

Knowledge and Experiences of School Staff towards Student Self-Injury

Final report for schools and universities



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Executive Summary

Non-suicidal self-injury (NSSI) is defined as the deliberate destruction of body tissue without suicidal intent (Nock & Favazza, 2009). Self-injury usually begins in adolescence between 12 and 14 years of age (Jacobson & Gould, 2007), and approximately 10 to 23% of adolescents in Australia have engaged in self-injury (Martin, Swannell, Harrison, Hazell, & Taylor, 2010; Muehlenkamp, Claes, Havertape, & Plener, 2012; Swannell, Martin, Page, Hasking, & St John, 2014). Common methods of self-injury among adolescents include skin cutting, scratching and burning, and hitting or punching oneself (Ross & Heath, 2002). Common motivations for self-injury among adolescents are to manage overwhelming emotions and relieve distress (Klonsky, 2007). Although adolescents who self-injure are at increased risk for suicide, further self-injury and accidental death (Owens, Horrocks, & House, 2002), less than one in ten adolescents seek medical attention for the behaviour (Fortune, Sinclair, & Hawton, 2008; Hasking et al., 2010). Given the daily contact school staff have with a wide range of students, they are in a prime position to identify warning signs that may signal self-injury among students, and respond, which may prevent escalation of the behaviour and later suicide among youth.

However, school staff comment that they are unsure how to address self-injury in schools and are calling for further education and skills regarding this issue (Best, 2005, 2006; Carlson, DeGeer, Deur, & Fenton, 2005; Heath, Toste, & Beettam, 2006; McAllister, Hasking, Estefan, McClenaghan, & Lowe, 2010). Some professionals, including school staff, express shock, repulsion and horror towards the behaviour, and misinterpret self-injury as manipulative or attention seeking (Best, 2005, 2006; Heath et al., 2006; Heath, Toste, Sornberger, & Wagner, 2011). Together, negative attitudes and a lack of training may result in inappropriate responses to adolescents who self-injure (Gagnon & Hasking, 2011;



McAllister & Estefan, 2002; Warm, Murray, & Fox, 2002). To provide effective education to school staff we first need to establish their current knowledge and training needs towards self-injury.

The aims of this project were to investigate the knowledge, attitudes and training needs of pre-service teachers and school staff towards self-injury, and their confidence to respond to the behaviour. We hope results of this project will inform the development of targeted education and training tools to better equip school staff to identify at risk youth, and provide early intervention and referral, and thus improve wellbeing among students who self-injure and confidence of staff. Data were collected from 768 pre-service secondary school teachers and school staff, including school principals, teachers, counsellors and psychologists (aged 18 to 67 years) in all Australian states and territories. The survey included self-report questionnaires to investigate the knowledge and attitudes of pre-service teachers and school staff towards self-injury, and their confidence to respond to students who self-injure. Open-ended questions explored how school staff usually respond to students who self-injure, and the training and school policy needs of school staff regarding self-injury.

Results indicated that although pre-service teachers and school staff are concerned about self-injury among adolescents and willing to help students who self-injure, the majority acknowledged their need for further education and training, and improved access to school-based resources and community services. Overall, the majority of pre-service teachers and school staff had not received training regarding self-injury (74.7%), and most acknowledged their need for training in the area (80.2%). Thus, pre-service teachers and school staff are often “working in the dark” when addressing self-injury in the school setting. Integration of self-injury content into existing university teaching courses for pre-service teachers and professional development programs for teachers and other school staff is critical to enhance the knowledge and confidence of current and future teachers, and other school staff to detect



and respond to students who self-injure. Results of this project also suggest online resources and training courses may enhance the knowledge and confidence of teachers and other school staff to respond to students who self-injure. Finally, pre-service teachers and school staff indicate that policies for responding to students who self-injure are needed in the Australian education system. Additional research is required to minimise potential sources of bias and validate findings of this project among secondary school staff in Australia.



1. Introduction

1.1. Adolescent mental health and self-injury

Adolescence is a critical period of development between childhood and adulthood, when physical, biological, cognitive, and emotional changes occur, and youth begin to assume adult roles and responsibilities (Yurgelun-Todd, 2007). The primary developmental tasks and challenges of adolescence include pubertal development and sexual maturation, formation of personal and sexual identity, independence from parents and other adults, development of peer and intimate relationships, and formation of vocational skills for economic independence in adulthood (Christie & Viner, 2005). Given these developmental challenges, and because physical, biological, cognitive, and emotional processes mature at different rates, adolescence can be a period of increased psychological vulnerability and stress (Steinberg, 2005). Consequently, emotional and behavioural problems, such as substance abuse, anxiety, depression, and suicidal behaviour typically begin in adolescence and young adulthood.

Non-suicidal self-injury (NSSI), also known as self-injury, defined as the deliberate destruction of one's own body tissue without suicidal intent (Nock & Favazza, 2009), typically begins in adolescence (12 to 14 years of age; Jacobson & Gould, 2007). Common methods of NSSI in adolescence include skin cutting, scratching and burning, interfering with wounds, self-hitting, punching and slapping, and hitting a part of the body on a hard surface (Hasking et al., 2010; Martin et al., 2010; Ross & Heath, 2002). Skin cutting is the most common form of self-injury in adolescence, followed by hitting or punching oneself (Martin et al., 2010; Ross & Heath, 2002). Self-injury is equally common among males and females. However, males are more likely to hit and punch themselves, or bang a part of their body against a hard surface (e.g., punching a wall), while females are more likely to cut themselves



(Whitlock, Eckenrode, & Sliverman, 2006). Self-injury does not include socially or culturally sanctioned behaviours that cause tissue damage, such as body piercing and tattooing (Heath et al., 2006), and behaviours that result in unintentional or gradual tissue damage, such as substance abuse, eating disorders, and unsafe sex or dangerous driving (Jacobson & Gould, 2008).

Although self-injury in adolescence is often mild and transient, the behaviour can persist into adulthood (Storey, Hurry, Jowitt, Owens, & House, 2005). Between 10 and 33% of adolescents have self-injured at least once, while between 12 and 44% of young adults have engaged in self-injury at least once in their lifetime (Hasking, Momeni, Swannell, & Chia, 2008; Martin et al., 2010; Muehlenkamp et al., 2012; Ross & Heath, 2002; Swannell et al., 2014; Whitlock et al., 2006). The prevalence of self-injury in adolescence translates to approximately 2 to 6 students in every Australian classroom. The most common motivations for self-injury in adolescence are to regulate emotions and alleviate distress, to express anger or hatred towards oneself, to alleviate experiences of dissociation, to communicate with or influence others, to avoid the impulse to commit suicide, and to generate excitement or exhilaration (Klonsky, 2007; Laye-Gindhu & Schonert-Reichl, 2005). Self-injury is a risk factor for further, more severe self-injury and attempted suicide (Whitlock et al., 2013). Approximately 16% of individuals who self-injure repeat the behaviour within one year, 20 to 25% self-injure again within four years, and 7% attempt suicide within nine years (Owens et al., 2002). In Australia, the annual economic burden of self-injury is over \$180 million for hospitalisations alone (Martin et al., 2010).

Risk factors for self-injury may include: [childhood abuse](#), [maltreatment or trauma](#) (Gratz, 2006; Hawton, Rodham, Evans, & Weatherall, 2002; Van der Kolk, Perry, & Herman, 1991); [parental separation or divorce](#) (Suyemoto, 1998); [gay, lesbian, bisexual or transgender sexuality](#) (Whitlock et al., 2006); [bullying](#) (Hawton et al., 2002; Hay & Meldrum, 2010);



[exposure to family or peer self-injury](#) (Hawton et al., 2002; O'Connor, Rasmussen, Miles, & Hawton, 2009); [alcohol or drug abuse](#) (Haw, Hawton, Casey, Bale, & Sheperd, 2005; Matsumoto & Imamura, 2008; Rossow et al., 2007); [psychiatric disorders, such as depression, anxiety, post-traumatic stress disorder, substance abuse, eating disorders and personality disorders](#) (Csorba, Dinya, Plener, Nagy, & Pali, 2009; Haw, Hawton, Houston, & Townsend, 2001; Hawton, Kingsbury, Steinhardt, James, & Fagg, 1999; Hawton et al., 2002; Klonsky, Oltmanns, & Turkheimer, 2003; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006); [maladaptive or avoidant coping styles](#) (Hasking et al., 2008; Messer & Fremouw, 2008); [impulsivity](#) (Hawton et al., 2002); [low optimism or self-esteem](#) (Hawton et al., 1999; O'Connor et al., 2009); [poor problem-solving](#) (Hawton et al., 1999); and [poor school performance or unemployment](#) (Young, Sweeting, & Ellaway, 2011; Young, Van Beinum, Sweeting, & West, 2007). Despite the extensive list of risk factors attributed to self-injury, many adolescents who self-injure are functioning well both academically and socially, can come from caring and nurturing family homes, and are not suffering from any mental illness (Toste & Heath, 2010).

Adolescents who self-injure often conceal the behaviour from adults and avoid seeking professional help. Instead, adolescents who self-injure turn to friends and peers for support (Evans, Hawton, & Rodham, 2005; Fortune et al., 2008). Teachers and other school staff are among the first to access professional support for adolescents who self-injure (Oldershaw, Richards, Simic, & Schmidt, 2008; Roberts-Dobie & Donatelle, 2007), but are often unsure how to respond (Muehlenkamp, Walsh, & McDade, 2010). Given the adverse outcomes for adolescents who engage in self-injury and the increased suicide risk associated with self-injury (Conner, Langley, Tomaszewski, & Conwell, 2003; Owens et al., 2002), strategies to improve detection and early intervention of self-injury among adolescents in the school setting are crucial.



1.2. Perceptions and response of school staff towards self-injury

School staff, including teachers and school-based mental health workers, in frequent contact with adolescents are in a unique position to recognise early indicators of self-injury, and respond, preventing escalation of the behaviour and later suicide (Heath et al., 2011). However school staff in the UK, Canada and the US have expressed fear, uncertainty and helplessness when responding to students who self-injure, sometimes misinterpret self-injury as attention-seeking and manipulative, and are calling for further education to improve their confidence and skills to in response to youth self-injury (Best, 2005, 2006; Carlson et al., 2005; Heath et al., 2006; Heath et al., 2011). Together, negative attitudes and limited training can result in inappropriate responses to adolescents who self-injure (Gagnon & Hasking, 2011; Harris, 2000; Hultén et al., 2000; McAllister & Estefan, 2002; Warm et al., 2002), which may influence whether adolescents feel comfortable seeking help for self-injury in the school setting (Hadfield, Brown, Pembroke, & Hayward, 2009; Patterson, Whittington, & Bogg, 2007). To best educate school staff about self-injury we first need to establish the current knowledge and training needs of Australian teachers and other school staff towards the behaviour. Although many teachers and other school staff are not trained mental health professionals (Koller, Osterlind, Paris, & Weston, 2004), many have responded to students who self-injure and desire further education to enhance their response (Carlson et al., 2005; Heath et al., 2006; Oldershaw et al., 2008; Roberts-Dobie & Donatelle, 2007).

1.3. Rationale and aims of the study

Before effective training tools and guidelines for best practice can be provided to pre-service teachers and school staff, we first need to understand how pre-service teachers and school staff currently view and respond to self-injury, and establish their knowledge, confidence and training needs. Understanding the views of pre-service teachers and school



staff will inform the development of effective and targeted education programs and training tools that aim to increase confidence among school staff, and enhance detection and early intervention of self-injury in the school setting. As such, the aims of this project were to investigate the knowledge and training needs of pre-service teachers and school staff, including school principals, teachers, counsellors and psychologists, towards self-injury. This project is significant because it was the first to investigate how pre-service teachers and school staff in Australia view self-injury among adolescents, and their response and training needs regarding this behaviour.

Based on the limited research that has investigated the perceptions of school staff towards self-injury, this study sought to establish:

- The knowledge and attitudes of pre-service teachers and school staff regarding self-injury, and their confidence to respond to students who self-injure.
- How pre-service teachers and school staff currently respond to students who self-injure, how effective they believe these responses to be, and perceived barriers to prevention of self-injury in schools.
- The training needs of pre-service teachers and school staff towards youth self-injury.



2. Methodology

2.1. Participants

Seven hundred and sixty eight pre-service teachers and school staff (556 females, 206 males, and 6 unspecified; aged 18 to 67 years; *Mean age* = 38.35, *SD* = 12.94) working in the Australian secondary education sector completed an online questionnaire. Most were pre-service teachers ($n = 267$, 34.8%), followed by in-service teachers ($n = 261$, 34.0%), school mental health workers, including counsellors, psychologists and welfare coordinators ($n = 105$, 13.7%), school leaders, including principals, deputy principals and year levels coordinators ($n = 82$, 10.7%), and administrative and school support staff, including school nurses, integration (i.e., teacher) aides and administration staff ($n = 53$, 6.9%). Pre-service teachers were recruited from Universities in all Australian states and territories, excluding Western Australia. In-service teachers and other school staff were recruited from publically funded and private secondary schools in all Australian states and territories. Among in-service teachers and school staff, years working in secondary schools ranged from less than one year to 45 years (*Mean years* = 14.75, *SD* = 11.01).

2.2. Survey

Participants completed anonymous online questionnaires launched through a URL link included on the information sheet, and returned anonymously to the researchers via the online survey supplier to a password protected account accessible only to the researchers. All questionnaires had demonstrated reliability and validity, or were measures designed to elicit personal feedback rather than standardised scores. Open-ended questions allowed participants to elaborate on their responses to the standardised questionnaires, and helped the researchers



to gain a better understanding of the experiences and challenges of teachers and other school staff regarding this important, yet under-researched topic.

The project comprised several questionnaires which assessed five main areas, including: 1) knowledge of self-injury; 2) attitudes and confidence towards self-injury; 3) response to students who self-injure; 4) training needs regarding self-injury; and 5) perceptions of a template policy for responding to students who self-injure.

- Background questionnaire: Age, gender, occupation, years of professional experience in schools, and experience of mental health issues and self-injury among students.
- Knowledge of self-injury: 20-item Self-Injury Knowledge Questionnaire (Jeffery & Warm, 2002) assessed knowledge of self-injury and the functions it may serve for adolescents who self-injure. The 19-item Teachers' Knowledge and Beliefs about Self-Injury questionnaire (Heath et al., 2006; Heath et al., 2011) measured knowledge regarding the age of onset, prevalence and common methods of self-injury.
- Attitudes and confidence towards self-injury: A modified version of the 25-item Attitudes towards Deliberate Self-Harm Questionnaire (ADSHQ; McAllister, Creedy, Moyle, & Farrugia, 2002), originally developed to investigate nurses' attitudes towards self-injury, assessed attitudes and confidence towards adolescents who self-injure. The Teachers' Knowledge and Beliefs about Self-Injury questionnaire (Heath et al., 2006; Heath et al., 2011) also assessed attitudes and confidence in response to adolescents who self-injure.
- Response to students who self-injure: Participants were asked to outline their usual response to students who self-injure, how effective and confident they felt when helping students who self-injure, and any barriers they perceive when helping students who self-injure.



- Training needs regarding self-injury: Participants were asked to answer open-ended questions about whether they had ever participated in training programs regarding self-injury, and whether they would be willing to participate in education programs addressing self-injury in the future. Space was provided for participants to voice their views about the content and delivery of such training, and to express any other thoughts they have about their education and training needs regarding youth self-injury.
- Perceptions of a template policy for responding to students who self-injure: Participants were asked about the availability of policies for responding to students who self-injure in the secondary education sector, and provided written comments to four open-ended questions regarding the acceptability of a template policy for responding to students who self-injure, challenges to implementing the template policy in schools, the need for a school policy addressing youth self-injury, and any other suggested changes school staff would make to the template policy for responding to students who self-injure.

2.3. Procedure

After obtaining approval from the Monash University Human Research Ethics Committee (MUHREC), and Departments of Education and Catholic Education Offices across Australia, university subject/course coordinators and school principals nationwide were mailed information about the project, and invited to advertise the project among pre-service teachers and school staff, respectively. Of the 129 subject/course coordinators contacted, 66 agreed to distribute information to pre-service teachers, while 86 of the 1488 school principals contacted agreed to provide information about the project to school staff. Interested pre-service teachers and school staff (including principals, teachers, counsellors, psychologists, and administrative staff) completed the anonymous questionnaires at a time and location of their convenience, which was then returned to the researchers online. The



project was also advertised to school psychologists on the Australian Psychological Society (APS) website. Participants were reminded on information sheets that participation was voluntary and they could withdraw from the study prior to submitting the questionnaires. The online questionnaires took approximately 40 minutes to complete and participants were invited to enter a draw to win cinema tickets to thank them for their time. Telephone numbers and websites of crisis help lines were provided to participants with information sheets and on completion of the questionnaires.

2.4. Data Analysis

Descriptive statistics were used to examine the knowledge, attitudes and confidence of pre-service teachers and school staff based on their responses to the questionnaires. Analyses of relationships were then used to determine whether these factors varied among participants with different roles in the secondary education sector (e.g., pre-service teachers vs. in-service teachers), and as a function of experience with students who self-injure and training in the area. Open-ended responses were analysed using a process of thematic analysis. Key concepts or ideas were identified from participants' responses and numeric codes assigned to the data. Responses were constantly re-read and re-coded to verify concepts and patterns, and where necessary, to validate new ideas or merge existing concepts from participants' responses (Braun & Clarke, 2006).



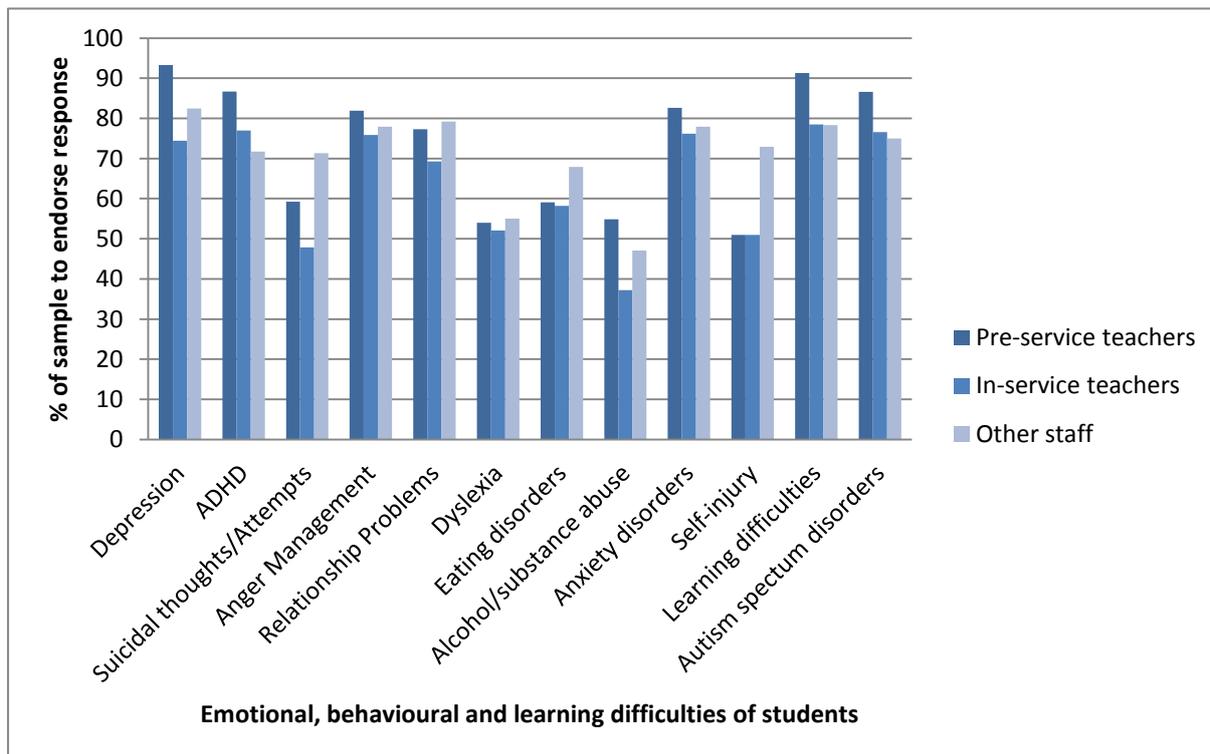
3. Key Findings

3.1. Analysis of questionnaires

3.1.1. Experience of mental health issues and self-injury among students

School staff were asked which mental health issues they commonly observe among students. Depression, attention deficit hyperactivity disorder (ADHD), eating disorders, anxiety disorders, self-injury and suicidal behaviour, learning difficulties, autism spectrum disorders, and anger management and relationship problems were some of the most common emotional and behavioural issues in schools (see Figures 1 and 2).

Figure 1: Emotional, behavioural and learning difficulties among students

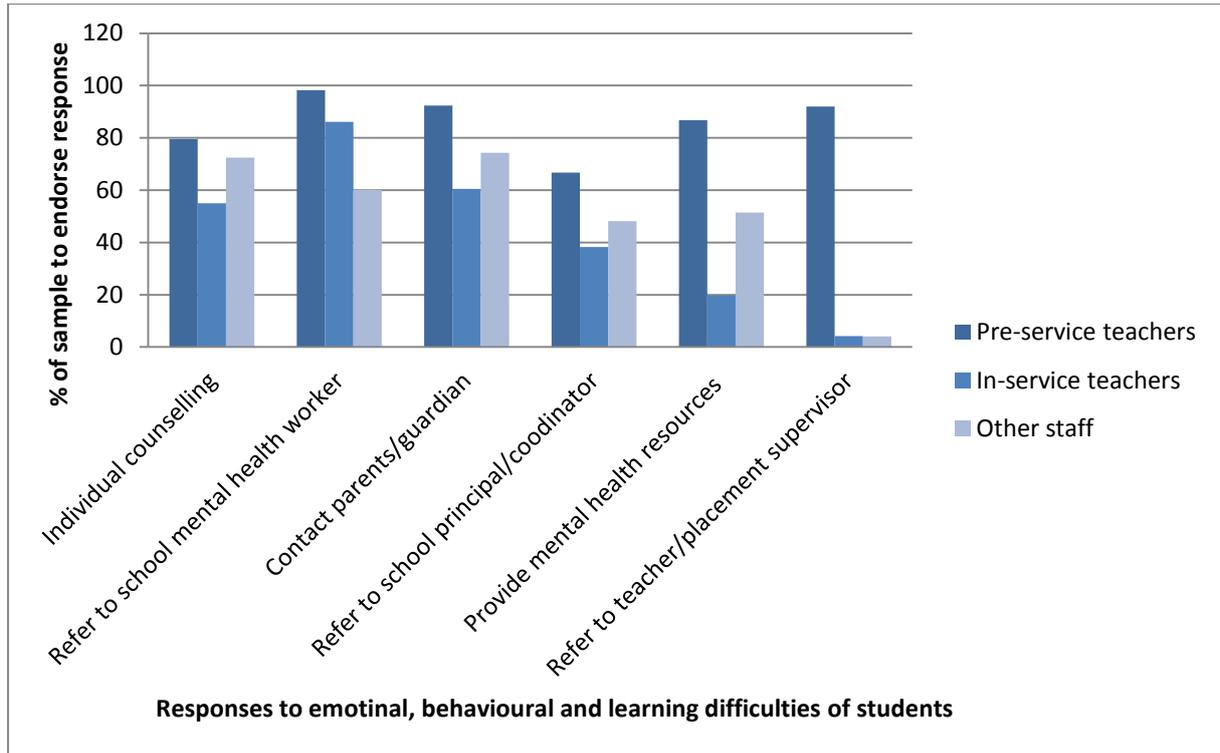


Note: Other staff includes school leaders, mental health workers and administrative and support staff



Individual counselling, referral to a mental health professional, contact parents or colleagues, and provision of mental health resources or contact details of crisis help lines were the most common responses to mental health issues in schools.

Figure 2: Responses to emotional, behavioural and learning difficulties among students



Note: Other staff includes school leaders, mental health workers and administrative and support staff



Table 1 shows the distribution of participants who had encountered students who self-injure. Overall, over half of participants had responded to students who self-injure. Mental health workers were most likely to respond to students who self-injure, however, over half of in-service teachers had also responded to students who self-injure.

Table 1: Experience with students who self-injure

Role	Yes		No	
	<i>n</i>	%	<i>n</i>	%
Pre-Service Teachers	33	21.4	121	78.6
In-Service Teachers	111	58.7	78	41.3
School Leaders	50	83.3	10	16.7
School Mental Health Workers	72	93.5	5	6.5
Administrative and Support Staff	22	53.7	19	46.3
All Participants	288	55.3	233	44.7

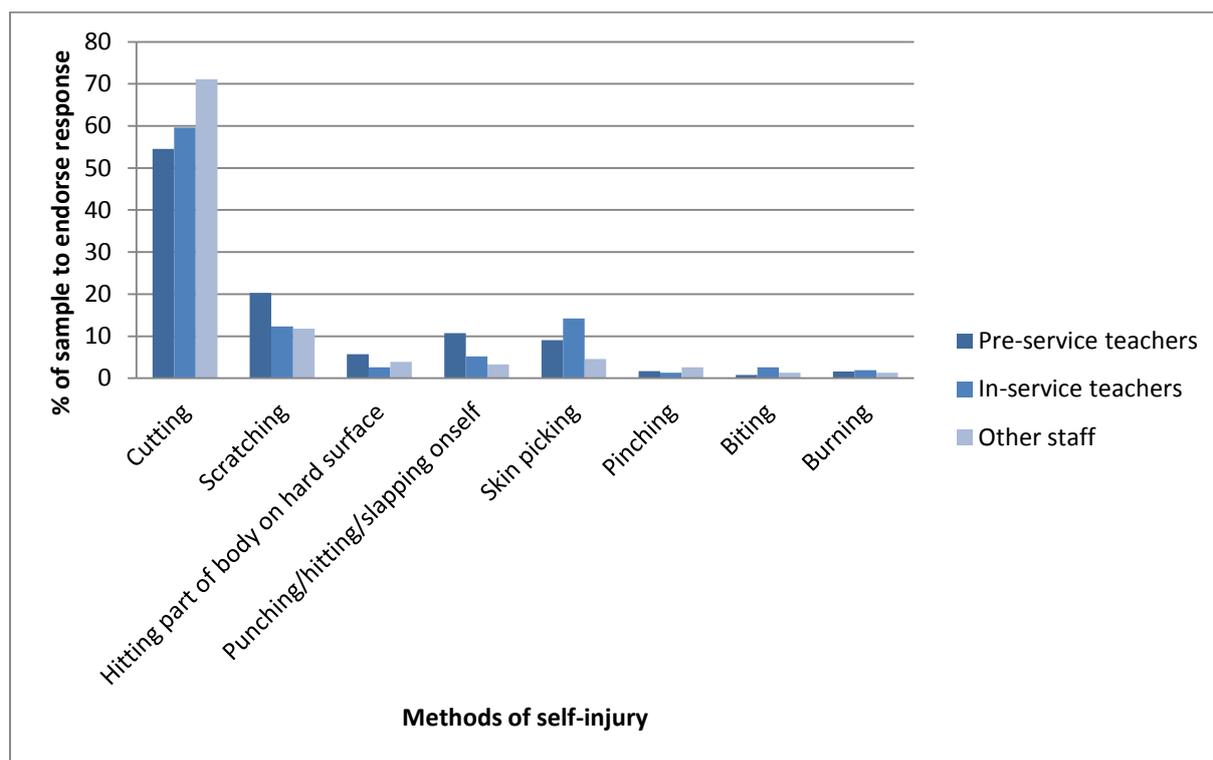
Note: *n* is the number of respondents and % is the proportion of respondents who have encountered students who self-injure



3.1.2. Knowledge of and attitudes toward self-injury

Participants were asked to indicate the most common methods and motivations for self-injury, as well as the prevalence of self-injury among adolescents (see Figures 3 to 5). The majority correctly considered skin cutting and scratching, and self-hitting and punching as common methods of self-injury. Pre- and in-service teachers were less likely to report that cutting is the most common method of self-injury. In-service teachers were more likely than other school staff to mention skin picking.

Figure 3: Common methods of self-injury among adolescents

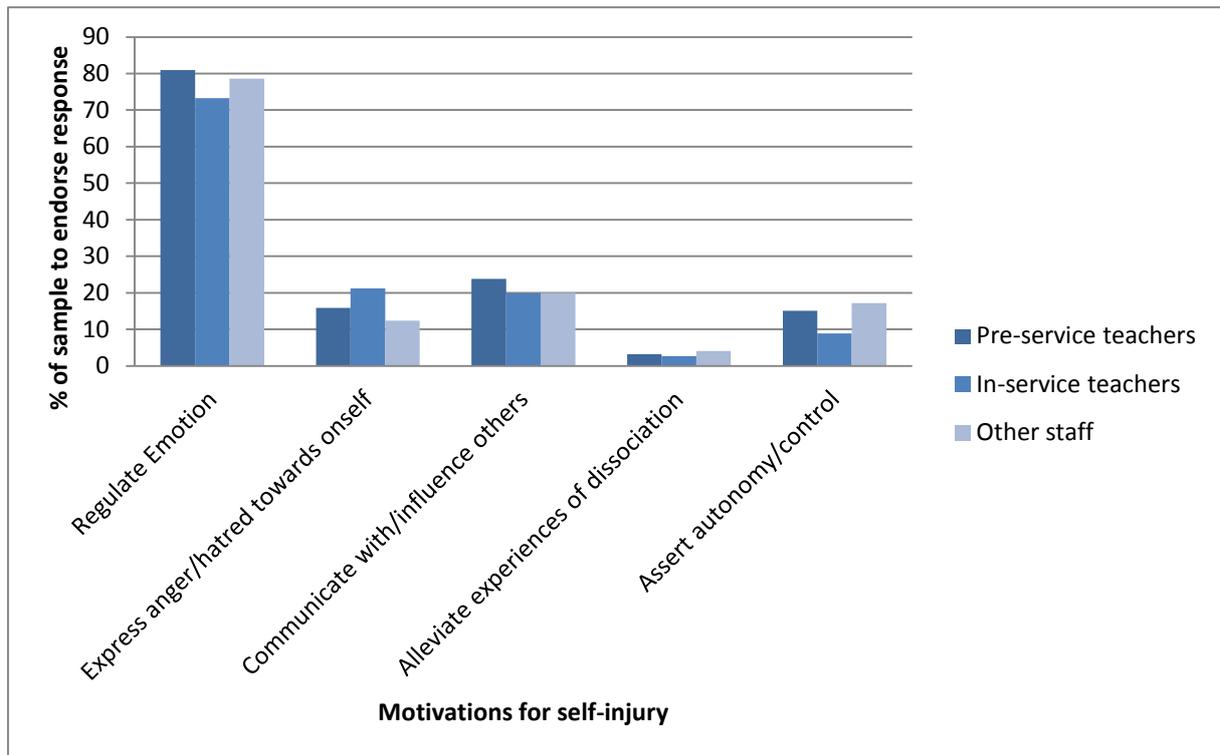


Note: Other staff includes school leaders, mental health workers and administrative and support staff



Most participants correctly identified emotion regulation, and expression of self-hatred and anger as common motivations for self-injury. Less frequently mentioned motivations included to communicate with or influence others, and to assert autonomy or self-control. No differences were found between the groups.

Figure 4: Common motivations for self-injury among adolescents

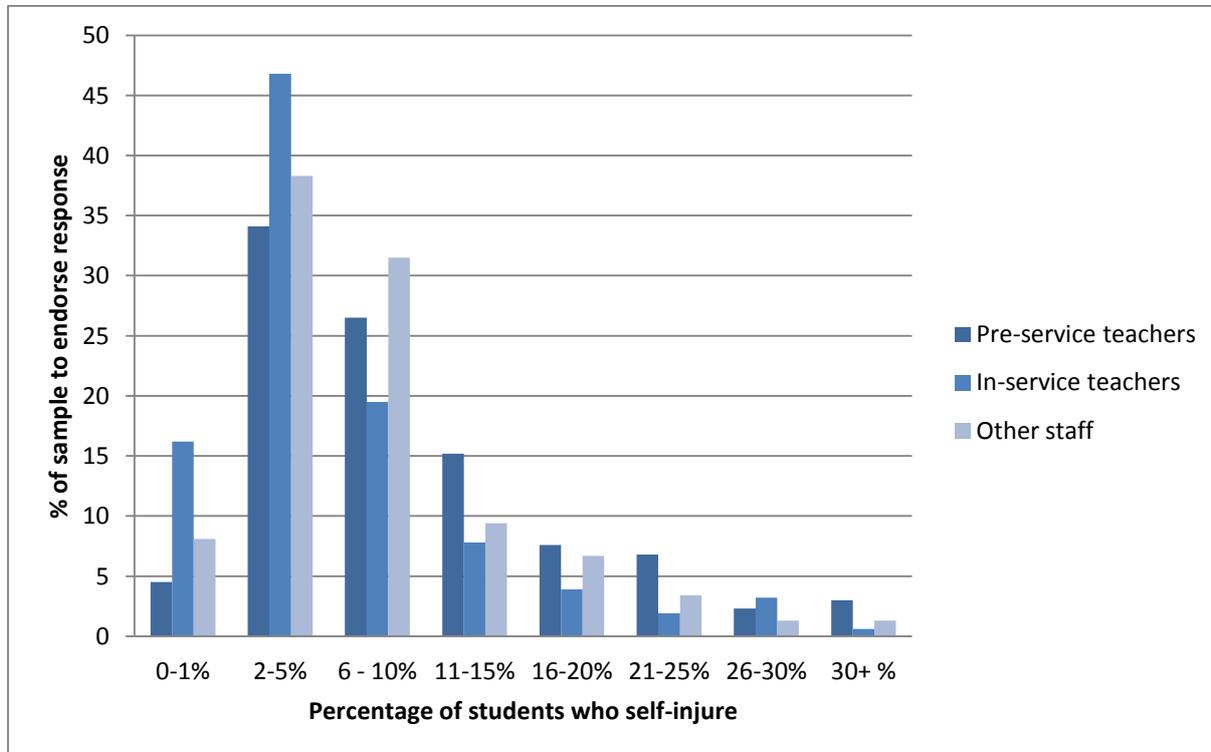


Note: Other staff includes school leaders, mental health workers and administrative and support staff



Most participants correctly recognised 10 to 17 years as the age of onset for self-injury. However, the majority mistakenly identified 10 to 17 years as the age when self-injury is most prevalent, with fewer participants correctly identifying 18 to 24 years of age. Research has found that although self-injury begins in adolescence between 12 and 14 years of age, young adulthood between 18 to 24 years of age is when the prevalence of self-injury peaks (Martin et al., 2010). Most participants significantly underestimated the prevalence of self-injury in adolescence, suggesting that fewer than 5% of adolescents self-injure. Current research puts the rate at approximately 17% (Muehlenkamp et al., 2012; Swannell et al., 2014). In-service teachers were more likely than pre-service teachers and other school staff to underestimate the prevalence of self-injury among students.

Figure 5: Percentage of students who engage in self-injury



Note: Other staff includes school leaders, mental health workers and administrative and support staff



Overall, participants had relatively accurate knowledge about self-injury. The majority correctly reported that self-injury is a coping mechanism, and not usually related to suicide, or an attempt to manipulate or seek attention from others. Most participants correctly reported that self-injury does not necessarily indicate that someone has a mental illness or has been sexual abuse, and that self-injury is equally prevalent among males and females. Pre-service teachers were less clear whether self-injury is manipulative, and in-service teachers were unsure if self-injury is a coping strategy. Most school mental health workers believed they are equipped to communicate with students who self-injure and disagreed that self-injury is horrifying (see Tables 2 and 3).

Table 2: I feel knowledgeable about the area of self-injury

Role	Strongly Disagree		Disagree		Unsure		Agree		Strongly Agree	
	n	%	n	%	n	%	n	%	n	%
Pre-Service Teachers	16	10.5	65	42.1	31	20.4	35	23.0	6	3.9
In-Service Teachers	13	7.3	76	42.9	47	26.6	38	21.5	3	1.7
School Leaders	2	3.2	21	33.9	20	32.3	19	30.6	0	0.0
School Mental Health Workers	0	0.0	4	5.3	14	18.4	44	57.9	14	18.4
Administrative and Support Staff	5	12.2	12	29.3	8	19.5	13	31.7	3	7.3
All Participants	36	7.1	178	34.9	120	23.5	150	29.4	26	5.1

Note: n is the number of respondents and % is the proportion of respondents who indicated on a scale from 1 to 5 (strongly disagree to strongly agree) whether they feel knowledgeable about the area of self-injury



Table 3: I find the idea of students cutting or burning their skin horrifying

Role	Strongly Disagree		Disagree		Unsure		Agree		Strongly Agree	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Pre-Service Teachers	6	4.0	42	28.0	17	11.3	58	38.7	27	18.0
In-Service Teachers	6	3.4	30	17.0	21	11.9	99	56.3	20	11.4
School Leaders	4	6.5	22	35.5	7	11.3	25	40.3	4	6.5
School Mental Health Workers	14	18.2	36	46.8	8	10.4	16	20.8	3	3.9
Administrative and Support Staff	3	7.3	10	24.4	5	12.2	19	46.3	4	9.8
All Participants	34	6.7	140	27.6	58	11.4	218	42.9	58	11.4

Note: *n* is the number of respondents and % is the proportion of respondents who indicated on a scale from 1 to 5 (strongly disagree to strongly agree) whether they find the idea of students cutting or burning their skin horrifying



3.1.3. Confidence in addressing self-injury

Participants reported feeling useful and comfortable when helping students who self-injure. However, most indicated that they lack knowledge and skills to respond to students who self-injure, and require ongoing training to efficiently address self-injury in the school setting (see Table 4).

Table 4: Ongoing education and training would be useful in helping me deal appropriately with students who self-injure

Role	Strongly Disagree		Disagree		Agree		Strongly Agree	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Pre-Service Teachers	1	0.6	4	2.5	56	34.6	101	62.3
In-Service Teachers	2	1.0	8	3.9	115	56.4	79	38.7
School Leaders	0	0.0	2	2.9	40	58.8	26	38.2
School Mental Health Workers	0	0.0	3	3.5	46	54.1	36	42.4
Administrative and Support Staff	0	0.0	1	2.4	25	59.5	16	38.1
All Participants	3	0.5	18	3.2	282	50.3	258	46.0

Note: *n* is the number of respondents and % is the proportion of respondents who indicated on a scale from 1 to 4 (strongly disagree to strongly agree) whether ongoing education and training would be useful in helping them deal appropriately with students who self-injure



3.1.4. Training in self-injury

Three quarters of participants had not received training in the area of self-injury and over three quarters would like to receive training in the area (see Tables 5 and 6).

Table 5: Have you ever received training in the area of self-injury

Role	Yes		No	
	<i>n</i>	%	<i>n</i>	%
Pre-Service Teachers	14	10.2	123	89.8
In-Service Teachers	27	14.9	154	85.1
School Leaders	16	30.8	36	69.2
School Mental Health Workers	54	77.8	16	23.2
Administrative and Support Staff	10	28.2	28	71.8
All Participants	121	25.3	357	74.7

Note: *n* is the number of respondents and % is the proportion of respondents who have received training in self-injury

Table 6: Do you think you need training in the area of self-injury

Role	Yes		Unsure		No	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Pre-Service Teachers	119	90.8	9	6.9	3	1.1
In-Service Teachers	76	72.4	23	21.9	6	5.7
School Leaders	24	70.6	8	23.5	2	5.9
School Mental Health Workers	49	76.6	8	12.5	7	10.9
Administrative and Support Staff	20	37.7	4	16.0	1	4.0
All Participants	288	80.2	52	14.5	19	5.3

Note: *n* is the number of respondents and % is the proportion of respondents who need training in self-injury



Based on the questionnaires investigating the knowledge, attitudes and confidence of pre-service teachers and school staff regarding self-injury, as well as their experience and training needs in the area, results indicate that:

- Pre-service teachers and in-service teachers are aware of the risk factors for self-injury, however, they are less certain about common motivations for the behaviour. School leaders, mental health workers, and administrative and support staff are knowledgeable about the risk factors and motivations for self-injury.
- Pre-service teachers, in-service teachers, and administrative and support staff feel ill-equipped to identify and respond to students who self-injure. School leaders and mental health workers feel skilled to address self-injury in schools.
- Although many pre-service teachers, and the majority of in-service teachers and other school staff have responded to students who self-injure, most have not received training in the area and would like to learn more about self-injury.

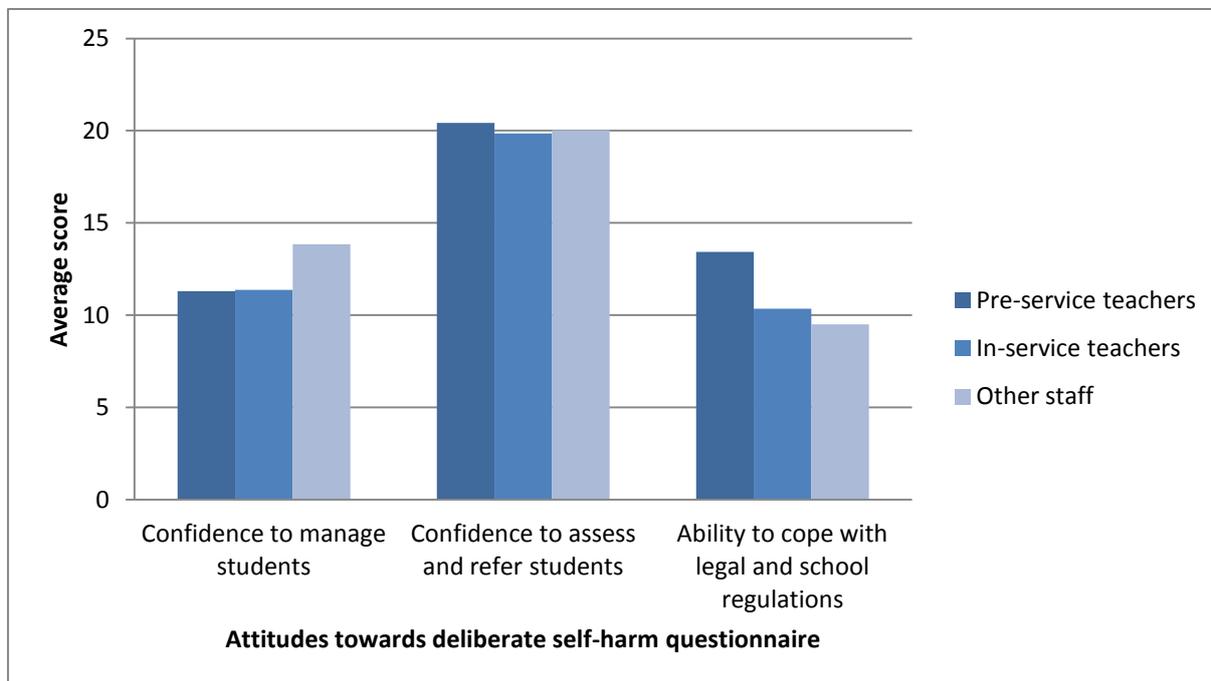


3.1.5 Relationships between key variables

The last section of this report explored the percentage of participants who disagreed or agreed to questions relating to their knowledge, attitudes and confidence regarding youth self-injury. In this section we compare participants' perceptions of self-injury based on their occupation in the secondary school sector, and whether they have experience with students who self-injure or training in the area (see Figures 6 to 8). Pre- and in-service teachers were less confident that they could manage students who self-injure than other school staff. However, pre-service teachers were more confident they could cope with legal and school regulations than in-service teachers and other school staff. Participants experienced with students who self-injure were more confident that they could identify accurate information about self-injury than those without experience with students who self-injure. Participants with training in self-injury were more confident that they could respond to students who self-injure, and more able to identify accurate information about self-injury than participants without training in the area.

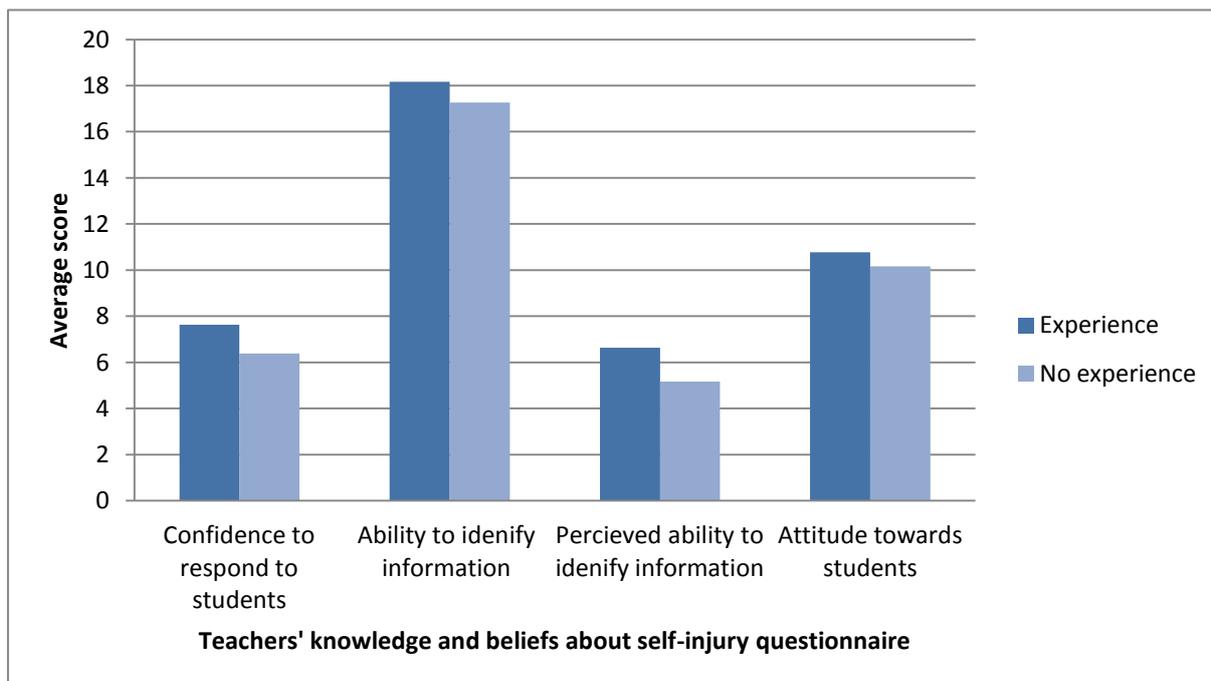


Figure 6: Relationship between occupation and subscales of the Attitudes towards Deliberate Self-Harm Questionnaire (ADSHQ)



Note: Other staff includes school leaders, mental health workers and administrative and support staff

Figure 7: Relationship between experience with students who self-injure and subscales of the Teachers’ Knowledge and Beliefs about Self-Injury questionnaire

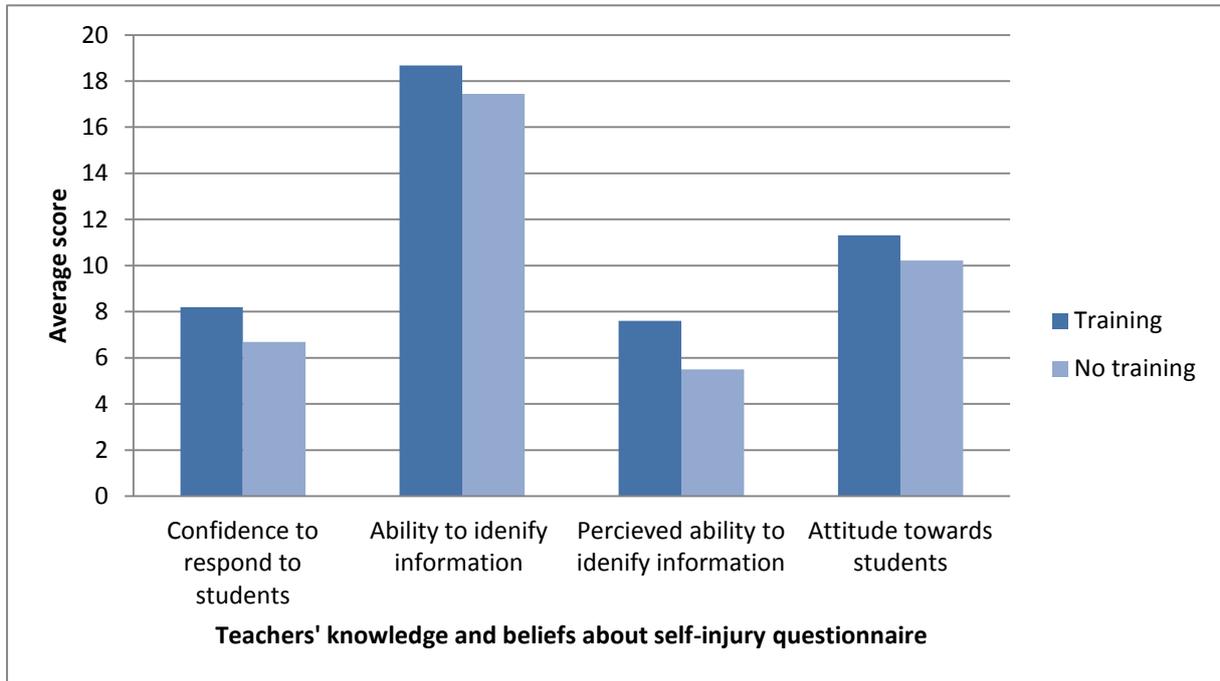


Note: Experience includes those who have responded to students who self-injure. No experience includes those who have not responded to students who self-injure



Figure 8: Relationship between training in self-injury and subscales of the Teachers’

Knowledge and Beliefs about Self-Injury questionnaire



Note: Training includes those who have received training in the area of self-injury. No training includes those who have not received training in the area of self-injury



Results of the comparisons between pre-service teachers, in-service teachers and other school staff, and between those with and without experience and training in the area of self-injury suggest that:

- Pre-service teachers and in-service teachers are less confident than other school staff that they can respond effectively to students who self-injure. However, pre-service teachers are more confident in their ability to cope with legal and school regulations relating to self-injury.
- Experience with students who self-injure and training in the area was associated with greater knowledge of self-injury.
- Training in self-injury was related to feeling more confident to address self-injury in schools.



3.2. Analysis of open-ended questions

The previous sections of this report investigated and compared the knowledge and attitudes of pre-service teachers and school staff towards self-injury, and their confidence responding to students who self-injure. This next section will focus on participants' responses to the open-ended questions, which investigated their typical response to students who self-injure and their training and school policy needs regarding youth self-injury. Several key issues emerged from participants' accounts regarding their experiences in response to students who self-injure, and training and school policy needs in the area, which are summarised below.

3.2.1. Response to students who self-injure

To learn more about how schools respond to students who engage in self-injury, participants were asked to describe how they usually respond to students who self-injure, how confident and effective they are in helping these students, and to outline perceived barriers in schools that could impede their ability to respond effectively to students who self-injure. Four concepts were identified, including: 1) the process of responding to students who self-injure; 2) perceived effectiveness in response to students who self-injure; 3) perceived confidence in response to students who self-injure; and 4) barriers to responding to students who self-injure.

1. The process of responding of students who self-injure

When asked to outline their typical response to students who self-injure, the majority of participants regularly referred students who self-injure to school mental health professionals ($n = 201, 76.7\%$), or performed risk assessments and provided individual counselling ($n = 190, 72.5\%$). Others typically contacted the students' parents or guardian ($n = 80, 30.5\%$), referred students who self-injure to school principals, coordinators or



colleagues ($n = 40$, 15.3%), or supplied mental health resources and telephone numbers of crisis help lines (i.e., Kids Helpline; $n = 13$, 5.0%).

2. Perceived effectiveness of response to students who self-injure

Most participants described their response as somewhat effective ($n = 134$, 50.8%) but many were unsure ($n = 77$, 29.2%) how effective their typical response was in helping students who self-injure). Respondents described the process of helping students who self-injure as gradual, with waxing and waning recovery depending on the students' commitment to seek help and implement strategies, and the quality of parental support.

“Very effective for some, however this takes time and depends on their efforts to implement strategies. Many factors can affect this. Things change rapidly for young people so it’s hard to measure” (Administrative and support worker)

“Relatively effective, dependent upon support given at home and motivation of student to get help and follow through with advice” (Mental health worker)

“It is still an ongoing process for those who are dealing with the self-harm. It has been effective so far because the students and parents have been referred to professionals and the parents are highly involved. Sometimes it feels like ‘one step forward, two steps back’, however it is about perseverance and constant monitoring”
(School leader)

Participants who described their response as ineffective or quite ineffective ($n = 21$, 8.0%) highlighted that their response could improve with additional education and resources in schools addressing youth self-injury.

“My supervising teacher was not very effective in dealing with the problem and I ended up passing it on again to the head teacher...” (Pre-service teacher)



“This student had a history of self-harm and had been seeing a psychologist outside, which we tried to work with. I feel more needed to be done, especially as we did not have a trained mental health person in the school” (In-service teacher)

“I don't think I was very effective at all. My training has not prepared me for this sort of interaction with students. I could have handled it better, if I had been trained to deal with it” (In-service teacher)

3. Perceived confidence in response to students who self-injure

Several participants reported feeling quite confident ($n = 126$, 48.1%) about their usual response to students who self-injure particularly when school policies and mental health services are available. However a significant proportion also feel uncertain ($n = 44$, 16.8%) about their usual response.

“Varied - sometimes I was very uncomfortable because I knew the situation was beyond me but good processes were in place to ensure no adult worked alone with students and there was support there at all times” (Mental health worker)

“As I was simply required to delegate the management of the problem to trained professionals, I felt very confident. If ... I have no trained professionals within the school to call on, I would feel far less confident. I would have to trust that the teachers [in] student management positions would be able to refer the student on to the appropriate professional help” (In-service teacher)

Others expressed a personal lack of confidence ($n = 56$, 21.4%) regarding their typical response to students who self-injure, especially participants without experience and training in the area.



“Not as confident as I would like. It is hard to conceal one's own feelings of shock or discomfort or fear” (Mental health worker)

“I don't feel confident. I really haven't been given enough training” (In-service teacher)

“Not very confident, it was my first experience with someone who self-injured” (In-service teacher)

School mental health workers acknowledged that through their experience and training they had learnt how to respond to students who self-injure.

“The first student was hard to comprehend why and to not respond negatively towards the action they had inflicted, but I have gained more advice and experience in my responses to students and feel more confident in responding appropriately”
(Mental health worker)

“First time was the hardest but since then I learnt different techniques and information that has helped me deal with each case” (Mental health worker)

“Reasonably confident as I had just completed a fairly intense training course on self-harm” (Mental health worker)

Following experience and training in the area, participants were no longer afraid to broach the issue with students who self-injure, but would discuss limits of confidentiality with students who self-injure and refer these students earlier to mental health professionals.

“Talk to the student first and try and find out the whole situation (what's going on at home, etc.). Be clear to the student from the start that I can't just keep a secret and have to refer on. Refer to the Student wellbeing co-ordinator” (School leader)



“I would probably refer on quicker now” (Administrative and support worker)

4. Barriers to responding to students who self-injure

Inadequate knowledge and training were identified as barriers which may prevent school staff from responding effectively to students who self-injure.

“The only barrier would be my own lack of training and knowledge” (Pre-service teacher)

“We are teachers and not trained to deal in depth with these issues, but as the students are in our classes we need some idea about the way to handle the situations”

(In-service teacher)

“Poor understanding among non-counselling staff members and the processes involved for supporting students, particularly around the grey area of confidentiality”

(Mental health worker)

Others perceived that a lack of school resources, including time and finances, can prevent school staff from responding efficiently to students who self-injure, and mentioned that existing mental health services in schools and the community are insufficient.

“Time, money and specialised resources are a huge barrier as many people perceive that these young people are attention seekers and not suffering a significant mental health episode” (School leader)

“Time - as a classroom teacher there are more and more tasks placed on me which makes it difficult to effectively support all students.” (In-service teacher)



“Overworked and extremely burdened social workers and child welfare workers have so many cases where the harm is being dealt out by others that they hardly have time for the ones who want to self-harm” (Administrative and support worker)

It was also suggested that clear policies and response protocols need to be implemented in schools and communicated to school staff.

“I would only add that it would be good to have some discussion over a plan of action. In my role as reception to the students I wasn't aware if we have a certain protocol to follow regarding self-harm. I would like input into this if we have one or make one” (Administrative and support worker)

“I think the best thing for early career teachers is an action plan, particularly the first steps to be taken” (Pre-service teacher)

Reactions of parents and their reluctance to seek help were also emphasised as significant barriers by school staff to responding efficiently to students who self-injure.

“If the parents don't have the correct headset and see it as just attention seeking and aren't prepared to work at addressing the real cause of the problem” (School leader)

Sometimes the parents will not admit what is happening or do not want to know as it is really hard for them. I understand why they take that stance, but it doesn't help” (In-service teacher)

“Reactions of parents when their response is the student is just self-harming for attention or they are excessively horrified and can't cope with the situation” (Mental health worker)



Participants also remarked on students' reluctance to seek or accept help for self-injury, especially when they are concerned about stigma and confidentiality, or negative reactions among parents and peers to their self-injury.

“The largest barrier is that of the student themselves if they do not want help then it is going to be very hard to help them get past their self-injury. Once a student decides that they want to stop help comes much easier” (Pre-service teacher)

“Students may be embarrassed about the problem or not want to communicate. Some students feel that their self-harm is a form of control in their lives and may not want assistance” (Pre-service teacher)

“Confidentiality: Young people are concerned that health professionals may tell their parents/teachers/other students. Think that an adult won't understand them. Feel shame and the fear of being stigmatised. Fear the impact it may have on their family/friends” (Administrative and support worker)

3.2.2. Training needs regarding self-injury

Having identified that pre-service teachers and school staff feel they require training to respond confidently to students who self-injure, we were interested to understand how pre-service teachers and school staff would prefer to be educated about self-injury. Three concepts were identified, including: 1) the process of learning about self-injury; 2) strengths of previous training; and 3) directions for future training.

1. The process of learning about self-injury

Among participants who had received training addressing self-injury, workshops were the most common method for learning about self-injury ($n = 74, 62.7\%$), followed by seminars and lectures ($n = 72, 61.0\%$), independent reading, workbooks and multimedia



sources ($n = 22$, 18.6%), or professional supervision and consultation ($n = 12$, 10.2%). Many of these participants learnt about the referral process and mental health services ($n = 83$, 70.9%), risk assessment procedures ($n = 70$, 59.8), counselling and communication skills ($n = 62$, 53.0%), and general information about self-injury, as well as how to identify self-injury and respond to students who engage in this behaviour ($n = 43$, 36.8%).

2. Strengths of previous training

Several participants ($n = 107$, 89.9%) derived considerable benefits from participating in training which can be implemented into future training for self-injury, including acquiring practical strategies and confidence to talk to students who self-injure, clarified roles and responsibilities when addressing self-injury in schools, and discredited myths about self-injury which are perpetuated in the community and media.

“It was very practical and gave me confidence in approaching mental health as a common issue, I did not realise how common self-injury was until this workshop. When the staff were asked if they knew anyone or were related to anyone who had self-harmed nearly every hand went up” (Pre-service teacher)

“Made me aware that it is more than attention seeking, that the student was experiencing mental health issues” (School leader)

“It helped me to recognise symptoms and signs, and to understand the illness aspect of mental health behavioural symptoms, as well as equipping me with both the understanding that I am not necessarily expected to fix the problem for the students, but that I can and should take action if severe enough, and that I feel equipped to broach the subject with the student to begin with. It took away a lot of fears about tackling such a big problem” (Pre-service teacher)



To improve on previous training and provide directions for future education programs, we also sought to understand limitations of previous training in the area. Some participants ($n = 11$, 10.1%), reported that existing training was too brief and did not focus on self-injury.

“But it's only been a little bit. The seminar might have been 5 minutes in a staff meeting” (In-service teacher)

“Focus was not so much on self-harm but on suicide prevention” (In-service teacher)

3. Directions for future training

Based on participants' accounts regarding further training, and additional free comments, pre-service teacher and school staff suggested they require information to confidently identify and address self-injury in the school setting.

“I think it would be beneficial to have a better understanding of the problem so you could deal with it with greater confidence” (In-service teacher)

“To understand why a young person would self-harm and learn how to help a young person who is self-harming. What help is available in the community for a young person who self-harms?” (Administrative and support worker)

“Were working in the dark here” (In-service teacher)

Some participants acknowledged that while responding to mental health problems among students is not typically the role of teachers, it could help for staff “on the ground” to be aware of self-injury, particularly in remote areas of Australia.

“While you don't want every teacher to be playing the role of the School Psychologist it makes sense to have those who work on a daily basis with the student aware of danger signals and knowledgeable about processes for intervention and help” (In-service teacher)



“I think it is beneficial for teachers to learn how to identify students who may be self-harming and also receive education on how to help these students with their problems. Often we may be the only ones the student can turn to for help” (In-service teacher)

“It is important to get as much information as possible, particularly being in a remote area with very few accessible resources” (Mental health worker)

It was also suggested that training has become more important due to the perception that the prevalence of self-injury is increasing among youth and schools need to be prepared to respond to these students.

“I feel as though these issues are becoming more and more common with secondary students, and I do want to be more prepared” (In-service teacher)

“It is becoming more difficult to identify but more prevalent” (School leader)

Participants reported desiring training in:

- Conducting risk assessments ($n = 177$, 56.9%)
- Referring students who self-injure ($n = 175$, 56.3%)
- Counselling and communicating with students ($n = 203$, 65.3%)
- General information about self-injury, including how to identify and react to self-injury in schools ($n = 93$, 29.9%)

When asked the ideal format for training participants nominated:

- Workshops ($n = 212$, 67.9%)
- Seminars and lectures ($n = 166$, 53.2%)
- Workbooks, multimedia and online resources ($n = 84$, 26.9%)



Most participants would like to receive training yearly ($n = 122$, 45.0%), less the once a year ($n = 108$, 39.9%) or biannually ($n = 32$, 11.8%).

Participants who did not wish to participate in training explained that they were concerned about having limited time and resources to participate in training about self-injury or to respond to students who self-injure.

“There are many things a teacher has to be across, it is a small % students’ in class, and I cannot be the expert in all areas” (In-service teacher)

“Depend on the length of the training, its proximity and the cost involved” (School leader)

3.2.3. Policy needs regarding self-injury

The final stage of this project involved assessing the suitability of a draft policy for responding to students who self-injure in schools, which was developed based on a review of the literature and previous stages of this project which demonstrated a need and desire for such a policy in the Australian education system. Although guidelines for responding to self-injury in schools have increased in recent years (Bubrick, Goodman, & Whitlock, 2010; Onacki, 2005; Toste & Heath, 2010; Walsh, 2012), limited research has investigated the utility of these policies for managing self-injury in the school setting. Forty eight teachers and other school staff (including year level coordinators, psychologists, and counsellors) reviewed a draft policy for addressing self-injury in schools and provided written feedback. Input from school staff was then used to refine the policy and develop a flowchart for responding to and referring students who self-injure (see Appendix A and B). This template policy and flowchart can be used by Education Departments and school leaders as a guideline when developing their own self-injury policy, or when reviewing existing policies and practices in response to youth self-injury in schools.



Results built upon existing literature suggesting that the majority of teachers and other school staff work in schools *without* a policy regarding self-injury (37.5%), or are *unsure* whether their school had such a policy (29.2%), while a third work in schools *with* a policy addressing youth self-injury (33.3%). Participants working in schools without a policy reported that their school needed a policy regarding self-injury (94.4%). However, most participants with a policy addressing self-injury in schools were satisfied with existing school policies regarding self-injury (68.7%). Participants without a policy addressing self-injury in schools were also generally positive about the presented policy (83.0%) and supported its implementation in their school (70.8%). Perceived challenges to policy implementation in schools included a lack of knowledge about self-injury among school staff and limited referral services available to students who self-injure. Widespread support from stakeholders within the education system was also suggested to improve uptake of the policy in schools. Suggested changes included developing a flowchart of the referral process, and increasing collaboration between school staff, changes which were subsequently implemented.



Based on participants' responses to the open-ended questions addressing their typical response to students who self-injure and training needs findings indicate that:

- To respond effectively and confidently to students who self-injure participants feel they need training and school policies which address areas such as how to encourage students to seek help and how to work with parents.
- Participants would like training in risk assessment and referral strategies, counselling and communication skills, and general information addressing how to identify students who self-injure and how to react helpfully.
- Workshops, seminars and lectures, and workbooks, multimedia and online e-resources were suggested methods for delivering training to pre-service teachers and school staff.
- Participants were generally positive about the template policy, but suggested further education and training for teachers and other school staff, addition referral sources for adolescents who self-injure, and widespread support from stakeholders within the education system would improve implementation of the policy in schools.



4. Summary and Recommendations

4.1. Main findings

The aims of this study were to investigate the knowledge, attitudes, confidence, responses and training needs of pre-service teachers and school staff towards self-injury among students. Results indicate that although pre-service teachers and school staff are reasonably knowledgeable about self-injury, many are unsure how effectively they respond to students who self-injure due to a perceived lack of training, resources and school policies. Overall, we found strong support for the implementation of training programs and school policies to assist pre-service teachers and school staff to respond to self-injury in schools.

Although two training programs exist to educate school staff about self-injury, research to evaluate their effectiveness is yet to be conducted. The two programs include: the Signs of Self-Injury prevention programs developed by Mental Health Screening (<http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sosi/>) and S.A.F.E alternatives (<http://www.selfinjury.com/resources/interventions/school.php>). In addition to the lack of empirical evidence regarding their effectiveness, both programs are based in the US. A local approach, tailored to local needs and resources is sorely needed for Australian schools. Education initiatives and community resources for parents and students which encourage them to make contact with professional services earlier may also be warranted.

Taken together, results suggest that many pre-service teachers and school staff feel ill-equipped to discuss self-injury with students, and although teachers refer students to school mental health workers, they too may not have received training to address self-injury in schools. Results have implications for education programs for pre-service teachers and school staff, and school policies to enhance staff awareness of self-injury and confidence to respond.



The resultant template policy and flowchart will assist Education Departments and school leaders to develop their own self-injury policy, while also informing decisions about the effectiveness of existing policies and practices in response to students who self-injure, and providing directions for future revisions of policies addressing self-injury in schools. Awareness and education for school staff regarding self-injury combined with school policies for responding to adolescents who self-injure will enhance management of self-injury in schools, and improve the health and wellbeing of adolescents who self-injure.

4.2. Limitations

Although findings of this study provide important insights into the perceptions and training needs of pre-service teachers and school staff regarding self-injury, as with most self-report research, this project has some limitations. Firstly, since participation in this study was voluntary and participants accessed an online survey, it was not possible to determine the overall representativeness of the sample. The low response rate of principals and university subject/course coordinators who agreed to participate in this project calls into question how broadly the results of this study can be generalised across universities and schools in Australia. Results may be subject to a selection bias because participants may be those who have witnessed or responded to students who self-injure, and therefore the views of those without exposure to students who self-injure may not be adequately represented. Although we aimed to collect data from all states and territories of Australia, and from a range of geographical areas, additional research is needed to confirm findings of this study in different regions and schools of Australia. Further research exploring the preferred content and delivery of training for pre-service teachers and school staff is also necessary to support development and widespread implementation of pre- and in-service training tools and guidelines.



4.3. Recommendations

The primary goal of this project was to better understand the knowledge, attitudes and confidence of pre-service teachers and school staff, and provide recommendations to address the training and school policy needs of school staff based on the integration of data from several questionnaires. The following strategies are recommendations for those who may respond to students who self-injure, including school principals, teachers, psychologists, counsellors and nurses. It is important to understand that the following recommendations are a list of suggestions and not intended to be an exhaustive list of strategies. It is hoped that with further research and routine education for school staff the suggested strategies will promote discussion in schools about appropriate and effective interventions to help students who self-injure. The following recommendations should also be considered in light of current school policies and duty of care guidelines. Table 7 details the topics that universities and schools could target to address the training and school policy needs of pre-service teachers and school staff, respectively.

To address the training and school policy needs of pre-service teachers and school staff, it is recommended that self-injury content be included in university teaching courses for pre-service teachers and professional development programs for in-service teachers and school staff. Development and evaluation of online training programs and resources for pre-service teachers and school staff is also recommended based on findings of this project.



4.3.1. Content of training for pre-service teachers, in-service teachers and other school staff

Table 7: Training recommendations for universities and schools

Universities		Schools	
Pre-service teachers	Teachers/ administrative and support staff	Mental health workers	School leaders
Psycho-Education ¹	Psycho-Education ¹	Psycho-Education ¹	Psycho-Education ¹
Identification ²	Identification ²	Identification ²	Identification ²
Response ³	Response ³	Response ³	Response ³
Self-care strategies ⁴	Self-care strategies ⁴	Self-care strategies ⁴	Self-care strategies ⁴
Addressing contagion ⁵	Addressing contagion ⁵	Addressing contagion ⁵	Addressing contagion ⁵
		Risk assessment ⁶	Risk assessment ⁶
		Referral processes ⁷	Referral processes ⁷
		School policy ⁸	School policy ⁸

1. **Psycho-educational material** could be provided for pre-service teachers, in-service teachers and other school staff addressing:

- facts and myths of self-injury
- the range of self-injurious behaviours
- prevalence of self-injury
- risk factors and warning signs for self-injury
- differences between self-injury and suicide
- the functions of self-injury



- how to respond effectively to and refer students who self-injure

Educational programs that inform pre-service teachers and school staff how to respond to self-injury can also incorporate brainstorming and role playing activities. This will confirm for many teachers and other school staff that they are capable of responding efficiently to students who self-injure and have responded appropriately in the past, and thus will increase their confidence to respond to students who self-injure in the future.

2. Pre-service teachers, in-service teachers and other school staff can be taught to **identify warning signs** that may indicate that students have self-injured. Clear warning signs for self-injury include:

- frequent or unexplained bodily scars, bruises or burns;
- frequently wearing long sleeved/pant clothing when not appropriate (e.g. in warm weather);
- reluctance or refusal to participate in activities that require skin to be revealed (e.g. physical education lessons or swimming);
- frequent need for privacy and secretive behaviour, withdrawal from activities and changes in mood that exceeds normal adolescent behaviour; and
- frequent evidence of self-injury in creative writing, journals, or art projects

(Bubrick et al., 2010; Lieberman, Toste, & Heath, 2009; Toste & Heath, 2010; Walsh, 2012).

3. Pre-service teachers, in-service teachers and other school staff can utilise poems, narratives and art by individuals who self-injure, and be encouraged to **recognise and communicate their attitudes and reactions towards self-injury**. Group activities, vignettes or videotaped demonstrations could also be employed to help pre- and in-service teachers and other school staff to practice and internalise the process of



responding to students who self-injure, and strategies to encourage students who self-injure to seek or accept professional help for the behaviour. These approaches could also emphasise the importance of monitoring negative cognitive, emotional and behavioural reactions to students who self-injure, and allow pre-service teachers and school staff to reflect on challenges and evaluate approaches in response to youth self-injury. This approach could also address how to work with parents of adolescents who self-injure.

4. **Self-care strategies** should be addressed for all pre-service teachers and school staff, including:
 - familiarising yourself with and following the school's policy for responding to students who self-injure;
 - debriefing with a school leader, supervisor and mental health worker to discuss their feelings and reactions towards students who self-injure;
 - seeking support for yourself from family, friends or crisis support help lines and websites (i.e., Lifeline 13 11 14); and
 - seeking professional help for yourself from a trained mental health professional.
5. Training could also inform pre-service teachers, in-service teachers and other staff about the potential **risk of contagion or imitation** of self-injury among students and the importance of assessing potential sources and avenues for the spread of self-injury, such as through communication with peers, television and film, social networking and video sharing websites (e.g., Facebook, YouTube), and online discussion forums. Best practice recommends a cautious approach when discussing self-injury in schools, including discussing self-injury with students as one of many maladaptive coping strategies in response to depression, anxiety, and anger (Toste & Heath, 2010). In-service teachers and other school staff should discretely monitor the reactions of peers to students who self-injure and report potential sources of contagion in schools.



6. Teach and practice with school leaders, mental health workers and welfare staff the procedure for conducting a **suicide risk assessment** and a **self-injury risk assessment**, including helpful questions to ask. The risk assessment for suicide should consider:

- current suicidal thoughts or plans;
- previous suicide attempts; and
- history of family or peer suicide.

The risk assessment for self-injury should consider:

- severity of the physical injuries;
- frequency of self-injury (four or more episodes may increase risk);
- methods of self-injury (multiple methods may increase risk);
- escalation of self-injury over time;
- wound care strategies;
- triggers for self-injury; and
- mental state following self-injury and evidence of other mental health problems.

It is important that the student also receives follow-up assessments to monitor changes in their level of risk (Toste & Heath, 2010). School leaders, mental health workers and welfare staff could be educated about the types of self-injury requiring immediate referral to an emergency mental health service, including significant tissue damage requiring hospital treatment or self-injury involving the face, eyes, breasts or genitals (Walsh, 2012).



7. Following a risk assessment, it is essential for students deemed to be at moderate to high risk for further self-injury, suicide or accidental death (i.e., suicidal ideation or plans, significant tissue damage) to be referred to an external mental health professional with experience working with students who self-injure or to an emergency child and youth/adolescent mental health service. Students deemed to be at low risk for further self-injury, suicide or accidental death could continue to see the school mental health professional for further assessment and intervention if time, training and resources permit. Students at low risk could also be referred to an external mental health professional with experience working with adolescents who self-injure. It would be helpful for school leaders, mental health workers and welfare staff to familiarise themselves with local emergency mental health services for young people, and **develop a referral list** of local mental health professionals who have experience working with adolescents who self-injure. School leaders and mental health workers could also learn how to communicate with and understand the perspectives of parents and carers of students who self-injure.
8. It is recommended that all schools have a clear **school policy** regarding how self-injury is best addressed within the school. It is important for school policy regarding self-injury to be developed and agreed upon by all school leaders, teachers, mental health workers, and other school staff. This collaborative approach will increase awareness of self-injury and inform staff of their role and responsibilities in its implementation (Toste & Heath, 2010). Furthermore, effective school policy addressing self-injury needs to be clearly communicated and readily accessible to staff. Although school policy will differ by region and school, and should be tailored to meet the unique needs of schools, there are some central issues that should be considered, including:



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- distinguishing self-injury from suicide, outline the prevalence and nature of self-injury, and distinguish school policy addressing self-injury from school policy addressing suicide;
- identifying the roles and responsibilities of teachers and other school staff in response to students who self-injure or are suspected of self-injuring;
- describe the warning signs that may signal that a student has self-injured;
- outline how teachers and other school staff should initially respond to students who self-injure or are suspected of self-injuring;
- describe when teachers and other school staff should report students who self-injure or are suspected of self-injury (e.g., school counsellor);
- outline to whom teachers and other school staff should report students who self-injure or are suspected of self-injuring (e.g., school counsellor). Outline what feedback should be provided to the teacher or other school staff member who initially referred the student;
- outline which staff member is responsible for conducting the initial risk assessment with students who self-injure or are suspected of self-injuring, and describe who is responsible for conducting follow-up risk assessments with students who self-injure or are suspected of self-injuring (e.g., school counsellor);
- describe when students who self-injure or are suspected of self-injuring should be referred to an external mental health professional;
- describe when students who self-injure or are suspected of self-injuring should be referred to an emergency mental health service;



- outline when and how parents of students who self-injure or are suspected of self-injuring should be notified about the behaviour;
- detail how to prevent contagion of self-injury among students; and
- describe how teachers and other school staff can care for themselves.

4.3.2. Delivery of training for pre-service teachers, in-service teachers and other school staff

Self-injury content could be included within already existing mental health teaching courses for pre-service teachers and professional development programs for teachers and other school staff. Implementation of time and cost effective strategies to educate pre-service teachers and school staff about self-injury, including multimedia programs, websites and e-resources to improve access to helpful and accurate self-injury information and new developments should also be considered in the future.

4.4. Summary

Although pre-service teachers and school staff respond to students who self-injure, most described that they are working in the dark and lack training to effectively and confidently address self-injury in the school setting. Education for pre-service teachers and school staff delivered through existing university teaching courses for pre-service teachers and school professional development days for school staff are important strategies to foster early detection and intervention of self-injury in schools, and will improve the confidence of school staff as they continue to support the mental health and wellbeing of students who self-injure.



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Appendices

Appendix A: Template Policy for Managing Non-Suicidal Self-Injury in Schools

1. Overview

1.1. Purpose

This school policy aims to address the issue of non-suicidal self-injury (NSSI), defined as the deliberate destruction of body tissue without suicidal intent. This policy recommends actions to be taken by school staff in response to students who self-injure or are suspected of self-injuring, and sets out guiding questions for schools to consider when developing their own policy, in line with respective state and territory governing education department policies. It is recommended that all schools have a written policy with systematic procedures for managing student self-injury. It is important to note that this policy does not address the issue of suicide among students and should be used in conjunction with school policy on suicide.

2. Definitions

2.1. Non-suicidal self-injury (NSSI)

NSSI refers to deliberate acts to harm one's own body without intending to die as a consequence (Nock & Favazza, 2009). Although self-injury and suicide are distinct behaviours, self-injury is a significant risk factor for further self-injury and attempted suicide (Owens et al., 2002). NSSI includes, but is not limited to, skin cutting, scratching, pinching, biting, and burning, self-hitting, punching and slapping, and hitting a part of the body on a hard surface (Martin et al., 2010). NSSI excludes socially sanctioned behaviours (i.e., piercing, tattooing), and behaviours resulting in unintentional or gradual tissue damage, such as substance abuse, eating disorders, and other risk taking behaviours (i.e., unsafe sex and dangerous driving; Nock & Favazza, 2009).



NSSI typically begins in adolescence between 12 and 14 years of age (Jacobson & Gould, 2007), with approximately 10% of Australian adolescents engaging in the behaviour (Martin et al., 2010). Adolescents typically engage in NSSI to relieve negative emotions and to punish themselves, rather than to end their own life (Klonsky, 2007). NSSI can be equally prevalent among males and females, and affects people of any age, and from different family backgrounds, religions, cultures, and socio-economic groups (Jacobson & Gould, 2007). Risk factors for NSSI include mental illness (e.g., depression, anxiety), earlier self-injury, and family or peer history of self-injury, drug or alcohol abuse, and childhood trauma or abuse (Toste & Heath, 2010). However, adolescents who self-injure can appear to be functioning well both academically and socially, experience caring home environments, and not have a mental illness (Toste & Heath, 2010). Adolescents often go to great lengths to conceal their injuries so it can be difficult to know if a student has self-injured.

2.2. Contagion

Contagion of self-injury refers to incidents when self-injury is imitated by a student, as a result of talking about self-injury with others, or after viewing self-injury content in television and film, or online (Toste & Heath, 2010).

3. Roles and responsibilities

3.1. Principal

3.1.1. Appoint a point person or school crisis team - The principal should appoint a school point person, such as a school psychologist or counsellor, or assemble a school crisis team (which can include the principal, school counsellor, psychologist, nurse, year level coordinators, and teachers) to serve as the point(s) of contact for other staff members when referring students who self-injure or are suspected of self-injuring



(Bubrick et al., 2010; Walsh, 2012). It is essential that the point person/members of the crisis team have the appropriate level of training and expertise to respond to and conduct risk assessments with students who self-injure or are suspected of self-injuring, or are willing to undertake such training.

- 3.1.2. Disseminate the school policy - The principal should ensure that staff members are familiar with and follow the school's self-injury policy.

Education for staff members - The principal should ensure that staff members receive training on recognising, responding to, and referring students who self-injure or are suspected of self-injuring. Training should describe warning signs and risk factors of self-injury, difference between self-injury and suicide, functions of self-injury, common and severe forms of self-injury, and how to respond to students who self-injure (Walsh, 2012).

- 3.2. Point person/members of the crisis team

- 3.2.1. Risk assessment - The point person/members of the crisis team should conduct an initial risk assessment and follow-up assessments with students who self-injure or are suspected of self-injuring (see section 7).

- 3.2.2. Referral - The point person/members of the crisis team should develop a referral list of local mental health professionals experienced in working with adolescents who self-injure, and refer students who have self-injured to an external mental health professional and/or contact their parent/guardian (see section 8 and 10).

- 3.3. Staff members

- 3.3.1. Identification and referral - Staff members should learn about the warning signs of self-injury and how to respond appropriately to students who self-injure, and refer



students to the point person/member of the crisis team if they have self-injured or are suspected of self-injuring (see section 4, 5 and 6).

4. When staff members should report students suspected of self-injury

4.1. Any staff member should contact the assigned point person/member of the crisis team if a student has self-injured, is suspected of engaging in self-injury, or has displayed any of the following warning signs or behaviours, including:

- Frequent or unexplained bodily scars or wounds, such as cuts, burns, scratches and bruises appear anywhere on the body;
- Frequently wearing long sleeved/pants clothing at inappropriate times, such as in warm weather, and a reluctance or refusal to participate in activities resulting in skin exposure, such as physical education classes or swimming;
- Frequent need for privacy and secretive behaviour. Changes in mood, including irritability, hostility, anger, uncontrollable crying, or sadness. Unexplained withdrawal from activities or deterioration in academic performance and/or personal hygiene;
- Frequent mention of self-injury in creative writing, artwork, journals, internet postings, e-mails, notes, texts, and in communication with others (including jokes, rumours, threats); and
- Frequent high risk behaviours involving physical risk to the students that exceeds normal adolescent experimentation (e.g., train surfing, choking game, dangerous driving, substance abuse) (Bubrick et al., 2010; Lieberman et al., 2009; Toste & Heath, 2010; Walsh, 2012).



5. How to respond to students who self-injure or are suspected of self-injuring

5.1. Sometimes staff members will need to communicate with students who self-injure or are suspected of self-injuring until the point person/member of the crisis team can attend to the student.

Staff members should listen to students who self-injure or are suspected of self-injuring in a calm, caring, and non-judgmental way, trying not to communicate that they may be angry, horrified, panicked, frustrated, or upset. Staff members should monitor their reactions to these students. Walsh (2012) suggests school staff respond to students who self-injure with a low key, dispassionate demeanour and respectful curiosity.

Staff members should not attempt to solve the problems of students who self-injure or are suspected of self-injuring, should not deny their feelings or ask too many questions. Staff members should listen to these students and empathise with their situation.

Staff members should never promise students that they will keep what they tell them a secret, and should explain to the student that they have a duty of care to tell someone who can help (e.g., principal, coordinator, point person, member of crisis team). If the student refuses to see the point person/member of the crisis team, staff members should reiterate that while they understand their concerns they are obligated to tell the point person/member of the crisis team who is better equipped to help them.

If the student is upset, a staff member should stay with them until the point person/member of the crisis team can respond.

Staff members should respond to students who disclose that another student has self-injured or is suspected of self-injuring in the same way.



6. To whom staff members should report students suspected of self-injury

- 6.1. School nurse or first aid officer - Staff members should contact the school nurse or first aid officer as soon as possible to treat the student's wounds and assess whether the student has wounds requiring referral to a hospital emergency department (Bubrick et al., 2010; Onacki, 2005). If the school nurse or first aid officer is not available then first aid should be applied by a staff member. If the student's parent/guardian is unable to accompany the student to the emergency department then a staff member (ideally the point person/member of crisis team) should accompany the student and stay with them until their parent/guardian has arrived.
- 6.2. Point person/member of crisis team - Staff members should contact the point person/member of the crisis team if the student does not require treatment by the school nurse, first aid officer, or emergency department (Bubrick et al., 2010; Walsh, 2012).

7. Which staff member should conduct the initial risk assessment with students

- 7.1. Point person/member of crisis team - The point person/member of the crisis team should contact the student who self-injured or is suspected of self-injuring and confidentially conduct a thorough risk assessment with the student as soon as possible to assess the severity and intent of their self-injury (i.e., with or without suicidal intent), and determine the most appropriate course of action. The risk assessment should establish whether the student is at low, moderate, or high risk for further self-injury potentially causing severe physical injuries or death, including:
- Suicide - Previous suicide attempt, current suicidal thoughts or plans, history of family or peer suicide. If the student is at risk for suicide then the point person/member of the crisis team should follow the school's suicide policy;



- Self-injury - Severity of the physical injuries, frequency of self-injury, methods of self-injuring, escalation of self-injury, wound care strategies, triggers for self-injury, and mental state following self-injury; and
- Evidence of other co-occurring mental health problems - substance abuse, anxiety, depression, eating disorder, history of trauma or abuse, and current stressors (Bubrick et al., 2010; Toste & Heath, 2010).

- **Low risk** - if the student has self-injured with superficial tissue damage, has self-injured less than four times, typically engages in few forms of self-injury, and has no symptoms of co-occurring mental health problems then risk for further self-injury and death may be regarded as low. Intervention by the point person/member of the crisis team or referral to an external mental health professional may be considered.
- **Moderate risk** - if the student has self-injured with light tissue damage, has self-injured four or more times, has engaged in multiple methods of self-injury, or has mild symptoms of co-occurring mental health problems then risk for further self-injury and death may be regarded as moderate. Referral to an external mental health professional should be considered
- **High risk** - if the student has self-injured with severe tissue damage, has self-injured four or more times, frequently engages in multiple methods of self-injury, and has acute symptoms of mental health problems then risk for further self-injury and death may be regarded as high. Referral to an external mental health professional should be considered.

These categories of risk were developed based on studies with adolescents and young adults and guidelines for responding to NSSI in schools (Andrews, Martin, Hasking, & Page, 2013; Toste & Heath, 2010; Whitlock, Muehlenkamp, & Echenrode, 2008).



- 7.2. Feedback loop - The point person/member of the crisis team should ensure, within the confines of confidentiality, that the referring staff member is advised of the outcome of the assessment so they are aware that their report resulted in action (Walsh, 2012).
8. When students should be referred to external mental health professionals
 - 8.1. Low risk - If the student is at low risk for further self-injury and death, the point person/member of the crisis team may decide to continue with a more complete assessment and intervention, if their level of training and school resources permit, or they may elect to refer the student to an external mental health professional with experience working with adolescents who engage in NSSI (Bubrick et al., 2010; Toste & Heath, 2010; Walsh, 2012).
 - 8.2. Moderate or high risk - If the student is at moderate or high risk for further self-injury and death the point person/member of the crisis team should refer the student to an external mental health professional with experience working with adolescents who self-injure (Bubrick et al., 2010; Toste & Heath, 2010; Walsh, 2012).
9. Which staff member should conduct follow-up assessments with students
 - 9.1. Point person/member of the crisis team - The point person/member of the crisis team who conducted the initial risk assessment should follow-up with the student and periodically re-assess their level of risk for further self-injury and death, particularly following changes in life circumstances and during periods of stress, and if the student's initial level of risk was low and they were not referred to an external mental health professional (Toste & Heath, 2010).



10. When parents/guardians should be notified about the self-injury

- 10.1. Low risk - The point person/member of the crisis team may or may not elect to contact the student's parent/guardian if the student is at low risk for further self-injury and death (Bubrick et al., 2010; Toste & Heath, 2010; Walsh, 2012). However, the point person/member of the crisis team should encourage the student to discuss the matter with their parent/guardian even if they are at low risk for further self-injury and death (Bubrick et al., 2010). When deciding whether or not to contact parents of students who have self-injured or are suspected of self-injuring the point person/member of the crisis team should consider respective state and territory laws, and respective state and territory governing education department policies, the relevant codes of ethics and ethical guidelines, and consult with the school principal, coordinators, or members of the crisis team.
- 10.2. Moderate or high risk - The point person/member of the crisis team should contact the student's parent/guardian if the student is at moderate or high risk for further self-injury or death, and therefore, requires referral to an external mental health professional (Bubrick et al., 2010; Toste & Heath, 2010; Walsh, 2012). The student should be advised in advance by the point person/member of the crisis team that they will be contacting their parent/guardian, and the student should be invited to be present when the call is made to their parent/guardian so they are aware of what is discussed (Bubrick et al., 2010; Walsh, 2012). The point person/member of the crisis team should meet with the student and their parent/guardian(s) to discuss options for external support. If the parent/guardian does not follow up with the referral, dismisses the concerns, or indicates that they will not be following up with the referral, the point person/member of the crisis team should then meet with or contact the parent/guardian, and emphasise the importance of the referral (Walsh, 2012).



11. How to manage contagion or spread of self-injury among students

11.1. Peer communication - Staff members should be aware of the potential for contagion among students and refer students who may require additional support (e.g., close friends and vulnerable students) to the point person/member of the crisis team. Staff members should also refer students who disclose that another student has self-injured or are suspected of self-injuring to the point person/member of the crisis team.

Although communication about self-injury among peers should be discouraged and instead students should be told to speak to a staff member, it is not uncommon for students to discuss self-injury with friends, rather than seeking help from adults and teachers (Toste & Heath, 2010). Therefore, staff members may need to briefly respond to questions from friends of students who self-injure. In these instances, it may be helpful for staff to contextualise self-injury for students as one of many maladaptive coping strategies used by adolescents in response to overwhelming emotions, such as stress, anxiety, anger, and sadness (Toste & Heath, 2010).

11.2. Displaying unhealed wounds - Deliberately displaying unhealed wounds to peers should not be permitted at school as this may be triggering for others. Staff members who notice students deliberately displaying unhealed wounds to peers should report the behaviour to the point person/member of the crisis team who should meet with the student to explain that displaying wounds could trigger peers to self-injure. Given that treatment for self-injury usually takes time and it may be years before students stop self-injuring, suspending or expelling students from school, or requiring them to return to school only after their wounds have healed or their self-injury is eliminated is not recommended. If students continue to openly show their unhealed wounds to peers, despite repeated warnings from the point person and parents, then further disciplinary action may be taken (Walsh, 2012).



12. Self-care

- 12.1. Self-care for staff members - Staff members should debrief with the point person/member of the crisis team when necessary to discuss their feeling and reactions towards the self-injury. The point person/member of crisis team should provide a list of referral options to staff members in need of additional assistance, and should seek assistance themselves when necessary.

13. Training programs and websites for school staff

13.1. Training programs

- Self Abuse Finally Ends (S.A.F.E) Alternatives - <http://www.selfinjury.com/>
- Signs of Self-Injury (SOSI) Prevention Program - <http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sosi/>

13.2. Websites

- International Society for the Study of Self-Injury (ISSS) - <http://www.itriples.org/>
- Interdisciplinary National Self-Injury in Youth Network Canada (INSYNC) - <http://www.insync-group.ca/>
- Cornell Research Program on Self-Injurious Behaviour in Adolescents (CRPSIB) – <http://www.crpsib.com/>
- Self-Injury Outreach and Support (SIOS) - <http://sioutreach.org/>
- Non-Suicidal Self-Injury (NSSI).org - <http://www.self-injury.org.au>



Appendix B: Policy Flowchart for Responding to Non-Suicidal Self-Injury in Schools

The following policy flowchart provides teachers and other school staff with a quick reference for responding to students who self-injure. This flowchart was developed to accompany the policy. The key stages of the flowchart are summarised below.

It is essential that school staff respect the student's right to confidentiality and do not disclose a student's self-injury to other staff members, other students, or the student's parents unless otherwise stated in the policy and flowchart.

However, staff members should never promise students who self-injure that they will keep what they tell them a secret, and should explain to the student that they have a duty of care to tell someone who can help.

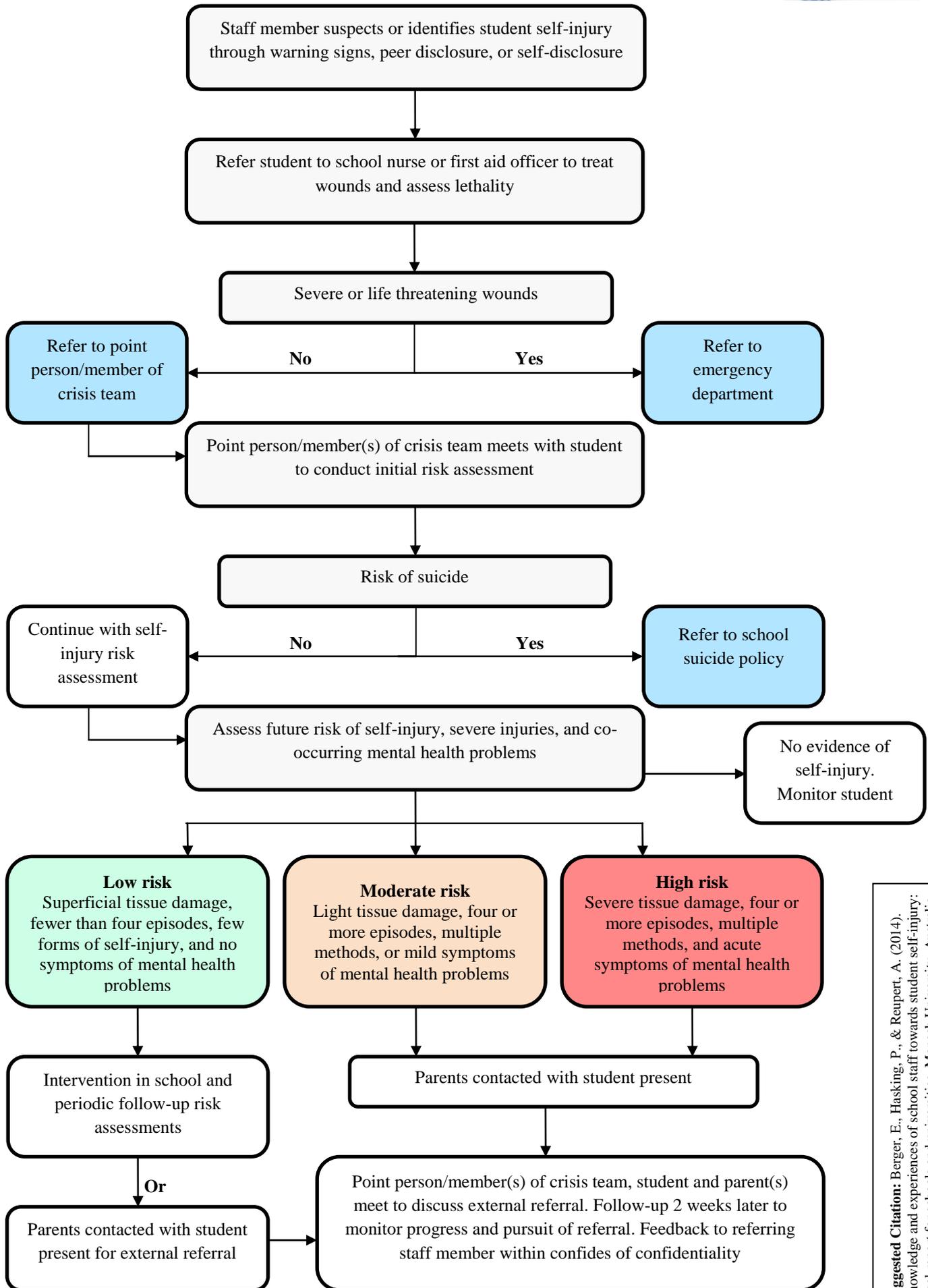
- School staff should contact the school nurse or first aid officer if they suspect a student has self-injured to treat the student's wounds and assess whether the student has wounds requiring medical treatment. If the student does have severe or life threatening wounds then the student should be referred to the nearest emergency department.
- If the student does not have severe or life-threatening wounds, the student should be referred to the school point person/member of the crisis team who can assess the student's risk of suicide. If the student is at risk of suicide then the point person/member of the crisis team should follow the school's suicide policy.
- If the student is not at risk of suicide, the point person/member of the crisis team should assess the student's risk of further self-injury, the severity of their injuries, and the presence of co-occurring mental health problems.



- If the student has self-injured with superficial tissue damage, has self-injured less than four times, typically engages in few forms of self-injury, and has no symptoms of co-occurring mental health problems then the student's risk for further self-injury and accidental death may be regarded as low. Intervention by the point person/member of the crisis team or referral to an external mental health professional may be considered. Students should be advised in advance and allowed to be present if their parents are contacted.
- If the student has self-injured with light to severe tissue damage, has self-injured four or more times, has engaged in multiple methods of self-injury, or has mild to acute symptoms of co-occurring mental health problems then risk for further self-injury and accidental death may be regarded as moderate to high. Referral to an external mental health professional should be made and the student's parents contacted. Students should be advised in advance and allowed to be present when their parents are contacted. The point person/member of the crisis team should ensure that within the confines of confidentiality the referring staff member is advised of the outcome of their referral so they are aware that their report resulted in action.



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