through CAMHS, counsellors or online resources. Strategies tend to promote techniques that create the same sensation as cutting or replace the harming behaviour with other forms of coping.

Participants discussed various methods used to encourage students not to wound themselves but to create the sensation of pain through alternative means*: 'ice cubes and elastic bands.'* Other strategies used by young people aim to divert them away from self-harm when they feel the urge to do so. These tended to be varied and described ad hoc: *'every time she felt like she wanted to self-harm she would break a glow stick and wait for the glow to go, and sometimes the feeling would pass after a while.'* Additional methods included drawing on skin rather than cutting, and writing in a journal.

Some schools utilise external services specialising in self-harm workshops to promote alternative coping strategies. Activities delivered include: art; therapeutic discussions; and meditation. One particular third sector organisation a school finds to be useful is Heads Above the Waves (hatw.co.uk). Students may refer themselves to this service or staff: *'can make like a discrete approach to them and say this is going to be made available to you.'* The sessions run for a double lesson every two weeks, and aim to support young people to develop *'positive coping mechanisms.'*

3.2.4 Key people involved

3.2.4.1 Parents

Schools perceive parents as having a vital role in addressing self-harm, as '*parents are ultimately responsible for them [the student].'* Parents, and their role in the development and or ceasing of self-harm, arose throughout focus groups where participants discussed informing parents about their child's self-harm and how much information should be disclosed to them.

3.2.4.1.1 Informing parents about self-harm

With a few exceptions, staff inform parents about a student's self-harm. There are occasions where they hesitate to do so immediately or to do so at all; however, they feel they are obliged to inform parents:

> '*We have a duty of care to tell the parents so we're stuck between a rock and a hard place. If we don't tell the parents and they go home and have an overdose, we you know, we haven't followed the legal process. And if we do, it can make it worse.'*

Participants talked about several elements that influence their decision to inform parents, with it generally being determined on a case by case basis:

> *'Interviewer: You mentioned parents there; do you routinely inform all parents of instances of self-harm?*
> *Member of staff X: 1 to 1 depending on the child, because … [talks about different cases of self-harm, with different context].*
> *Member of staff Y: I think it's the right policy to have because it's about that individual and what their need is.'*

When a case of self-harm is disclosed, staff discuss it with the student to determine the causes and severity of the harm. The course of action, specifically with regard to informing parents, is dependent on the nature and severity of the self-harm, the age of the student, the family situation and type of parent, and the reason behind the self-harm (if known). Schools prefer to work with the student and support them to inform their parents themselves:

> *'If it's a cry for help then [we will] not necessarily [inform parents immediately] depending on the nature of what they are doing and the conversation we have with them then we won't necessarily at that stage. We would always encourage them to do that themselves.'*

If it is a severe case of self-harming or the student promotes their self-harm online, it becomes a case of safeguarding and parents are informed immediately.

3.2.4.1.2 Family functioning and parenting style

Participants report that the family situation may be a reason for students' self-harm, and informing parents could worsen the situation. Indeed, the family situation might be fragile and incapable of supporting the young person, or the home situation could be part of the problem:

> *'We haven't rung home because dad has mental health issues and she has so much else going on that we are trying to support her through that. It's more of a worry for her for us to ring dad and worry him about what's going on so we're trying to support her in every way.'*

> *'Some of the cases that we have of students that self-harm is to do with a family issue that's going on at home, domestic violence or something else. And that could make it worse for the student if we'd inform them. So I suppose it's a very individual case over what we do. The majority of the time we do [tell parents], but there is that one off case where actually it wouldn't be in the best interests of the student to actually let them know.'*

Parents react differently to the knowledge and adopt different approaches to managing the behaviour; all of which participants mention affects the situation. Some get annoyed and tell their child to cease self-harming, a number hold positive and constructive discussions with their child, whilst others hide all sharp objects in order to keep them from cutting:

> '*I think sometimes parents unwittingly say the wrong thing, thinking they are helping, and undo a lot of the work that has been done in school and actually you know just by watching them [their child] and keeping them under lock and key and 'I can't trust you' and all of that negative language, it just doesn't help the situation.'*

3.2.4.1.3 School as a place for advice and consultation for parents

Once parents are informed, schools may support parents in dealing with the self-harm of their child. Participants find that parents have poor knowledge and understanding and often are in denial. In these instances, staff may work with parents to adopt positive coping strategies and advise on how to communicate with their child: '*Parents usually get cross and say stop doing this. We know this does not work; we teach them other ways of coping.'* Participants described their school's approach to working with parents as:

> '*We would join up with the parents and support them. And they will become the protective factors outside of school and we are the protective factors inside school. So that's how we work it.'*

In addition, parents worry they have done something wrong. They turn to school as a sounding board. Having that conversation with parents is considered important so they know they are not on their own, or become at risk of isolation. Positive and open communication with the school is considered to be important to prevent the parent from becoming isolated. Staff who are parents themselves reflect on this from a parent's perspective and sympathise with parents, they acknowledge that: '*it is difficult as a parent to know how much information you need to know and what are the right things to say and not to say.'*

3.2.4.2 Peers

A great deal of knowledge about students who are self-harming comes from peer disclosure. Participants describe peer disclosure as a useful tool, because they use the information to shape the way they approach students that are self-harming. Indeed, some staff report they are even reliant on peer disclosure to become aware of students who need help: '*that's when you have to rely on the other children.*' Students are therefore strongly praised when they inform staff if a friend is self-harming: '*I'd always go back to them and say keep telling us and really praise them for doing that, it's a really bold thing.*'

Peers are acknowledged as being a useful resource for helping one another, particularly when encouraging friends to seek support from staff: *'[A] year eight pupil came to the key stage office and reported that she'd self-harmed. Her friends had encouraged her to get support.'* One school's ethos is geared towards empowering students to get help for themselves and others when they need it: '*we have key values in our school…and since we've adopted them the children have been much more proactive in seeking help and support.*' At the same time, staff are fearful that a considerable burden is placed on students when they learn that a friend has self-harmed: '*as a group of students who never touched on self-harm and then suddenly one of your peers has disclosed this, I mean that's quite scary for them.'*

Despite this, peers share a level of understanding and lived experiences in their communities that is different to staff, which promotes the need for students to be a bridge of communication between students and staff:

'*Senior students who know the communities of course, that they're growing up in and they know what some of the issues are. So they tailor things then to what they know are going to be relevant for the younger [students].*'

3.2.4.2.1 Peer mentoring

Peer mentoring is not widely used by schools for self-harm, although schemes where older students mentor those younger than them are common. There are positive aspects identified by participants to involving students in prevention or intervention activities, although concerns about contagion remain. Students are considered to be more able to identify with other student's compared to staff: '*they can be very insightful, you know children probably know, they generally know more than us of course, going on, and what is going to be effective and what is not effective.'* These strengths can be used in peer mentoring, and engaging students when planning interventions: '*whether they're going to do assemblies, give out information and or, and it's, they're going to come up with a plan*.'

Provision of personal experience from a former student and her friend demonstrates both the strength of peer support and the use of peers in intervention and prevention strategies:

'W*e had a child who is now an adult who was suffering from anorexia. She is coming back in with a friend to talk to our groups of year 10 and 11 about what it was like and what it was like to be a friend of. So they are coming back to do an information day*.'

The effectiveness of providing tiered support where sixth form peer supporters work alongside professional staff is also recognised by participants: '*we've got the school counsellor and there's small pockets of people, we've got six form peer supporters, there's so much support out there*.'

However, there are issues raised when peer mentoring is discussed. Staff mention that lack of discretion amongst students about information shared in confidence makes peer support an inappropriate method of support for self-harm:

'Kids are kids, and they go out and they gossip and you know it wouldn't stay confidential. So people would be genuinely opening up to people and then it, some of their private things would be then divulged down the corridor.'

Also, participants worry about the level of responsibility and pressure that would be placed on students when providing peer support, which would be far too great: *'I, think it's a big ask to ask a teenager to look after and look out for somebody who's in that state of mind.'* Staff also consider that mentors would need to be specifically chosen for the role: '*look if there was an old student that had had experience.'*

Participants also considered the type of training sixth form peer supporters might undertake to support younger students. For example, anxiety and resilience training rather than specific training on self-harm is thought to be more appropriate:

> '*This is about mental health, rather than self-harm but if it comes under that umbrella, then they'll be doing that as well' but not specific training in self-harm.*'

3.2.4.2.2 Social media: Peer culture around self-harm

Staff are aware that social media is a tool that provides students with extensive information on numerous types of self-harm. In particular, social media provides students with a way to find groups or communities that they can identify with: '*They are looking to belong to a group, to conform.*' Participants think that social media can influence trends of whether to self-harm, or fashions of how to self-harm, '*some of it was all about, you know, 'Do you cut, are you cutting?' and 'Are you cutting tonight?'* It is clear to participants that the internet and social media can be negative to students: '*I don't think they are looking at any of the positive-aspects I don't think they'd look at the preventative.'*

In addition, social media and the culture of 24 hour communication is seen by participants to potentially have a detrimental impact on peers of those who self-harm. Being able to constantly access friends puts pressure on peers: '*some of these conversations actually went into the night, absolutely scare the living daylights out of the friend (...)*' Participants understand social media as having a wider impact than just on the individual. There is an effect not only on the student who self-harms but on other students too. For example when pictures appear on their timelines: '*You get some horrendous pictures. So it's not just about the young person's self-harm. That can affect other people as well.*'

Students may identify peers who self-harm from social media, which they then share with staff, leading to an additional method of disclosure of self-harm: '*students are very aware of what's always happening and through social media as well, I've had 'Miss look at this'.*' If alerted to a particular student, staff may browse the student's social media profiles to ascertain if they have potential issues: '*and most of the students still have an open profile.*'

Participants noted that addressing claims of self-harm based on social media profiles can reveal the claim to be unfounded: '*We've had some really strange things where we've had some students that have put up pictures of self-harm, and then it's not them!'* Staff report that they are shocked by what can be found on social media: '*somebody had hanged themselves and it was pictured on there and he had a fascination with hanging so that was quite horrific.*' When aware of this, schools restrict access

to certain web pages, for example self-harm picture websites: '*some of the most disturbing images, cos they could just download these images from anywhere around the world and add it to their own kind of 'self-harm page.*'

3.2.4.2.3 Social media intervention and management of self-harm

Schools find it difficult to address self-harm publicised or linked to social media because there is a lack of support and personal experience: '*social media the constant barrage and battery of you know, you know the 24 hour life. Um, so I think the services haven't caught up with the technology.*' Participants do however feel students would benefit from technological based prevention: '*So, us talking to them is not always the way, but to get them to engage with technology that they're using that we maybe don't use as much, I think that's the way to do it.'* LOTTIE and ZAK, which are online safeguarding tools are considered by staff to be both useful and effective: '*just giving them the opportunity to do what they normally do, which is to go on social media pages, get them to understand the processes.*'

3.2.5 Future aspirations and unmet needs

There were several subthemes to emerge from discussion around schools' unmet needs and future aspirations for self-harm prevention or intervention: early identification; awareness and prevention; improved links with external services; and toolkits of support.

3.2.5.1 Early identification

Being able to identify young people who are *'vulnerable'* and at risk of self-harm early on is considered to be key to preventing serious self-harm: *'when they first sit in front of me and they tell me they are not eating or they've started cutting themselves...put the support in then before it escalates further.'* Participants see this early identification as something they can do within school rather than it being the responsibility of an external agency. One way that early identification can be implemented is through training of staff and students to identify warning signs of self-harm:

> '*… some kind of programme that trains…tutors, to actually be guided a little bit more on the pointers of how to look for it and what sort of things you might be looking for.'*
>
> *'The ones we've missed or tended not to get as early as we could would be those high-level students, you know those kind of bright people that suddenly become very anxious and very concerned…and that's the one area that we potentially could do some more work with and have some more help on.'*

Examples were given of action undertaken for improved identification of students at risk of self-harm. This includes training for staff and students on identifying signs of general mental ill-health, for example by noting changes in mood, peer groups, behaviour and (for self-harm specifically) whether the young person starts wearing long sleeves. In line with this, PE teachers are identified by participants as being instrumental in noting changes in pupils' attire that may reflect self-harm.

Participants cited examples of students who they felt did not show any early indication of potential to self-harm: staff mentioned they could be unaware and *'it can just literally hit you.'* This early awareness was considered by staff to be a clear training need:

> *'The ones we've missed or tended not to get as early as we could would be those high-level students, you know those kind of bright people that suddenly become very anxious and very concerned…and that's the one area that we potentially could do some more work with and have some more help on.'*

3.2.5.2 Awareness and prevention

More preventative work is thought to be important, although this primarily takes the form of mental health awareness:

> *'I think it's really important to have good quality PSE in place so that you can do preventative work.*'

> *'setting aside time in the curriculum to talk about emotional health and well-being (…)*'

Promotion of positive mental health links to schools' predominant understanding of serious self-harm as being the consequence of poor mental health in some students. However, the timing of this preventative work requires further exploration.

Parents were also discussed as being an avenue through which awareness could be raised, with participants reported having discussed how information could be disseminated to them:

> '*There are open sessions with me around SEN [special educational needs] and safeguarding so parents can come in, but it's not specifically around about self-harm so that might be something to think about in the future in terms of having a drop-in.'*

Other ways participants thought parents could be contacted to provide information included putting information in newsletters and on the school websites: '*send maybe a leaflet home to mum and dad.*'

Participants felt that student involvement in prevention and intervention provision planning could be pursued further in the future, although concerns about contagion did form part of these considerations:

> *'Although we've definitely set against doing student group work, it might be interesting, I don't know how you'd do it but, to talk to students about how they think schools deal with it, and how they think it could be improved*.'

3.2.5.3 Improved links with external services

Schools desire more input from other services. This primarily includes CAMHS, but also GPs and A&E. Participants described a number of mechanisms for improving current provision. This includes having better access to CAMHS for advice on how best to manage students who self-harm before the behaviour escalates and later necessitates a referral to the service. Participants suggest that this improved communication could take the form of an advice line. In addition, having external supervision is considered to be useful, especially where this is made available to the counsellor and safeguarding staff. However, such supervision is only rarely made available, and participants in general favour more support and supervision from CAMHS.

Improved links with external services are sought to address staff concerns about not doing the right thing, and to ensure that schools are in possession of the most recent knowledge and information: *'to make sure that we're doing everything correctly, and update us on anything else as well that we need to know.*' Improved links with services are also desired in order to glean advice on managing individual behaviour and to know when it is appropriate to refer a student for additional support or treatment. Participants highlighted the potential benefit of having external experts deliver prevention and awareness raising activities to staff so that they are in receipt of the necessary knowledge and information. This person with expertise, although often mentioned by participants as potentially coming from CAMHS, could take the form of a counsellor, or nurse based in school: '*to have…a qualified person within a school with experience or at least a level of expertise within that.'*

2.2.5.4 Toolkits of strategies

Participants discussed the need for schools to have access to a '*toolbox*' of strategies they can use to address and manage self-harm amongst students within the school context. This can take many forms. One participant describes it as a self-harm first aid box with: *'things that those students can do to alleviate the situations where they're feeling tempted to maybe do something harmful to*

themselves but maybe choose to do something else.' These strategies are thought to be particularly needed when a young person is awaiting an appointment with an external service.

4. Discussion

This mixed methods study utilised a survey and qualitative consultation with secondary schools in order to answer the following three research questions: What student self-harm prevention and intervention activities are currently delivered by secondary schools in England and Wales? What prevention or intervention needs do secondary schools in England and Wales have in regard to student self-harm? And what would be key to an acceptable and feasible prevention or intervention approach for addressing student self-harm in secondary schools in England and Wales? These are discussed in turn below.

4.1 Current delivery of self-harm prevention and intervention activities

Prevention activities that particularly target self-harm in schools are limited and they are not schools' preferred approach to deal with self-harm in the school setting. The focus in schools is on the promotion of students' positive mental health and raising awareness of key staff in safeguarding and pastoral roles. The latter ties in with schools' structured, yet reactive response when presented with a case of self-harm. School processes following disclosure focus on risk assessment, first aid and referring to appropriate services, either within or external to the school. This reflects findings of a recent meta-ethnography (14), that schools tend to escalate what they perceive as severe self-harm for expert, often external help from specialist services. Decisions on the course of action is generally undertaken on a 'case-by-case basis' with the approach being tailored to the needs of the individual student, and being dependent on the severity and history of harm, plus the home environment.

4.2 Prevention or intervention needs

Half of responding schools in Wales and 58% of schools in the South West reported school staff training was either voluntary or mandatory. Half of respondents rated the training received as adequate, with a further 22% rating it as high or very highly adequate. Lack of training, time and resources were reported by survey respondents as being barriers to delivering prevention and intervention activities. High quality training is needed for schools to effectively carry out activities to prevent or intervene with self-harm; in particular participants discuss that training for staff around how to respond to disclosures or incidents of self-harm would be of use. Early identification of young people at risk of self-harm, raising awareness of the importance of good mental health and actively promoting good mental health to prevent the onset of self-harm were activities mentioned that could be done within the school if provided with appropriate training.

Few schools provided training to students around self-harm (around 30% for one off or routine provision), although almost 40% of schools indicated this was something they would like to provide.

The point at which the process of managing self-harm within schools is most challenging is when a student has been referred to external services but have a long wait before treatment: the school feels caught in the middle in these cases and not sufficiently equipped to provide the level of specialist support they perceive the student needs. Improved links and advice from external services such as CAMHS and toolkits of strategies they can use within school to appropriately manage less severe cases of self-harm were identified as helpful. Incorporating trained professionals into the school context is seen as useful by participants. Counsellors and nurses, who are already present in schools, are seen as one of the main in-house resources of expertise on self-harm.

Participants mentioned that future research should include young people as they are likely to know more about what may be acceptable or feasible, and they are currently rarely consulted due to fears around the sensitive nature of the topic of self-harm.

4.3 What would be key to prevention or intervention?

Our survey findings indicated that schools consider emotional health and wellbeing to be of high priority in terms of health. The qualitative findings showed that participants believed that by focussing on mental health more broadly they could both prevent self-harm from occurring in some cases and cover issues relevant to self-harm. This is supported in part by a recent study that found that effective psychosocial interventions also need to address other risk factors associated with self-harm, such as poor mental health (18). Targeted support, external training and 1:1 intervention were considered by 90% of survey respondents to have high or very high utility as methods of health promotion or intervention. This was echoed in the qualitative consultation, where participants expressed a preference for a small number of staff to be involved in issues around self-harm.

Although schools see the need for early identification of those at risk of self-harm as key, they are reticent to explicitly discuss self-harm with the student population due to fears of contagion and the balance between raising awareness and promoting self-harm. Fear of contagion of self-harm emerged from the qualitative consultation as the main reason for schools not doing more prevention activities. This was identified in the survey by ninety percent of survey respondents as a minor or major barrier. Without addressing these fears, further work on prevention or awareness of self-harm in schools will be unacceptable and will not succeed.

The school context and pressures of the school environment impact on relationships and communication between staff, parents, students and external professionals. As the role of parents and peers were discussed in depth in the focus groups, involving all parties in developing school based strategies to address self-harm will be useful. Schools discussed examples of successfully liaising with

parents in order to provide the best support possible for young people: these links are important and could be further encouraged. Our findings reflect studies that showed that involving parents in psychosocial interventions for deliberate self-harm in young people is key to their success (19, 20).

Finally, young people's culture and involvement in social media is an important issue for schools: social media is considered by participants to have a mainly detrimental impact on self-harm. Schools feel they do not know enough about this and they see it playing a large part in self-harm, yet they have little control over social media use and this poses a difficult challenge.

4.4 Implications and future directions for policy and research

Findings from our study indicate that schools have reservations about delivering universal interventions that target self-harm due to potential for adverse consequences, unless they target mental health more generally or are delivered by external experts. Access to external services will depends on the geographical location of individual schools: having appropriately trained individuals within schools or clear pathways of communication with local services is needed and future work could examine the most appropriate way to address this.

Allaying concerns about contagion caused by openly discussing self-harm requires more research and will be important in order for schools to consider prevention programmes feasible: current evidence shows that those who have been exposed to self-harm or suicide are more likely themselves to self-harm, however it is unclear what direction this operates in and how this may operate within the school context (perhaps those who share similar risk factors are likely to become friends) (20). Overcoming barriers to carrying out prevention in schools is needed as studies, including one that analysed the views of almost 3,000 teenagers, suggested that schools are a key place for primary prevention activities around self-harm (13, 21).

The lack of a standard policy for self-harm across schools was an interesting finding given that the schools involved in the qualitative consultation tended to follow a similar procedure following disclosure of self-harm. Statutory guidance exists for other aspects of safeguarding in schools, although the guidance around mental health is advisory and contains less than one page on deliberate self-harm (22). This could be expanded to cover self-harm and suicidal behaviour specifically. Implementing national guidelines or policy for self-harm and suicide prevention for schools would allow for consistency across geographical areas as well as being an avenue through which staff knowledge could be increased. Additionally, schools in our study discussed that if a topic is covered in the National Curriculum they have to deliver it to students: including topics such as self-harm in an age-appropriate way in the curriculum may address awareness and prevention for young

people at a population level. Similarly, although schools mention there is little time to deliver training to staff around self-harm, if this was encompassed within safeguarding training it would be mandatory to deliver. Alternately, trainee teachers could be educated about self-harm in young people prior to beginning their professional careers.

Although schools are reluctant to involve students in prevention and intervention activities, evidence has shown that students who self-harm are more likely to turn to their peers for support as opposed to adults (12). In conjunction with the prevalence of self-harm in adolescence and that young people are likely to know peers who self-harm, reluctance to openly talk about self-harm with students may be detrimental to preventing or treating self-harm. Although concerns about and fears of promoting self-harm are valid, evidence is lacking to what extent this impacts on young people and whether awareness of self-harm may have a long term beneficial effect. One study evaluating a school-based programme aiming to increase knowledge about and improve help-seeking attitudes for self-harm found no evidence that their programme increased rates of self-harm (13). This needs further research in order to determine whether this is generalizable and in order to understand how best to manage schools' concerns about these effects if a school-based intervention is to be implemented in the UK. Additionally, young people's own views as to how an intervention or prevention programme may operate in the school context is important in developing a programme that will engage and support them.

In a recent Government report on suicide prevention (22), it is suggested that education and awareness raising may be the best way to address issues around suicide and social media: this may also be the case for self-harm. As schools spontaneously discuss the role of social media and it plays a large part in the lives of many young people, encouraging awareness around self-harm and social media is going to be an important avenue for further research. Online safeguarding education tools such as Lottie and Zak are acceptable interventions and could be adapted in order to facilitate delivery of self-harm interventions. The role of social media in self-harm contagion also requires further research. A systematic review found 14 studies that explored internet use and self-harm or suicidal ideation and found mixed evidence as to whether internet use was positive (e.g. promoted coping strategies and help seeking) or negative (e.g. encouraged or increased self-harm). Many of these studies were however limited to internet forum use: something that may not reflect young people's internet use today (23). Further research should examine the role of social media in young people's self-harm.

From the survey and qualitative consultation, it appears that although schools are willing to address mental health promotion and to some extent self-harm, there is a lack of time, expertise and capacity to address this. Improved training is called for, however the time in which this could be done is limited and staff inset days are already used for a large amount of training and information-delivering. Incorporating self-harm under safeguarding allows schools to have a defined 'space' to discuss self-harm, and those that ask staff to look out for early indications of poor mental health or self-harm tend to deliver this training in the existing protected safeguarding training time. The emotional burden and staff reactions to self-harm should not be underestimated: one study explicitly acknowledges this and the need for 'non-judgemental compassion' in responding to disclosures of self-harm: acknowledgement of and this and the appropriate way to respond could be delivered in staff training (24).

4.5 Methodological issues (strengths and limitations)

A comprehensive survey of a large number of secondary schools allowed for a good understanding of the current provision and needs for prevention and intervention of self-harm in schools in the South West of England and across Wales. The survey had a high response rate, particularly in Wales where it was embedded within a questionnaire that schools routinely complete as part of the School Health Research Network. The quantitative and qualitative findings complement each other, and conducing focus groups allowed for in depth exploration of the activities undertaken by individual schools and their views on what would and would not work in their current context. Schools involved in the qualitative consultation are keen to be involved in future collaborations and made use of the focus groups to understand the views of the staff within the school on self-harm: many made notes during the group and discussed how to implement ideas that came up. For example one school discussed, unprompted by the facilitator, how they would subsequently ensure that information for parents was available on the school website and considered adding to the safeguarding section of the school newsletter that is routinely sent out. Limitations of the study are that as it was carried out in two defined areas in the UK it is not representative of the UK population as a whole. Within the survey sample we did purposively sample schools for focus groups: due to the short duration of the project and limited budget eight focus groups were conducted. As qualitative research, the findings from the consultation are not generalisable, although they do provide new in-depth information that can be taken into account designing further studies or interventions.

5. References

1. Owens C, Hansford L, Sharkey S, Ford T. 2016. Needs and fears of young people presenting at accident and emergency department following an act of self-harm: secondary analysis of qualitative data. Brit J Psychiat. 208: 286-291.

2. Muehlenkamp JJ, Kerr PL. (2010) Untangling a complex web: how non-suicidal self-injury and suicide attempts differ. Prev Res, 17:8

3. Nock MK. (2010) Self-injury. Annu Rev Clin Psychology, 6:339

4. Ougrin D, Tranah T, Leigh E, Asarnow JR.(2012) Practitioner review: Self-harm in adolescents. J Child Psychol Psychiatry. 53:337

5. Mars B, Heron J, Crane C, Hawton K, Kidger J, Lewis G, et al. (2014) Differences in risk factors for self-harm with and without suicidal intent: Findings from the ALSPAC cohort. J Affective Disorders. 168:407

6. Kidger J, Heron J, Lewis G, Evans J, Gunnell D. (2012) Adolescent self-harm and suicidal thoughts in the ALSPAC cohort: a self-report survey in England. BMC Psychiatry. 12:69.

7. Hawton K, Harriss L. (2007) Deliberate self-harm in young people: characteristics and subsequent mortality in a 20-year cohort of patients presenting to hospital. J Clin Psychiat. 68:1574-83.

8. Hawton K, Zahl D. 2003.Suicide following deliberate self-harm: long-term follow-up of patients who resented to a general hospital. Brit J Psychiat. 182:537

9. Hawton K, Rodham K, Evans E, Weatherall R. 2002 Deliberate self-harm in adolescents: self-report survey in schools in England. BMJ. 325:1207.

10. Morey C, Corcoran P, Arensman E, Perry IJ. 2008. The prevalence of self-reported deliberate self-harm in Irish adolescents. BMC Public Health. 8:79

11. Connor R, Rasmussen S, Miles J, Hawton K. 2008 Self-harm in adolescents: self-report survey in schools in Scotland. Brit J Psychiat. 194:68-72

12. Hawton K, Witt KG, Taylor Salisbury TL, Arensman E, Gunnell D, Townsend E, van Heeringen K, Hazell P. 2015. Interventions for self-harm in children and adolescents. Cochrane. Available from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD012013/abstract;jsessionid=E72C23094F0130BE1156DE73AE3C9840.f01t02

13. Muehlenkamp JJ, Walsh BW, McDade M. 2010. Preventing non-suicidal self-injury in adolescents: The signs of self-injury program. Journal of Youth and Adolescence. 39; 306-14.

14. Evans R, Hurrell C. 2016. The role of schools in children and young people. BMC Public Health. Online first.

15. Welsh Government. 2015 Free school meal eligibility by local authority and assembly. Wales: StatsWales.

16. Braun V, Clarke V. 2006. Using thematic analysis in psychology. Qualitative research in psychology. 3(2):77-101.

17. Ritchie J, Spencer L. 2002. Qualitative data analysis for applied policy research. The qualitative researcher's companion. 573:305-29.

18. Glenn CR, Franklin JC, Nock MK. 2015. Evidence-based psychosocial treatments for self-injurious thoughts and behaviors in youth. Journal of Clinical Child & Adolescent Psychology 44 (1):1-29

19. Calear AL, Christensen H, Freeman A, Fenton K, Busby Grant J, van Spijker B, Donker T. 2016. A systematic review of psychosocial suicide prevention interventions for youth. Eur Child Adolesc Psychiatry 25 (5):467-482. doi:10.1007/s00787-015-0783-4

20. Hawton K, Saunders KE, O'Connor RC. 2012. Self-harm and suicide in adolescents. The Lancet 379 (9834):2373-2382

21. Fortune S, Sinclair J, Hawton K. 2008. Adolescents' views on preventing self-harm. A large community study. Soc Psychiatry Psychiatr Epidemiol 43 (2):96-104. doi:10.1007/s00127-007-0273-1

22. Department for Education. 2016. Mental Health and Behaviour In Schools Departmental Advice DFE-00435-2014.

23. Daine K, Hawton K, Singaravelu V, Stewart A, Simkin S, Montgomery P. 2013. The power of the web: a systematic review of studies of the influence of the internet on self-harm and suicide in young people. PloS one 8 (10):e77555

24. Shapiro A, Heath N, Roberts E Treatment of Nonsuicidal Self-Injury: Critical Review and Implications for School Applications. In: School Psychology Forum, 2013. vol 4.

6. Appendices

Appendix A: Survey administered to secondary schools in Wales

PAGE 1:



School name automatically inserted here

WELCOME TO THE SCHOOL HEALTH RESEARCH NETWORK 2015-16 SCHOOL ENVIRONMENT QUESTIONNAIRE

ENTER

CROESO I HOLIADUR AMGYLCHEDD YSGOL RHWYDWAITH YMCHWIL IECHYD YSGOLION 2015-16

ENTER

Completing the questionnaire

[GH to provide text]

- Refer to documentation sent via email for full instructions
- Re-iterate key points about how the survey functions in 4-5 bullet points here

Click the button below to enter your school's data

ENTER

SELF-HARM PREVENTION AND INTERVENTION IN SECONDARY SCHOOLS

The aim of this section of the questionnaire is to scope schools' existing practices around self-harm.

The information you provide will inform the development of interventions that address self-harm and are appropriate and feasible in the school setting.

Health priorities and interventions in your school

Q61 The following are a list of health related areas often dealt with in schools through teaching and other activities. What level of importance is given to each by your school?
Please note, this may not reflect your personal view.

PLEASE RANK THE 9 HEALTH AREAS IN ORDER OF IMPORTANCE, STARTING WITH 1 AS THE MOST IMPORTANT TO YOUR SCHOOL.

	Rank number
Sex and relationships	☐
Suicide prevention	☐
Smoking	☐
Emotional health and wellbeing	☐
Alcohol	☐
Healthy eating	☐
Self-harm	☐
Physical activity	☐
Drugs	☐

Health priorities and interventions in your school

Q62 The following are a list of different types of interventions that schools may use to address a range of health related topics. What is the level of usefulness (for both staff and students) of these intervention types in addressing the health areas prioritised by your school?

PLEASE TICK ONE BOX ON EACH ROW

	Very high	High	Average	Low	Very low
Posters and leaflets	☐	☐	☐	☐	☐
One-to-one intervention	☐	☐	☐	☐	☐
Targeted group support	☐	☐	☐	☐	☐
Student peer support	☐	☐	☐	☐	☐
Curriculum lessons	☐	☐	☐	☐	☐
Staff information and training	☐	☐	☐	☐	☐
External agency intervention	☐	☐	☐	☐	☐
Whole school approaches (e.g. addressing school policies and relationships)	☐	☐	☐	☐	☐
Other **(PLEASE WRITE IN BELOW)**	☐	☐	☐	☐	☐

✎

Self-harm, your students and school

Q63 Approximately 10% of young people in the UK self-harm, so for the purpose of this survey we define an **'average' level of self-harm within a school** as **10% of students** intentionally harming themselves.

How do you think the level of self-harm amongst students in your school compares to the average?

For each type of self-harm behaviour listed below, please indicate whether you think the proportion of your student body that engage in the behaviour is very high, high, average (~10%), low or very low.

PLEASE TICK ONE BOX ON EACH ROW

	Very high	High	Average (~ 10%)	Low	Very low
Cutting	☐	☐	☐	☐	☐
Poisoning	☐	☐	☐	☐	☐
Over-eating or under-eating	☐	☐	☐	☐	☐
Burning of the skin	☐	☐	☐	☐	☐
Hitting or scratching self	☐	☐	☐	☐	☐
Excessive exercise	☐	☐	☐	☐	☐
Hair pulling	☐	☐	☐	☐	☐
Excessive alcohol or drug use	☐	☐	☐	☐	☐
Other **(PLEASE WRITE IN BELOW)**	☐	☐	☐	☐	☐

✎

Self-harm prevention and activities

For the purposes of this survey we define self-harm as any behaviour that is intended to intentionally hurt oneself. It may or may not be associated with suicidal intent.

Self-harm prevention and activities

Q64 Which of the following self-harm prevention and intervention activities are delivered in your school?

For each item, please select 'Yes. Routine provision' *if it is provided in your school at least on an annual basis. If an item is provided on an ad-hoc, one-off basis, please tick* 'Yes. One-off provision'. *If an item is not provided and you do not think it needs to be, please tick* 'No'. *If an item is not provided but you would like it to be, please tick* 'No, but would like to'.

		Yes. Routine provision	Yes. One-off provision	No	No, but would like to
A	Assemblies themed around self-harm	☐	☐	☐	☐
B	PSE sessions themed around self-harm	☐	☐	☐	☐
C	An on-site counsellor (paid or voluntary)	☐	☐	☐	☐
D	A drop-in health service, provided by school nurse or other health professional	☐	☐	☐	☐
E	Specialist self-harm prevention training for students	☐	☐	☐	☐
F	Posters on display about self-harm	☐	☐	☐	☐
G	Visits from outside speakers or organisations to talk to students about self-harm	☐	☐	☐	☐
H	Clear procedures known to all staff for identifying and supporting students who self harm	☐	☐	☐	☐
I	Training for teachers and staff about self-harm	☐	☐	☐	☐
J	Regular contact with relevant health services, e.g. Child & Adolescent Mental Health Service (CAMHS)	☐	☐	☐	☐

Please list below any other prevention and intervention activities undertaken by your school

K

L

M

N

O

Self-harm prevention and activities

Q6 Considering the prevention and intervention activities listed in Q63 (options A to O), which **five** do you consider to be **most useful** for a school to provide?

5 **PLEASE ENTER '1' BESIDE THE ACTIVITY YOU CONSIDER MOST USEFUL THROUGH TO '5' NEXT TO THE FIFTH MOST USEFUL**

A	Assemblies themed around self-harm	☐
B	PSE sessions themed around self-harm	☐
C	An on-site counsellor (paid or voluntary)	☐
D	A drop-in health service, provided by school nurse or other health professional	☐
E	Specialist self-harm prevention training for students	☐
F	Posters on display about self-harm	☐
G	Visits from outside speakers or organisations to talk to students about self-harm	☐
H	Clear procedures known to all staff for identifying and supporting students who self harm	☐
I	Training for teachers and staff about self-harm	☐
J	Regular contact with relevant health services, e.g. Child & Adolescent Mental Health Service (CAMHS)	☐
K		☐
L		☐
M		☐
N		☐
O		☐

Self-harm prevention and activities

Q66 If provided, who contributes to self-harm prevention or intervention activities in your school?

PLEASE TICK ONE BOX ON EACH ROW

	Yes	No
Teachers	☐	☐
Teaching support staff	☐	☐
Pastoral care team	☐	☐
School senior management	☐	☐
Students	☐	☐
School nurse	☐	☐
School counsellor	☐	☐
Mental health specialists (e.g. CAMHS)	☐	☐
Other health professional **(PLEASE TICK AND WRITE IN BELOW)**	☐	☐
✍		
Voluntary sector worker, e.g. Samaritan volunteer **(PLEASE TICK AND WRITE IN BELOW)**	☐	☐
✍		
Other, e.g. youth worker **(PLEASE TICK AND WRITE IN BELOW)**	☐	☐
✍		

Self-harm prevention and activities

Q67a Have school staff received training in self-harm prevention and intervention?

TICK ONE BOX ONLY

- ☐ Yes, mandatory training **(GO TO Q66b)**
- ☐ No **(GO TO Q67a)**
- ☐ Yes, voluntary training **(GO TO Q66b)**
- ☐ Don't know **(GO TO Q67a)**

Q67b **IF YES AT Q66a,** Please state:

Training provider	✎
Training funder	✎

Future provision in self-harm prevention and intervention

Q68a How would you rate the adequacy of lessons, activities and services that address self-harm in your school?

TICK ONE BOX ONLY

- ☐ Very low
- ☐ Low
- ☐ Moderate
- ☐ High
- ☐ Very high

Q68b Please explain your reasons for selecting this level.

✎

Future provision in self-harm prevention and intervention

Q69 How much of a barrier are the following to delivering self-harm prevention and intervention activities in your school?

PLEASE TICK ONE BOX ON EACH ROW

	Major barrier	Minor barrier	Not a barrier
Self-harm is not seen as a problem by senior management in my school	☐	☐	☐
Self-harm is not seen as a problem by teachers in my school	☐	☐	☐
Other health topics are given higher priority in health related lessons and activities	☐	☐	☐
A lack of staff time to deliver self-harm related activities	☐	☐	☐
School staff are not adequately trained in self-harm to be able to deliver activities	☐	☐	☐
Fear about encouraging self-harm in students	☐	☐	☐
A lack of available resources such as worksheets, videos and ideas for activities	☐	☐	☐
Pressures to deliver core curriculum subjects mean teachers have little time left to spend on health related activities	☐	☐	☐
School is not an appropriate place to deal with this topic	☐	☐	☐
Students fail to engage with activities on this topic	☐	☐	☐
Other **(PLEASE TICK AND WRITE IN BELOW)**	☐	☐	☐

✎

Future provision in self-harm prevention and intervention

Q70 Would your school be prepared to participate in future research to develop student self-harm prevention and intervention activities for delivery in schools?

TICK ONE BOX ONLY

- ☐ Yes
- ☐ No
- ☐ Don't know

Click the button below when you have entered ***all*** the data for your school.
Once you have clicked this button your survey will close and you will not be able to return to it!

Submit my answers and close my survey

If you still have more data to enter, use the 'Back' buttons to enter it now or click the 'Save and return later' button.

Appendix B: Survey administered to secondary schools in South-West England

SELF-HARM PREVENTION AND INTERVENTION IN SECONDARY SCHOOLS

SCHOOLS' QUESTIONNAIRE

We request that this questionnaire is completed by the pastoral care lead or staff member who takes a lead on self-harm prevention and intervention activities in your school.

SECTION 1: What is Your Role in Your School?

1. What is your job title?

.....

SECTION 2: Health Priorities and Interventions in Your School

2. The following are a list of health related areas often dealt with in schools through teaching and other activities. What level of importance is given to each by your school? Please note, this may not reflect your personal view.
   Please tick one option per row.

	Very high[1]	High [2]	Average [3]	*Low [4]*	*Very Low[5]*
a) Sex and relationships	☐	☐	☐	☐	☐
b) Suicide	☐	☐	☐	☐	☐
c) Smoking	☐	☐	☐	☐	☐
d) Emotional health and well-being	☐	☐	☐	☐	☐
e) Alcohol	☐	☐	☐	☐	☐
f) Healthy eating	☐	☐	☐	☐	☐
g) Self-harm	☐	☐	☐	☐	☐
h) Physical activity	☐	☐	☐	☐	☐
i) Drugs	☐	☐	☐	☐	☐

3. The following are a list of different types of interventions that schools use to address a range of health related topics. Please indicate how useful each intervention is – for both staff AND students – in addressing areas of health prioritised by your school.
   Please tick one option per row.

	Very high[1]	High [2]	Average [3]	*Low [4]*	*Very Low[5]*
a) Posters and leaflets	☐	☐	☐	☐	☐
b) One-to-one intervention	☐	☐	☐	☐	☐
c) Targeted group support	☐	☐	☐	☐	☐
d) Student peer support	☐	☐	☐	☐	☐
e) Curriculum lessons	☐	☐	☐	☐	☐
f) Staff information and training	☐	☐	☐	☐	☐

g) External agency intervention	☐	☐	☐	☐	☐
h) Whole school approaches (e.g. addressing school policies and relationships)	☐	☐	☐	☐	☐
i) Other	☐	☐	☐	☐	☐

If other please give details……

SECTION 3: Self-harm, Your Students & School

4. Prevalence of self-harm in young people in the UK has been estimated at approximately 10%. For the purpose of this study we define 'average' frequency as 10%. What is the frequency of the following self-harm behaviours in your school?
   Please tick one option per row. Please select 'Not Known' if you wish to indicate that you are not aware of any incidences of this type of self-harm.

	Very high[1]	High [2]	Average [3]	Low [4]	Very Low	Not Known
a) Cutting	☐	☐	☐	☐	☐	☐
b) Poisoning	☐	☐	☐	☐	☐	☐
c) Over-eating or under-eating	☐	☐	☐	☐	☐	☐
d) Burning of the skin	☐	☐	☐	☐	☐	☐
e) Hitting or scratching self	☐	☐	☐	☐	☐	☐
f) Excessive exercise	☐	☐	☐	☐	☐	☐
g) Hair pulling	☐	☐	☐	☐	☐	☐
h) Excessive alcohol or drug use	☐	☐	☐	☐	☐	☐
i) Other	☐	☐	☐	☐	☐	☐

If other please give details……

SECTION 4: Self-harm Prevention & Intervention Activities

For the purposes of this survey we define *self-harm* as any behaviour that is intended to intentionally hurt oneself. If may or may not be associated with suicidal intent.

5a. Which of the following self-harm prevention and intervention activities are delivered in your school?

Please tick one option per row. Please select:

- 'Yes. Routine provision' if an option is provided in your school at least on an annual basis
- 'Yes. One-off provision' if an option is provided on an ad-hoc, one-off basis
- 'No' if an option is not provided and you do not think it needs to be
- 'No, but would like to' if an item is not provided but you would like it to be

	Yes. Routine provision[1]	Yes. One-off provision[2]	No[3]	No, but would like to[4]
a) School or year group assemblies themed around self-harm	☐	☐	☐	☐
b) PSHE sessions themed around self-harm	☐	☐	☐	☐
c) An on-site counsellor (paid or voluntary)	☐	☐	☐	☐
d) A drop-in health service, provided by a school nurse or other health professional	☐	☐	☐	☐
e) Specialist self-harm prevention training for students	☐	☐	☐	☐
f) Posters on display about self-harm	☐	☐	☐	☐
g) Visits from outside speakers or organisations to talk to students about self-harm	☐	☐	☐	☐
h) Clear procedures known to all staff for identifying and supporting students who self-harm	☐	☐	☐	☐
i) Training for teachers and staff about self-harm	☐	☐	☐	☐
j) Regular contact with relevant health services e.g. child and adolescent mental health service (CAMHS)	☐	☐	☐	☐

5b. Please list below any other prevention and intervention activities undertaken by your school.

1)……..

2)……

3)……

4)……..

5)……..

5c. Considering the prevention and intervention activities presented in 5a and 5b, please rank five activities that you consider to be the **most useful** list the five that you consider to be the most useful for a school to provide (1=most useful, 5=least useful):

1)……..

2)……

3)……

4)……..

5)……..

6a. If provided, who contributes to self-harm prevention or intervention activities in your school? Please tick yes or no for each item.

	Yes[1]	No[2]
a) Teachers	☐	☐
b) Teaching support staff	☐	☐
c) Pastoral care team	☐	☐
d) Senior school management	☐	☐
e) Students	☐	☐
f) School Nurse	☐	☐
g) School Counsellor	☐	☐
h) Mental Health specialists (e.g.CAMHS)	☐	☐
i) Other health professional	☐	☐
Please give details below		
j) Voluntary sector worker e.g. Samaritan volunteer	☐	☐
Please give details below		
k) Other e.g. youth worker	☐	☐
Please give details below		

Please indicate which of the options you are providing details to:

……

6b. Have school staff received training in self-harm prevention and intervention?

Yes. Mandatory Training ☐[1] Yes. Voluntary Training ☐[2]

No ☐[3] Don't Know ☐[4]

6c. If you answered yes, please state below:

1) Training provider: ……...

2) Training funder: ……...

SECTION 5: Future Provision in Self-harm Prevention & Intervention

7a. How would you rate the adequacy of lessons, activities and services that address self-harm in your school? Please tick one.

Very low ☐[1] Low ☐[2] Moderate ☐[3] High ☐[4] Very high ☐[5]

7b. Please explain below your reasons for selecting this level.

.....

.....

.....

8. How much of a barrier are the following to delivering self-harm prevention and intervention activities in your school? Please tick one box for each item.

	Major barrier[1]	Minor barrier[2]	Not a barrier[3]
a) Self-harm is not seen as a problem by senior management in my school	☐	☐	☐
b) Self-harm is not seen as a problem by teachers in my school	☐	☐	☐
c) Other health topics (e.g. exercise) are given higher priority in health related lessons and activities	☐	☐	☐
d) A lack of staff time to deliver self-harm related activities	☐	☐	☐
e) School staff are not adequately trained in self-harm to be able to deliver activities	☐	☐	☐
f) Fear about encouraging self-harm in students	☐	☐	☐
g) A lack of available resources such as worksheets, videos and ideas for activities	☐	☐	☐
h) Pressures to deliver core curriculum subjects mean teachers have little time left to spend on health related activities	☐	☐	☐
i) School is not an appropriate place to deal with this topic	☐	☐	☐
j) Students fail to engage with activities on this topic	☐	☐	☐
k) Other	☐	☐	☐

If other please give details.....

9. Please list below any self-harm prevention or intervention activities that you have plans to introduce in the next 12 months.

1)……..

2)……

3)……

4)……..

5)……..

10. Please use the space below to write anything that you would like researchers to know about your school's experiences of students' self-harm.

……..

……..

……..

……..

……..

……..

……..

……..

……..

……..

……..

……..

11. Would your school be prepared to participate in future research undertaken aiming to develop student self-harm prevention and intervention activities for delivery in schools?

Yes ☐[1] No ☐[2] Don't Know ☐[3]

Appendix C: School research agreement

Self-harm Prevention and Intervention in Secondary Schools

RESEARCH AGREEMENT FOR SCHOOLS

For the purposes of the study entitled ***Children and Young people's Self-harm and Suicide Research Collaboration: Consultation with Secondary Schools on Self-harm Prevention and Intervention Practices and Needs*** funded by the ***GW4 Building Communities Programme Accelerator Fund.***

This agreement dated _____ is made between:

The GW4 Collaboration led by:

Dr Rhiannon Evans. DECIPHer, School of Social Sciences, Cardiff University, 1-3 Museum Place, Cardiff, CF10 3BD

Dr Astrid Janssens, University of Exeter Medical School, University of Exeter, St Luke's Campus, Heavitree Road, Exeter, EX1 2LU

AND

[school name] [school address]

IT IS AGREED AS FOLLOWS,

1 Commitment from the study team

The study team will:

- Work with your school to identify the most convenient times to conduct focus groups or interviews with school staff.
- Provide your school with a payment of £200 to cover staff time used to attend focus groups or interviews.
- Ensure that school staff are aware of ethical procedures.
- Provide sources of help sheets to all staff who attend a focus group or interview.
- Pass information on to schools in the event that concerns around child protection or serious risk of harm to a student is disclosed.
- Disseminate study findings to schools. Dissemination will take the form of a newsletter and a webinar.
- Invite a nominated school representative to attend a study dissemination meeting (In Exeter – will be deleted for Welsh schools as SHRN provide additional dissemination activities).
- Anonymise all published data from the study, so no schools or individuals can be identified from any reports

2 Commitment from the schools

All participating schools will:

- Provide a contact in the school to liaise with the research team and co-ordinate all research activities.
- Agree with the research team the number of focus groups and/or interviews that can be feasibly conducted at your school.
- Identify and support recruitment of school staff to attend a focus group or interview.
- Release identified school staff to attend a focus group or interview.
- Allow a member of the research team to conduct focus groups and interviews at the school site.
- Inform the research team of child protection and risk of harm procedures. Identify your school's safeguarding officer to the research team.

AS AGREED BY:

For and on behalf of:

The GW4 Collaboration

Name:

Position:

Signature:

Date:

For and on behalf of:

[school]

Name:

Position:

Signature:

Date:

Appendix D: Participant information sheet

Self-harm Prevention and Intervention in Secondary Schools

PARTICIPANT INFORMATION SHEET

You have been invited to take part in a research study. Before you decide whether to consent to participate please take the time to read the following information.

What is the purpose of this study?

This study aims to explore what secondary schools in Wales and England do with regard to student self-harm prevention and intervention. Schools have been asked to complete a survey reporting their current activities and the types of provision they would like to see developed in future. We are now asking staff in four secondary schools to engage in a more in-depth discussion about their views on this topic. The study is intended to inform the development of effective, school-based approaches to student self-harm prevention and intervention.

Who is undertaking this study?

Researchers from the Universities of Cardiff and Exeter are conducting this study. The work is being funded by the GW4 Building Communities Programme. Dr Rhiannon Evans is the lead researcher at Cardiff University. Dr Astrid Janssens is the lead researcher at the University of Exeter.

What am I being asked to do?

We would like to invite you to attend an informal focus group with about 7 colleagues in which we will explore your views of student self-harm prevention and intervention in secondary schools. If you have been invited to a focus group but would rather speak to us in private then we can arrange an individual interview instead. During the focus group or interview we will consider your opinion of existing practice and recommendations for future prevention and intervention approaches. We are interested in your views – there are no right or wrong answers.

Will this information be anonymous and confidential?

All data that is collected during this study will remain private and confidential. Data will only be available to the research team and will be securely stored. Data will be stored for a minimum of five years. Findings from this research will be presented to schools, policy-makers and other researchers. When we present or publish the findings we may use quotes from the interviews and focus groups. However, all names of participating schools and individuals will be removed.

Please note that the confidentiality of this study will be broken if the researcher becomes concerned about child protection issues.

What if I change my mind?

Participation in this research is entirely voluntary and you are not obliged to take part. If you do consent to participate and then change your mind you are free to do so. Any data that has been collected can be erased on request.

Has this study had ethical approval?

The study has been awarded ethical approval by Cardiff University's School of Social Sciences Ethics Committee. If you are concerned with any aspect of how this research has been conducted, please contact:

Professor Adam Hedgecoe: HedgecoeAM@cardiff.ac.uk
Cardiff University's School of Social Science Research Ethics Committee:
Chair of Research Ethics Committee
Cardiff University School of Social Sciences
Glamorgan Building
King Edward V11 Avenue
Cardiff
CF10 3WT

What do I do now?

If you are happy to take part in this study please use the follow contact details to let us know. We can also answer any questions you might have. We will then arrange an interview or focus group at your convenience.

Name
Research Assistant
Telephone: ###
Email: ###

Appendix E: Participant consent form

Self-harm Prevention and Intervention in Secondary Schools

PARTICIPANT CONSENT FORM

FOCUS GROUPS AND INTERVIEWS

	Please initial
I have read and understood the information sheet and have had the opportunity to ask questions	_____
I understand that my participation is voluntary, and I am free to stop at any time without giving a reason	_____
I consent to the focus group/interview being recorded	_____
I understand the recording and transcript will be stored securely and used in the write up of the project	_____
I understand that my data will be retained for at least five years	_____
I agree to take part in the focus group / interview	_____

Name _____

Signature _____

Date _____

School _____

Appendix F: Focus group and interview topic guide

Note: Main questions accompanied by prompts if required.

Facilitator introduction (rough guide): Name; Background of study.

The aim of this focus group is to explore your experiences of student self-harm in your school along with current approaches to addressing it. We plan to develop an intervention for schools and would like to get your thoughts on what it might look like, what might be feasible, and what might be acceptable.

Consent: Explain consent procedures; Explain recording procedures; Distribute information sheets; Complete consent forms.

We have a range of topics I would like to discuss with you today but feel free to raise anything else you think is relevant.

Does anyone have any questions before I start recording?

1. Introductions:
    - What is your name and role? Can you briefly outline your experience with self-harm amongst students in your school?
    - How might you detect if a student is at risk of/engaging in self-harm?
    - How frequently are you confronted with instances of self-harm amongst students?

2. What provisions does your school currently have around self-harm prevention or intervention?
    - Prompts from school survey responses.
    - Ensure both prevention and intervention discussed if not spontaneously differentiated.
    - Why have you used these particular approaches?
    - How well do you think these provisions have worked?
    - What are the barriers and facilitators associated with the delivery of these approaches?
    - Are current provisions sufficient given the needs of your school? Why?

3. Who delivers existing provisions around self-harm? (If not fully explored in Q.2).
    - School staff (e.g. teachers)
    - Pastoral team (e.g. counsellor)
    - Parents
    - Students
    - External professionals
    - Community groups
    - Third sector
    - Anyone else

4. What, if any governance structures does you school have around self-harm?
    - School policy
    - Council policy
    - General school ethos (may not be encompassed in specific policies). Consider issues around 'hidden harm', taboo etc.

5. Based on your past experiences, what role do schools have in preventing or intervening with students' self-harm?

    If participants state no role:

    - Why not? Whose role might it be?

    If participants state a role:

    - What is this role? How has this role changed over time? Who else might have a role?

6. We are thinking about developing an intervention aiming prevent self-harm in students. We would like to know what you think might be feasible, acceptable and successful. Reflecting on what your school already does:
    - What approaches might work well/ have an impact on staff/students? Why?
    - What approaches might not worked? Why?
        - Is there anything you used to do but stopped? Why?
    - What might be the barriers and facilitators associated with a new intervention?
        - Prioritisation of self-harm
        - Time and resources
        - Staff knowledge and training
        - Student engagement
    - What would be feasible given the current school context?
        - (Devil's advocate e.g. if ethos of keeping it quiet, would they be prepared to change this for a new intervention emphasising reducing stigma/being open about things)

7. Who might be involved in a successful intervention?
    - School staff (e.g. teachers)
    - Pastoral team (e.g. counsellor)
    - Parents
    - Students
    - External professionals
    - Community groups
    - Third sector
    - Anyone else?

8. *(linked in with 6 as needed / in case we need to provide structure and generate ideas)*
   Are there other programmes within the school that work well e.g. for bullying, alcohol, smoking?
    - What worked?

- Who was involved?
- When thinking about an intervention for self-harm which of these strategies do you think might be successful? Why?

9. Does anyone have any further points they would like to add?

Additional Prompts

Other points for facilitator to be aware of and ask about throughout focus group:

- Prevention or intervention
- What has worked and not worked?
- Barriers and facilitators
- Following up details e.g. if mention leaflets on self-harm, where did they source them from etc, who do the staff get their info from?
- Who is responsible for dealing with self-harm e.g. is the school responsible or prepared to be responsible, or do they view as external issue and want to refer incidents to other agencies (why)
- Pupil involvement in self-harm prevention and intervention.

Appendix G: School survey data

Table S1. Usefulness of health promotion and intervention provisions (All schools n=153)

Schools: All	Very high (%)	High (%)	Moderate (%)	Low (%)	Very low (%)
Posters and leaflets (n=150)	8	31	49	9	3
One-to-one intervention (n=152)	68	30	1	1	-
Targeted support (n=151)	38	52	9	1	-
Peer support (n=150)	20	40	30	8	2
Curriculum (n=151)	16	54	27	2	1
Whole school approach (n=148)	26	52	18	3	1
Staff training (n=150)	22	50	25	3	1
External training (n=150)	47	44	8	1	-

Table S2. Prevalence of student self-harm (All schools n=153)

Schools: All	Very high (%)	High (%)	Average (%)	Low (%)	Very low (%)	Not known (%)
Cutting (n=151)	7	15	49	22	7	-
Poisoning (n=150)	1	1	5	24	56	14
Over/under eating (n=152)	1	8	42	35	14	-
Burning (n=150)	-	1	10	31	46	13
Hitting self (n=152)	3	8	36	31	21	2
Excessive exercise (n=151)	-	1	16	34	40	9
Hairpulling (n=150)	-	1	7	33	51	8
Alcohol and drugs (n=150)	1	13	39	23	19	5

Table S3. Self-harm prevention and intervention provision (All schools n=153)

Schools: All	Yes, routinely provided (%)	Yes, one off (%)	Not provided (%)	Not provided, but would like to provide (%)
Assemblies (n=150)	23	32	24	21
On-site counselling (n=151)	79	10	3	8
PSHE (n=145)	41	33	12	14
Drop-in health services (n=151)	75	13	3	9
Specialist training to students (n=148)	7	22	34	36
Outside speakers or organisations (n=150)	15	34	25	25
Posters (n=150)	32	9	32	27
Procedures (n=153)	75	11	2	12
Training for staff (n=152)	38	29	11	23
Health services (e.g. CAMHS) (n=153)	82	10	1	7

Table S4: Usefulness of self-harm prevention and intervention provisions (All schools n=153)

Schools: All	1st Most useful (%) (n=129)	2nd Most useful (%) (n=128)	3rd Most useful (%) (n=128)	4th Most useful(%) (n=125)	5thMost useful (%) (n=124)
Assemblies	2	2	4	2	6
PSHE	9	8	5	9	15
Counsellor	25	13	14	6	6
Student drop-in	8	15	11	15	9
Student training	8	9	3	6	4
Posters	1	-	-	5	6
Outside speakers	3	7	11	6	8
Procedures	9	17	14	7	10
Teacher training	12	10	13	17	15
CAMHS	14	11	16	13	10
Awareness raising	1	2	2	1	-
Student support programme	2	-	1	1	1
One-to-one support	3	2	-	1	2
Whole school approaches	1	1	1	2	-
External help	1	-	3	1	2
Extra support	4	2	1	1	2
Wellbeing coordinator	-	-	1	-	1
Signposting (students; staff; parents)	-	1	1	3	2
Kooth	-	-	-	1	2
Extra resources	-	1	-	-	
Up to date information	-	-	-	2	-

Table S5: Delivery agents of self-harm prevention and intervention provisions (All schools n=153)

Schools: All	Yes (%)	No (%)
Teacher (n=120)	74	26
Teaching support staff (n=121)	79	21
Pastoral care team (n=149)	97	3
Senior management (n=134)	86	14
Students (n=110)	45	55
School nurse (n=140)	91	9
School counsellor (n=146)	92	8
CAMHS (n=152)	92	8
Other health professional (n=74)	34	66
Voluntary sector (n=74)	18	82

Table S6. Barriers to self-harm prevention and intervention (All schools n=153)

	Major Barrier (%)	Minor Barrier (%)	Not a Barrier (%)
Not seen as a problem by senior management (n=150)	3	9	88
Not seen as problem by teachers (n=150)	3	19	79
Other health topics given higher priority (n=150)	11	47	41
Lack of staff time to deliver activities (n=150)	36	37	27
Inadequate training for school staff (n=151)	42	39	19
Fear of encouraging students (n=150)	36	44	20
Lack of available resources (n=150)	38	36	26
Lack of time in curriculum to deliver activities (n=150)	47	31	21
School not an appropriate place (n=150)	1	15	83
Students fail to engage with the topic (n=149)	3	23	74