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Commentary: Adolescent self-harm prevention and intervention in secondary schools: a survey of staff in England and Wales – a reflection on Evans et al. (2018)

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Abstract

Self-harm (SH) continues to be a worldwide concern among adolescents and there is a great need for programming aimed at reducing SH in adolescents. Evans and colleagues discuss the opinions of school staff from a representative sample of secondary schools across England and Wales regarding their school's current prevention and intervention practices in responding to self-harm and how this should be addressed in future practice. The most salient points include the high prevalence of SH internationally, the existing barriers to SH prevention and intervention and possible solutions to these barriers. There is clearly an urgent need for high quality, evidence based interventions that can be embedded in school settings, and have the capacity to overcome both the individual and structural barriers to supporting these vulnerable young people. **Keywords:** Self-harm; adolescents; prevention; intervention

The study by Evans and colleagues is one of only a few studies that reports on adolescent self-harm in secondary schools. The investigators surveyed school staff across parts of England and Wales and found that both teachers and senior management identified self-harm as a priority that needs to be addressed with further staff training and resources. The study highlights the importance of understanding current school practices in responding to self-harm, pre-existing barriers to implementation of interventions, and the acceptability of various approaches.

Adolescent self-harm is a leading public health concern internationally, with an estimated prevalence somewhere between 12 and 31% (Muehlenkamp, Claes, Havertape, & Plener, 2012) in western countries. The reporting of self-harm occurs more among young females and is more common among people who identify as LGBTQI+ and those experiencing mental ill-health. Self-harm is not only distressing and problematic in its own right; it is also indicative of other problems (such as mental ill-health), and is associated with a range of negative outcomes, including poor educational and vocational outcomes, further self-harm, and suicide (Robinson, McCutcheon, Browne, & Witt, 2016). As such this is an issue that needs to be taken seriously.

Schools are optimal locations for addressing self-harm, both because of the accessibility to students and families and the opportunities they afford for intervention and

prevention (Robinson et al., 2016). For this reason, school staff are uniquely placed to recognise and support adolescents who self-harm. However, despite this Evans and colleagues report that teachers often feel under-qualified to respond to self-harm, and report high stress levels when confronted by such challenges. This is not a new finding, and it echoes previous research from around the world that has also reported staff to feel under-skilled and poorly equipped to identify and support students at risk of self-harm and suicide. For example, Berger, Hasking and Reupert (2014) reported that school staff feel that they possess insufficient knowledge, leading them to describe themselves as "*working in the dark*" and feeling "*emotionally drained*". Similarly, Heath, Toste, and Beettam (2006) reported 50% of secondary school teachers in an urban area of Canada felt unknowledgeable about self-harm and 78% miscalculated how commonly it occurred.

Gatekeeper training programs designed to better equip school staff identify and support students at risk are a widely accepted approach to suicide prevention, however just over half of respondents in the study by Evans and colleagues had received specific training on adolescent self-harm, and only 22% of them rated the standard of training as high. Again this is not new. In an Australian study staff expressed concern for students, but felt ill-equipped in how to respond to such behaviours calling not just for education and training but also citing the need for supervision and additional school policies to help them respond to these students (Best, 2006).

In addition to the need for high quality training, Evans and colleagues identify a number of structural barriers to self-harm prevention and intervention in schools. These include limited resources, time in the curriculum, negative attitudes, and fear of encouraging self-harm. These barriers have been raised in a number of international studies including by Best (2006), who also highlights the importance of addressing the culture of fear and high anxiety among staff who encounter self-harm. This culture of fear may be the result of a number of factors. It may arise from a fear of contagion (i.e. where one students self-harm behaviour leads others to act in the same way). Indeed this is a real concern – schools are one of the environments in which clusters of suicide and self-harm commonly occur (Niedzwiedz, Haw, Hawton, & Platt, 2014), therefore being able to respond quickly and appropriately is critical, and having robust policies in place and building capacity of school staff are key. It may also be the result of concerns that talking about self-harm will inadvertently encourage it. This was identified as an issue in the study by Evans and colleagues, and it is not unique to school settings. Indeed the notion that talking about suicide or self-harm will '*put ideas into people's heads*' has hampered prevention efforts in this area for several decades. However,

there is a growing body of evidence to suggest that this is not the case, and in our experience young people want to have open conversations about these topics, including in schools (Robinson et al., 2016). Therefore, this internal barrier among staff urgently needs to be addressed, as this misconception could not only inhibit the willingness of staff to intervene but also students' likelihood of seeking help. Finally, attitudinal change is required. There is a growing body of evidence to suggest that adolescents are less likely to seek help when confronted with negative attitudes towards their self-harming behaviour, and young people who engage in self-harm are often fearful of being labelled as "attention-seeking" and their needs being dismissed (Robinson et al., 2016). Thus, shifting the attitudes and opinions of school staff is crucial to creating a culture of help-seeking, and to building the capacity of the school community to both develop and implement an effective response to these vulnerable young people.

Because they feel ill-equipped to respond themselves, teachers frequently refer cases of self-harm to Child and Adolescent Mental Health Service or counsellors. However, this is not always the ideal solution. Like mental health services worldwide, CAMHS are burdened by long waitlists, limited resources and high thresholds for admission. The implementation of a multi-faceted upstream in schools but downstream from health providers could be an effective strategy for distributing training resources efficiently. For example, the downstream of information to teachers using a school counsellor led approach could be a cost and time effective strategy to overcome the barrier of time in the curriculum whilst still enabling teachers to enhance their training for identifying and responding to students who self-harm.

An additional barrier to help-seeking, and ongoing engagement, is fear of confidentiality being breached. Compounded by the inherently secretive nature of self-harm adolescents and pervasive stigmatizing attitudes, many adolescents who self-harm don't access help (often for the reasons described above) **(**Robinson et al, 2016), therefore specific and proactive support from those around them is also crucial (Yuan, Kwok & Ougrin, 2019). Several school-based studies conducted in Europe and the United States have tested multi-component interventions that combine psycho-education with screening and gatekeeper training programs in order to identify those students at risk. These studies appear to show promise, not least because they provide education directly to young people as well as staff, and because they have the capacity to overcome young peoples' reluctance to seek help (Robinson et al, 2018). One example is the Saving and Empowering Young Lives in Europe (SEYLE) study which combined a Mental Health program with gatekeeper training and reported a 50% reduction in suicidal ideation and a 55% reduction in suicide attempts at 12

month follow-up. Similarly, the Empowering a Multimodal Pathway Toward Healthy Youth (EMPATHY) study found a school-based multimodal program was successful in significantly reducing rates of suicidality, depression and anxiety among adolescents. Future comparisons between school-based interventions and those implemented in clinical settings are crucial to understanding which are the underlying mechanisms of effective interventions in reducing self-harm in different populations of young people (Yuan et al., 2019). However, despite the potential of these large multi modal interventions, they are complex and can be difficult to mount in school settings, due to curriculum challenges and cost. Indeed, as identified by Evans and colleagues both time and resources can act as a barrier to addressing self-harm in the school setting, with the busy nature of the school timetable acting not only as a barrier to help seeking but also making it difficult to squeeze in specific programs designed to address self-harm and suicide risk among students. Some have suggested that online training and resources may facilitate access whist overcoming time and cost barriers. Whilst others have talked about establishing 'drop-in' spaces for students, where they could come to talk with trained school staff and receive support.

Given that young people often seek help from their friends as opposed to professionals, peers have an influential and important role to play in identifying and responding to self-harm among their friends. Thus a greater emphasis on the delivery of peer support programs in school settings may to help reduce students' hesitancy to intervene and help to build the skills necessary to respond safely is required. Preliminary findings from a U.S. based study (Muehlenkamp, Walsh, & McDade, 2010) suggest that these types of programs show promise, however further research is needed to establish their effectiveness.

In the study by Evans, only 22% of schools who received training on self-harm rated the quality of the training as high. This finding may in part be explained by the implementation of staff training programs without a sufficient evidence base. Indeed, a recent meta-analysis by Robinson and colleagues (2018) highlights the need for more high quality research testing of school based interventions, including gatekeeper training. One important factor commonly overlooked in the evaluation of gatekeeper training programs is the impact of the training on young people themselves; i.e. does providing training to school staff lead to increased help-seeking or better outcomes for students? Despite the growing evidence base for gatekeeper training these are questions that are yet to be answered. Building on the work of Evans and colleagues study, further research also needs to assess the feasibility, acceptability and effectiveness of delivering online training programs to teachers on how to manage and respond to self-harm. This approach could effectively overcome some of the

issues raised by Evans and colleagues by enabling the greater distribution of resources to more school staff in a time effective manner.

Given the increasing rates of both self-harm and suicide among young people (Robinson et al., 2016), addressing self-harm among students needs to be prioritised across settings and including in schools, and the provision of training is likely to be insufficient on its own. In this study the issue of supervision for school staff supporting students who engage in self-harm was raised. Such support or supervision systems for staff are rarely provided within schools' approaches to managing self-harm. Rather it is not uncommon to refer such cases to external 'experts', and whilst this may be an important part of the solution for some, (indeed evidence suggests that treatments such as Dialectical Behavioural Therapy and Mentalisation-based therapy can be effective when delivered in clinical settings to adolescents with a history of self-harm (Cox & Farrelly-Rosch, 2018). In many cases school staff will still need to provide support to the student at some level, and as such they need to be adequately equipped and supported. To this end timely and well developed referral and communication pathways between schools and external services are also important when supporting young people with self-harm. This can both increase the levels of support provided to staff and make it easier for young people to navigate the pathways between school and external sources of support. One example of integration between education and health services is the Doctors in Schools Program in Victoria, Australia, which funds general practitioners to attend up to 100 Victorian government secondary schools once a week. This initiative provides adolescents with support and helps to identify and address health concerns among adolescents most in need. However it is just one example, that is still in its infancy and yet to be evaluated.

Whatever the solution, it needs to be feasible to implement in a school setting, acceptable to young people, and based upon sound evidence. Given the increasing rates of self-harm among young people (Robinson et al., 2016), there is clearly an urgent need for high quality, evidence-based interventions that can be embedded in school settings, and have the capacity to overcome both the individual and structural barriers that exist, and the study by Evans and colleagues is an important and timely step in that direction.

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Ethical information

No ethical consent was required for this article.

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