To What Extent do Teachers Feel they are Equipped to Help Children and Young People aged 11–16 who Self-harm? A Qualitative Study

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This work was sponsored by the Florence Nightingale Foundation and Charlie Waller Memorial Trust Research Scholarship 2016-2017.

The act of self–harming, also known as deliberate self-harm, in young people is now regarded as a major public health issue in the UK and Europe, and has been called the new epidemic among adolescents (Heath *et al.*, 2011), as it affects the health and well-being of at least 25% of 15-year-olds (World Health Organisation, 2015).

Most young people who self-harm do not seek help, and "many remain 'hidden' within the community" (Madge *et al.*, 2008, p. 676). In one UK cohort study, only 12% of 11–16-year-olds who self-harmed sought help from health providers (Kidger *et al.,* 2015). Similarly, in the Child and Adolescent Self-harm in Europe study, 87.4% of young people did not seek help from an acute hospital (Hawton *et al*., 2012). The small proportion of young self-harmers that seek help emphasises the difficulties schools in both the UK and Europe have in identifying self-harm and providing necessary support (Madge *et al.*, 2008, Crow *et al.*, 2020).

It is widely acknowledged that schools provide an ideal setting to promote emotional health and well-being in young people, and to identify those at risk of developing mental health problems (Department for Education 2020). However, in relation to self-harm, Crow et al (2020), in their one-year population-based study, reported that teachers felt unsupported, had limited training, or support structures in place.

This chapter will briefly review some of the literature on self-harm, its prevalence, relevant national policies, and research with teachers, before reporting the findings of a qualitative study conducted in 2016

which investigated how prepared secondary-school teachers were dealing with young people who self-harm.

What is Self-harm?

Self-harming is defined as the deliberate act of harming or injuring oneself intentionally but non-fatally (Hawton *et al.*, 2012). Reasons for young people self-harming are complex and vary considerably (Young Minds, 2021). However, according to Madge *et al.* (2008), the motivation is usually a wish to escape or cope with emotions that cause feelings of self-disgust or self-anger.

According to Whitlock (2010), self-harm should be separated into three categories of psychological, social, and biological functions. Psychological functions centre around attempts to reduce emotional pain and alleviate distress, such as anxiety and depression; Social functions relate to how the young person manages interactions with others and him or herself, for example: relationships, sexuality, and academic pressures; Biological models focus on the role of self-harming in regulating endogenous opioids, (Whitlock, 2010).

It has also been argued that self-harm falls into two groups: (1) a larger group of adolescents engaging in self-harm as a transient and temporary behaviour, where young people may try self-harming once or twice to serve a purpose at the time; and (2) adolescents likely to suffer from life-long psychological difficulties and a high risk of suicide (Nock, 2009). Similarly, Fergusson *et al.* (2000), in their study of risks associated with the onset of suicide, suggest that self-harm is one of the strongest predictors of suicide and suicide attempts in young adults.

The most common form of self-harm is cutting the arms or the back of the legs with a razor or knife, but there are many other forms, such as burning, biting, hitting, scratching, jumping from a height or ingesting a toxic substance or objects (Crow *et al.*, 2020).

Indirect self-harm, according to Knightsmith (2015), is also a type of self-injury that takes various forms, including substance misuse, eating disorders, physical and sexual risk-taking and self-neglect. Although not discussed in this study, it is important to be aware that these forms can also indicate similar underlying issues (Knightsmith, 2015).

St Germain and Hooley (2012) agree but suggest that they should be treated as separate clinical entities.

Prevalence

According to Kidger *et al.* (2015) a significant portion of adolescents engage in self-injury at some time during their lifetime, and suggest that around 36 % of young people may deliberately hurt themselves between the ages of 11 and 16. Young Minds (2017), a UK National Charity that provides advice and support to young people, suggests that it is impossible to estimate the prevalence of self-harm in the UK, as only a minority of young people present to a health facility and disclose this behaviour. However, Tormeon *et al.* (2020), in their extensive research examining changes of self-harming prevalence in Norwegian school children, found that self-harm has increased four-fold over 15 years, from 4.1 % in 2002 to16.2% in 2017.

Policies

Current UK policies available to manage self-harm in young people include: *The Five Year Forward View for Mental Health* (NHS England, 2017), *Self-harm and Suicide prevention competence framework (Health Education England, 2018)*, the *Short-term Physical and Psychological Management and Secondary Prevention of Self-harm in Primary and Secondary Care* (NICE, 2004) and *Self-harm: longer-term management* (NICE, 2011). These guidelines have attempted to shift the focus from an approach that treats symptoms of self-harm to a more dynamic process that considers the needs of the young person and the development of resilience. The National Institute for Health and Clinical Excellence are currently revising their guidance to address the need to focus on self-harm in schools (NICE, 2019).

The available UK guidance advocates that evidence-based interventions should be provided to all professionals that have direct contact with clients who self-harm (NICE, 2011) and stresses that schools are ideally placed to do this (Department for Education UK, 2020).

The Impact of Self-harm on Teachers

Teachers are in a good position to help young people who self-harm because of the regular contact they have with pupils (Best, 2006; Health Education England, 2018, Department for Education UK,

2020). However, Dowling and Doyle (2016) argue that despite the increased focus on school-based interventions, there is limited evidence of how schools assess, treat, and manage the needs of these young people. In a study looking at the response of teachers in children who self- harm, Crow *et al.* (2020) argued for more research to understand the impact that the prevalence of self-harm has on the role of school staff and their ability to identify and respond.

Support systems to equip staff in the prevention and intervention of self-harm are limited, (Young Minds, 2019), with teachers having to look for information to give to young people who self-harm. O'Reilly *et al.* (2018) in their thematic analysis of teachers' roles in mental health, found that teachers were concerned about the increasing pressures on schools to manage mental health difficulties, when their primary role is to educate. Nevertheless, despite the complex and conflicting issues, Timson *et al.* (2012) in their study of teachers' attitude to mental health problems, observed that teachers take their role as front-line mental health professionals very seriously.

Teachers' Knowledge of Self-harm

Literature documenting teachers' knowledge of self-harm is limited; however Best (2006) and Carlson *et al.* (2005), in their small-scale qualitative studies of secondary school teachers, suggested that how an incident of self-harm is managed by teachers is reflective of their knowledge, understanding and confidence. Best (2006) and Carlson *et al.* (2005) both found that teachers' personal experience of self-harming from either previous incidents encountered at school, or from family members self-harming, tended to have a positive influence on their management of the behaviour.

Misconceptions about self-harm can also affect teachers' confidence and their initial reaction. Best (2006), in his qualitative analysis of teachers' attitude to self-harming, reported that teachers' responses tended towards repulsion, shock and panic. Crow *et al*. (2020) reiterated this, stating that teachers' reactions could alienate students, and possibly reinforce future incidents.

The Department for Education UK (2020) states that a child may be in need or likely to suffer significant harm, if they self-harm, and that child protection policies should be followed when concerns about a

child's welfare are identified. Young Minds (2010) suggested that this advice may limit a teacher's ability to assist a young person, by creating a sense that self-harm must be treated like a child protection issue.

Training and Support

The available research around professionals working with young people who self-harm, identifies that effective training and supervision are an integral part of enabling professionals to manage this behaviour. Best (2006), Timson *et al.* (2012), and the Royal College of Psychologists (2010) support this, emphasising the need for a more systematic approach to training, focusing on practical help, attitudes, misconceptions, and improving knowledge. The UK government's *The Five Year Forward View for Mental Health* (NHS England, 2017), has attempted to address these issues by recommending training for all front-line professionals working with young people to identify mental health problems by 2020, and on-site support to schools through the Child and Adolescent Mental Health Services (CAMHS). Crow *et al.* (2020), recognise that mental health training available to teachers is increasing slowly in recent years, but knowing which training is reputable and evidence-based is difficult to determine.

The National Institute of Health Clinical Evidence guidelines recognise the need for school staff to have supervision as well as training when dealing with young people who self-harm (NICE, 2019). Best (2006) suggested that supervision is equally important, both as a means of enhancing the quality of the response teachers give, and as a source of emotional support. O'Reilly *et al.* (2018) also emphasised that although incidents of self-harm had an emotional impact on teachers, supervision was not an established part of the teachers' support system.

The diversity of young people's needs and risks means that self-harm, according to Hawton *et al.* (2012), requires different responses from different services. Multi-agency working is advocated in the NICE guidelines (2011) to create a culture of inclusiveness and communication to deal with mental health issues safely. Crow *et al.* (2020) stated that effective and accessible mental health services were essential to work collaboratively and support teachers. However, teachers felt frustrated at the limited support available which affected their confidence and ability to deal with the situation.

Guidance

Recently published guidance from the Department for Education UK (2020), and the Self-harm and Suicide Prevention Competence Framework (Health Education England, 2018) both provide practical and structured guidance for professionals to deal with self-harm. Structured responses can assist schools to plan and implement strategies to support students; however, this escalation of responses may reinforce the stigma associated with self-harm, and keep it hidden (Townsend *et al.,* 2018). According to Young Minds (2019), teachers want guidance on what they should say, and what they can do personally. Knightsmith (2015) suggests that all schools should have clear, easily located-guidelines to help teachers respond to cases of self-harm, either within, or written separately from, the safeguarding policy. The Charlie Waller Memorial Trust (2019), in conjunction with the University of Oxford has recently published a comprehensive practical guide for teachers to support students who self-harm.

In summary, the increasing prevalence of self-harm, coupled with the close interaction provided by the school environment, makes it understandable that teachers are in a good position to provide support. However, because of the associated complexities, emotional impacts, and expectations, it is imperative that teachers have the support, correct training, and multi-agency connections to provide the care that vulnerable young people need. Due to the limited research in this area, this study sought to identify what actual support there is for teachers, and how equipped they feel to deal with and manage incidents of self-harm in the young people they teach.

Research Design

This study adopted a qualitative design to establish how equipped teachers were in assisting young people who self-harm. Qualitative research is useful for examining the perspective and experiences of people when little is known about a topic. In this study we were interested in the perceptions of senior schoolteachers who taught students from 11 to 16 years old.

Recruitment and sampling

A purposive sampling strategy was adopted to identify teachers willing to participate in semi-structured interviews. Following approval by the University Ethics Committee, ten schools from the south of

England were approached to take part: nine secondary state schools, (seven mixed and two all-girls) and one private school. The Head Teachers were sent information detailing the purpose of the proposed study and were asked to disseminate information about it to teachers. Three state schools (one mixed and two all-girls) agreed to participate, and in all, twelve teachers agreed to take part.

Data Collection

Semi-structured Interview and Vignettes:

Interviews were conducted in 2016 using face-to-face *semi-structured interviews* with open-ended questions and *vignettes*, which are a helpful tool for framing complex or sensitive topics (Kandemir & Bud, 2018). The vignettes in this study helped the researcher explore the teachers' experience and understanding in a controlled, unthreatening manner. The vignettes set two specific scenarios: in the first, the teacher *observed* that a pupil in their class was self-harming, and in the second *they were informed about* a pupil self-harming. The open-ended questions related to the scenarios and encouraged discussion on the teacher's experience of self-harm in relation to management of the behaviour, available guidelines, training, support, and multi-agency involvement.

An interview schedule was developed from the literature, piloted, and reviewed after the first interview, to refine questions and to aid consistency. With the consent of each participant, interviews were audio-recorded, in addition to the taking of manual notes. Each participant was assured that the data collected would be anonymised.

Data Analysis

Study data was analysed using Thematic Analysis (Braun & Clark, 2013). This enabled review, identification and coding of recurrent themes and commonalities within the data. The first author analysed and transcribed the interview recordings for each participant verbatim, for familiarisation, and then highlighted the transcripts for items of interest, relevance, and specific emerging themes. The highlighted data was given an appropriate label connected to the research question and/or theme, and then coded to identify the specific area it represented. From these codes, broader patterns and themes were developed and categorised to form sub-themes and overarching themes.

The codes and coded data were actively examined to identify emergent patterns and discussed with the second author (as research supervisor) (Table 1).

Table 1: *Example of data and code name.*

Transcript	**Code name identified**
"I know about safeguarding procedures, but there are no specific guidelines for self-harm – but we have a good pastoral team"	**No specific guidelines**
"I am really worried that what I say will make the situation worse"	**Make situation worse**
"I am continuously horrified and shocked that young people see self-harm as normal"	**Shock**

A visual map was used to explore the relationships between the codes, themes, sub-themes and overarching themes (see Figure 1). Extracts from the original transcripts were then selected to illustrate the facets of each theme and used to frame the discussion. This method highlights the links between the evidence and the arguments being made.

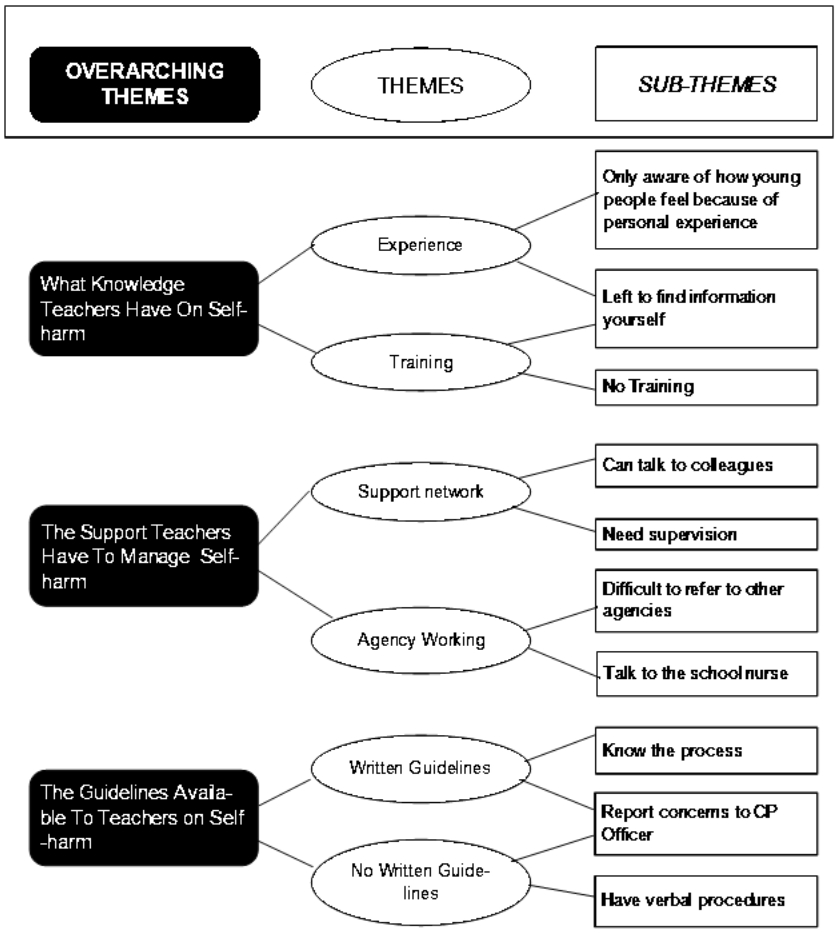

Figure 1: *Illustrations of Themes and Sub-Themes.*

Results

The Interviews

The participating teachers had a range of teaching experience from 3 to 23 years, and all but one had experience of self-harming in young people. They comprised two Deputy Heads, one Head of Year, one Special Educational Needs Co-ordinator (SENCO) from the wellbeing team, four senior teachers and four junior teachers (Table 2).

Table 2: *Role of teacher in school*

Deputy Head /Head of Year	Senior teacher	Junior teacher
1, 2,4	3, 5, 6, 7, 8	9,10, 11, 12

The three schools taking part in the study all had young people who had engaged in self-harm. One school had developed written procedures, owing to the increasing number of incidents. Although the schools had mechanisms in place that teachers followed when an incident of self-harm occurred, they were all different and specific to the individual school. In addition, all schools had a well-being team where pupils who self-harmed were referred.

Analysis

Three overarching themes emerged from the systematic data collection, coding, and analysis:

- What knowledge teachers have of self-harm;
- The support available to teachers to manage it; and
- The guidelines provided to teachers.

These are illustrated in the thematic map (Figure 1) and discussed individually below.

What Knowledge Teachers have of Self-harm

This overarching theme focused on the experience teachers had of self-harm and their training.

Experience of teachers with young people who self-harm

All teachers were passionate about the well-being of their students and the impact that self-harm had on the young person. The amount of teaching experience did affect the teacher's confidence and attitude to dealing with self-harm, but not conclusively:

> *"I have been a teacher for 20 years… but only appreciated how these young people felt when I had a mental health issue of my own."* ***5***

Participants reported that the most common method of self-harm identified in the school setting was cutting. This was identified in several different ways, but mostly by the young person pulling down jumpers, not wanting to change for Physical Education, and wearing long pullovers in the summer.

Participants also reported other ways of discovering self-harm including noticing changes in a student's behaviour or being told about the self-harm by the student or their friends.

> *"She was so bubbly and happy and wanted to be part of what was going on in the school – then she just suddenly withdrew – the light went from her eyes and even her appearance changed."* ***9***

Most participants felt very anxious about dealing with self-harm and were afraid of making the situation worse. Additionally, participants described a sense of helplessness around breaking confidentiality when reporting a case of self-harm, which they found particularly difficult.

> *"She was so upset and angry when I said that I was going to have to tell the pastoral team – she trusted me, and I felt that I was letting her down."* ***6***

In talking about self-harming in schools, participants drew from their own experiences, either in dealing with self-harm at school, or with family members:

> *"I would not be aware of how to deal with self-harm if it wasn't for the experience I have dealt with personally and the information I found out myself – it really is left to you to find information – I don't feel equipped to deal with it"* ***3***

Training

The teachers were aware of the importance of having training and knowledge:

"Knowledge is so important when dealing with something like self-harm – it is so difficult to comprehend why young people do it – and what to say to them." ***2***

However, it was apparent that training for teachers on self-harm in young people was limited or in some cases non-existent:

"We have three-yearly training on safeguarding children, but there is nothing on self-harm." ***4***

"The well-being team had some free training on self-harm in young people – I really want some of that" ***4***

All participants expressed concern about their lack of formal self-harm training and were clear as to what training they wanted to support them in managing the behaviour:

"We don't have any training on self-harm – what we need is training on what to do, how to spot it, the language to use and what to say." ***4***

"Someone from mental health came to talk to us about the right thing to say to young people who self-harm - it was really good." ***5***

The support available to teachers

This theme was derived from two emerging areas: support network and agency working.

Support network

It was apparent from the data collected that the teachers had limited forums to share their experiences in a structured way. One participant described getting support from weekly meetings where members of staff were able to share experiences and draw support from each other. Two teachers stated that they were able to access counselling through the school if required. Most said that they relied on informal support from colleagues, friends, or family members, although all emphasised that they were able to discuss issues with the Head Teacher and Well-being team.

"We don't have any supervision sessions, but there is a good relationship among colleagues, I can speak to the Head, and everyone is supported by the well-being team – the well-being team have supervision." ***2***

Most teachers recognised a need to have a structured forum to be able to "off-load" and discuss concerns with other staff members.

"Dealing with self-harm is an emotional burden you don't just leave at school - other professionals have supervision to off-load – but for teachers - there is nowhere really to go with it – it makes you feel emotionally drained." ***3***

The support for teachers dealing with episodes of self-harm in young people appeared to be provided on an *ad hoc* basis when an incident occurred. Although teachers stated that well-being teams and schools' child protection officers did have supervision to discuss challenging cases, teachers themselves did not. Teachers spoke positively about the support from the Head Teacher and the well-being team, although recognised that a more structured form of support would be of benefit.

Multi-agency working

This theme addressed multi-agency working and the support that teachers received from other professionals such as health and mental health. Most teachers in this study were unaware of any communication or joint working with outside agencies to support young people known to self-harm. However, the well-being team member of staff and a Deputy Head in one of the schools did discuss this.

"No, I didn't have any communication with other agencies – the pastoral team may have done – we do have a School Nurse, but it was the well-being team that really dealt with the incident." ***4***

Three teachers did state that young people would be referred to the school counsellor as a matter of course, taken to Urgent Care, and/or referred to Children and Adolescent Mental Health Services (CAMHS) if appropriate, but:

"It's really difficult to refer to outside agencies, especially CAMHS, as it is a long process, and it never reaches the threshold." ***5***

One teacher stated that they did have some communication from Urgent Care staff, but this was because of the high level of incidents.

*"We felt accused and somehow to blame for the high levels of self-harm in the school – they are unaware of how pro-active we are in trying to identify and deal with it"****1***

One teacher reported that they had a good relationship with the School Nurse, and any incidents of self-harm were immediately referred to her, and discussed at monthly meetings with the well-being team and the Deputy Head, who appeared to value this established communication network. The other nine teachers reported limited knowledge about communication or joint working with other agencies.

Guidelines for dealing with self-harm

This theme focussed on the guidelines provided to teachers to advise them on the best course of action to deal with an incident of self-harm. Of the twelve teachers, only one stated that they had written guidelines that they followed when dealing with issues of self-harm.

"We do have guidelines written down and this does help with knowing what to do initially – knowing the process helps us say to the young person this is what's going to happen – it takes the pressure off a little." ***1***

Nine teachers stated that there were no written procedures, but:

"We have verbal procedures that are sent by email when a young person has self-harmed, so we know what to do and what to look out for." ***4***

These informal procedures involved the well-being team informing the teachers of self-harming issues via email. The remaining two teachers stated that self-harm was addressed within the child protection guidance:

> *"There are no clear self-harming guidelines, but self-harm is a safeguarding judgement, and we have clear safeguarding procedures."**2***

Most of the teachers reported that if self-harm is identified it is referred directly to the well-being team or designated member of staff. They were generally unsure of the process or contact with other agencies following an initial referral.

It appeared that although staff referred the young person to the designated officer, most teachers wanted to do more.

> *"I know I needed to speak to someone about the self-harm and refer them to the pastoral team, but I didn't want to stop the conversation."* ***12***

One reported:

> *"We have clear procedures to deal with self-harm and are proactive in dealing with it - but – are we doing all we can?"* ***1***

All schools had a structure in place to deal with incidents of self-harm. Where written guidelines were in place, teachers were aware of the whole process, from what to do on identification of an incident, whom to contact, and the referrals to be made. Where there were no written procedures, teachers were informed of incidents via email, or verbally by the well-being/safeguarding team. By this method, teachers were made aware of the young person, but most were unaware of the procedure following the initial referral to the designated member of staff. Despite procedures being in place, all participants wanted to have more information than the procedures provided, and more support in dealing with young people who self-harm.

Discussion

This research sought to establish how equipped teachers were in managing self-harm amongst 11–16-year-olds. It was obvious when conducting the study that teachers were passionate and caring and took their front-line role to support their pupils very seriously.

However, in this admittedly small-scale study conducted in one geographical area, the findings suggest that teachers did not feel equipped to manage self-harm in young people. Considering the emotional impact that the associated traumatic issues can have on teachers, there was limited structural support, training, and guidelines available. The reasons for this will be discussed below.

Teachers' Knowledge of Self-Harm

Teachers in this study appeared to be emotionally affected by the experience they had of a young person self-harming and were keen to talk about the topic. The majority stated that they did not receive any training specific to self-harm, and this impacted their confidence and ability to manage the behaviour. This finding has been mirrored in other studies (Best, 2005, Crow *et al.* 2018, O'Reilly 2018), which all found that lack of training in self-harm could impact negatively on teachers' confidence in responding to students' needs.

The NICE (2011) guidelines advocate that all professionals working with young people who self-harm should be provided with evidence-based information. However, it was clear in this study that although teachers received three-yearly multi-agency safeguarding training, there was no *specific* information around self-harm. One teacher stated that they did receive a training session on self-harm at school by a CAMHS worker, and that it was invaluable, but this was not standard practice. The three-yearly safeguarding training for all professionals working with young people may be an opportunity to provide information on self-harming and encourage a joint working approach.

The teachers stressed that to deal with incidents of self-harm they required practical information on how to help the young person and on what to say – as reflected in Best (2005). Furthermore, they needed to be aware of the support available and the way young people prefer to communicate. Dowling and Doyle (2016) suggested that providing training for school staff on how to respond to a young person who self-harms can improve knowledge, attitudes, confidence, and effectiveness in dealing with adolescents who engage in the behaviour.

The Support available to Teachers to manage Self-harm

Safeguarding supervision, which is mandatory for many front-line professionals who work with vulnerable children (Department for Education UK, 2020), appeared in this study to be only available for the well-being team, and not the teachers. Whilst teachers were able to discuss issues with the Head Teacher and well-being team, this was only on an *ad hoc* basis or when an incident had occurred. In the absence of formal support, teachers debriefed with colleagues. This is in line with Rowe *et al.* (2014), who found that support systems to equip staff in the prevention and intervention of self-harm were rarely provided, and teachers had to escalate instances of self-harm through hierarchical structures to locate required expertise.

Most teachers believed that safeguarding supervision was vital as a debriefing resource to help reduce the emotional burden of responding to students who self-harm. This concurs with Best's (2006) suggestion that supervision should be provided to help teachers deal with the emotional impact of a student's self-harm. This is particularly relevant to the findings in this study, where self-harming incidents impacted the participants' personal lives, leaving teachers feeling "emotionally drained".

According to the NICE guidelines (2011), multi-agency working should be encouraged within schools, and across agencies, to create a culture of inclusiveness and communication in which poor mental health can be safely addressed. This was also advocated more recently by Keeping Children Safe (Department for Education UK, 2020) and Health Education England (2018), who recommended that collaboration between all professionals working with young people with mental health issues can improve the outcome and well-being. Although teachers in this study made references to CAMHS, Urgent Care and the School Nurse as agencies who work with young people who self-harm, the findings found limited evidence of joint working as a support factor for teachers.

The participants found it difficult to refer to CAMHS, owing to long waiting times and strict criteria to meet referral standards. The teachers reported that the well-being team and the school mostly addressed the situation themselves and only referred to outside agencies in cases of acute need. This reflects the finding of Timson *et al.* (2012), that

lengthy referral processes lead front-line staff to use alternative solutions to the issues, which makes it difficult to foster a culture of shared responsibility and joint working.

Most of the teachers in this study did not appear to be aware of the School Nurse's role in relation to self-harm, or whether any cases were referred to the school nursing service. The one teacher who automatically referred cases to the School Nurse developed a good working relationship, and appeared to value the support she provided. School Nurses provide health education addressing topics such as healthy lifestyles, risk-reducing behaviour, developmental needs, and can be the first point of contact and a gateway to other health services, for teachers concerned about pupils who self-harms (Shapiro, 2008).

Guidelines

The various schools in the study appeared to have different guidelines in place to manage incidents of self-harm in young people. These involved: treating it as a safeguarding issue; the well-being team giving email advice when an incident arose; or following specific protocol developed by the school.

Although at the time of the study NICE (2011), PSHE (2015) and the Departments of Health (2013) and Education (2016), provided guidance for teachers on self-harm, only one of the schools incorporated it into their management of the behaviour. This reflects Youth Net's (2012) finding that national guidelines are not consistently implemented across regions.

Teachers in the two schools without specific guidelines for managing self-harm expressed a feeling of anxiety, and were unsure of what support they could provide, other than referral to the well-being team. Carlson *et al.* (2005) suggested that guidance specific to self-harm should be provided for teachers, and regularly reviewed to increase levels of confidence, as teachers are on the front line for identifying the behaviour. Dowling and Doyle (2016) support this, suggesting that although self-harm is referred to specialist staff, it is important for teachers to have guidance, as a teacher's response to an incident could dictate how a young person will accept and respond to intervention.

Conversely the teacher whose school did have written guidance on self-harm appeared more confident and aware of what the process was from identification through to when the young person returned to the classroom. Knightsmith (2015) endorses this, suggesting that clear, easily-located guidelines help teachers respond to cases of self-harm appropriately and confidently in the initial identification process.

Conclusions

This small study conducted in one geographical area provides a greater understanding of some of the challenges faced by secondary-school teachers in managing the complexities of self-harm in young people. The teachers in this study were all passionate about the well-being of their pupils and wanted to support them to the best of their abilities. However, the research concluded that the teachers were not always adequately supported to fulfil their expected role of identifying and helping young people who self-harm in their schools. In line with related research, this study demonstrates that a combination of factors outside the teachers' control impacts their ability to provide the required care. A number of recommendations are suggested that may support teachers to manage the rising incidents of self-harm identified in the school. These include:

- provision of clear guidelines and training for secondary-school teachers specifically on self-harm to increase the teachers' confidence;
- instituting protected time to combine supervision and training to discuss cases and look at practical elements of what teachers need to do and say, to reduce anxiety and providing the requisite emotional support; and
- joint working with multi-agency teams to support teachers when young people self-harm.

Acknowledgments

We are grateful to the Florence Nightingale Foundation and Charlie Waller Memorial Trust for their encouragement and sponsorship of this Research Study, and to the schools and teachers who agreed to participate and give up their time to be interviewed.

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