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Counting the sharpeners: How do secondary school staff experience student self- harm?

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Mike, It's been a long and hard journey. Your support and belief in me are the reason why I'm here. To your parents and mine, thank you.

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Abstract

How do secondary school staff experience student self-harm?

Background: This is a mixed-methods study which explores how student self-harm is experienced by staff in a secondary school in the East Midlands. Research suggests that self-harm is becoming more common across the population and is particularly prevalent in girls aged 13-16. Schools are being given more responsibility to support their student's social, emotional, and mental health which includes supporting those who self-harm. The research has two phases, beginning with a questionnaire shared with all school staff (phase one) which is used to inform impressions of wider staff views, and then a classic grounded theory approach (phase two) to further explore the experiences of eight members of staff in greater depth.

Method: The research was made up of two phases. The first phase was heavily quantitative and used a questionnaire that was distributed to all members of staff within the secondary school. Questions were developed to gain knowledge on the overall experience of student self-harm from staff across the school and were piloted prior to distribution. The second phase of the research uses classic grounded theory with data being collected through focus groups and interviews. Three iterative rounds of data collection were completed before theoretical saturation was reached.

Analysis and discussion: The findings of this study were that there are barriers to what secondary school staff can offer students who self-harm. Currently, staff members are taking proactive steps to prevent self-harm, such as removing sharp objects and not allowing students to be without supervision if they are known to self-harm. Staff within the research have indicated that they may be taking such steps but they do not feel that this is enough. They feel they are unable to do more as they have not had any specific training or support and are also concerned about responding in the wrong way. They also feel there is not enough time or funding to provide additional support to these students.

Staff perceptions and understanding of self-harm do not differ from data previously found, yet the responsibility that they have to support students who self-harm has significantly increased given changes in policy direction and potential incidence. This mismatch will affect the outcomes of young people. Staff confidence and competence in supporting students who self-harm needs to be increased by reducing and removing the barriers that they face.

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Table of abbreviations

Acronym	Definition
A&E	Accident and Emergency
BPS	British Psychology Society
CAMHS	Child and Adolescent Mental Health Services
COVID-19	Coronavirus Disease 2019
DfE	Department for Education
EP	Educational Psychologist
FiM	Future in Mind
GDPR	General Data Protection Regulation
GT	Grounded Theory
HCPC	Health and Care Professions Council
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning +
MAT	Multi Academy Trust
MCS	Millennium Cohort Study
MMR	Mixed Methods Research
NHS	National Health Service
NICE	National Institute for Clinical Excellence
OFSTED	Office for Standards in Education, Children's Services and Skills
PSHE	Personal, Social, Health Education
SEAL	Social and Emotional Aspects of Learning
UK	United Kingdom
SENCO	Special Educational Needs Co-Ordinator

Chapter 1 Introduction and initial literature review

1.1 Introduction

This mixed methodology research aims to gather information from secondary school staff about their experience of student self-harm. Adults' understanding will have a direct impact on the support that students receive. The first phase of the research will use a largely quantitative questionnaire to gather information from as many staff members as possible within the secondary school. The information could be useful to bring about change within the school itself.

The second phase of the research uses grounded theory to explore secondary school staff experience of student self-harm in more depth, comprising of three rounds of data collection to understand the data provided by participants.

Memoing is a tool often used in grounded theory as it helps the researcher to be more aware of their own effects on the research (Backman & Kyngas, 1999). Memo boxes will appear throughout the thesis to demonstrate reflexivity within the research. Additional memos can be found in [Appendix 10](#) (page 175).

The topic of self-harm and mental health are of national (Department of Health & NHS England, 2015; Department for Health and Department for Education, 2017), and international (Choudhry, Mani, Ming & Khan, 2016) concern. 'Self-harm' is something that we seem to hear about more and more. This is not only seen within mental health services and the education system, but it often dominates headlines and film and TV show storylines. It is something that many people may not understand or feel confident in dealing with, yet it is something many people will do, or know somebody else that will.

1.2 Overview of chapters

Before introducing the chapters, it is important to note the use of grounded theory as the methodology. Grounded Theory (GT) comprises of 'several unique methodological elements' which differentiate it from other methodologies (Dunne, 2011). These unique differences impact the ordering of the chapters to reduce bias and preconceived problems within the research (Nathaniel, 2006).

Reading suggests that the timing of a literature review in GT has been debated for decades, beginning with the originators of Grounded Theory, Glaser and Strauss, disagreeing on its location.

Strauss advocated for the literature review to be located early in the research (Strauss & Corbin, 1990), whereas Glaser (1992) felt that the literature review should not occur until categories had begun to emerge. Part of this reasoning is simply practical, before collection the researcher does not know what will be found and where the data will lead. A literature review is time-consuming so to do this too early on could be wasteful and inefficient (Dick, 2007; Glaser, 1998; Locke, 2001). What is agreed to be important across the literature is for researchers to acknowledge their prior knowledge before data analysis (Giles, King & de Lacey, 2013; McGhee, Marland, & Atkinson, 2007).

While including a literature review itself is not debated, the disagreement within research is on when the literature review should occur and how extensive it should be (Cutcliffe, 2000; McGhee et al, 2007). Consequently, there is no set rule as to where the literature review should occur in GT, and instead, the researcher should be reflexive with this decision (Heath, 2006). I have chosen to write a [short literature review](#) before data collection (page 15) that holds the information that I feel I already had an awareness of, but not in the depth that the [later literature review](#) will outline (page 78). The [initial literature review](#) (page 15) is also broadly covering the topic of self-harm from the perspective of policy documentation within the UK.

[Chapter one](#) (page 10) of the research will cover a brief piece of information about the setting of the research. The researcher's rationale will also be included within chapter one to provide reflexivity from the beginning so that the potential impact the researcher may have on the research (Neill, 2006) is shared. Chapter one will end with an initial literature review to set the scene of the research and give broad information about the topic of self-harm. Finally, chapter one will end with the initial research question.

[Chapter two](#) (page 25) will discuss the methodology used. Since the research is separated into two phases and uses a mixed-methods approach, the reason behind this as well as the steps taken are discussed in this chapter.

[Chapter three](#) (page 49) will discuss the findings of the research, this chapter is also separated into phase one and phase two of data analysis and phase two follows three rounds of data collection.

[Chapter four](#) (page 78) is the main literature review of the research. This step was completed after data collection to reduce bias when gathering and interpreting the data.

[Chapter five](#) (page 96) discusses the findings of the research alongside the literature. This chapter also includes the researcher's insight into the findings alongside the strengths and limitations of the research. In addition to suggestions for future research, this chapter ends with the implications of the findings for schools and educational psychology.

1.3 The local context

The research is conducted in one secondary school meaning that specific details about the setting are not included to provide the school with anonymity. The school is based in the East Midlands in the UK and currently has a 'good' OFSTED rating. Records indicate that 95% of the population within the local area identify as white British. The area is also known to have high levels of socioeconomic deprivation. The most recent data is from the 2011 census which showed that 27.6% of the population within this area had no qualifications which was higher than the average across the UK which was 22.5%. Alongside this, 17.6% received benefits, including jobseekers allowance or incapacity benefits compared to 13.5% across the UK.

The secondary school is for students in year seven through to year eleven. Locally, the school is known to engage with different projects to help support the local community that its students are a part of. For example, the school has recently engaged with the Educational Psychology Service's work on antiracism, intending to roll out an antiracism policy and curriculum. Being aware of the high level of need within the student population, the school has an on-site support centre which is a separate building from the main part of the school. The support centre houses pastoral staff and 1:1 tutors that provide students with social, emotional and mental health support.

1.4 Researcher's position and rationale

As I am utilising Grounded Theory (GT), I will be providing the bulk of the literature review after the first round of the second phase of data collection and analysis. At this stage, I will be declaring my position and rationale. Neill (2006) states that the potential impact that the researcher may have on the data needs to be recorded with Charmaz (2000) stating that researchers in GT need to openly acknowledge the influence of prior work and experiences on their research. To remain true to the GT approach, I will hereby state my position and rationale for the research.

All data is collected through the lens of the researcher which means there is a strong possibility of bias. Having an interest in the topic alone declares particular viewpoints and experiences. To be transparent, I want to share the root of my interest in self-harm.

The main reason why I am personally interested in school staff experience of student self-harm is from my previous employment. In my most recent role before becoming a Trainee Educational Psychologist (TEP) I worked mostly with adults in a consultancy capacity derived from the relatively new agenda of preventative and early intervention of mental health needs in schools. I previously worked part-time for the National Health Service's (NHS) Child and Adolescent Mental Health Services (CAMHS) as an assistant psychologist alongside another role within a Multi-Academy Trust

(MAT) as a 'Psychological Welfare Lead'. In both of these roles, I spent some time working directly with children and young people who were struggling with their mental health but spent most of my roles with the adults in schools that would support them.

My experience of working with schools in both the East and the South of the UK was that staff in schools were mostly confident with many mental health needs, such as anxiety and low mood. The topic of self-harm, however, was approached with caution. Often, I would receive a phone call asking me to cancel my immediate plans as a member of staff had found out that a student had self-harmed the night before. They would also ask me to come '*as quickly as possible*' indicating that an emergency response was required. This was one common reaction, but on the other end of the spectrum, self-harm would simply be mentioned in a passing comment. It would often be dismissed as '*attention seeking*' and the passing on of information felt relaxed and a response was not sought. I was assigned all 57 schools in the locality and when discussing student self-harm, responses were either panic or shrugging.

To me, self-harm can be (but is not always) a symptom of mental health difficulties. Initially, self-harm requires a first aid response in the same way any physical harm would. Schools are generally comfortable with administering first aid, but the addition of self-harming behaviour appears to change this. I am aware, however, that my personal experience in education and my career thus far, have perhaps given me the skills to be able to respond to student self-harm with more confidence.

It was this experience, combined with recent government legislation that has resulted in curiosity and pushed my interest forward. During my time at CAMHS, my role was to liaise with schools as a 'school link worker', which was funded by Future in Mind (Department of Health & NHS England, 2015). Alongside the day to day role of supporting schools, I also worked closely with the commissioners and attended meetings about the mental health green paper (Department of Health and Social Care & Department for Education, 2018). I also joined a working group put together by the Department for Education to design the job descriptions for the new designated mental health leads that are being appointed in education settings across the UK. The recent paperwork, beginning with Future in Mind (Department of Health & NHS England, 2015), amounts to the idea that mental health is 'everyone's problem' and that schools are well placed to provide support. As such they have been given more responsibility to manage low-level mental health difficulties. The government documents do not explicitly say 'schools will manage self-harm', but it is heavily implied by the focus on schools being the first responders to many children and young people who may be struggling with their mental health, alongside the increase in responsibility.

To remain true to a GT approach, I felt it was important to give some insight to the reader as to where the idea of researching self-harm came from. Although using GT requires as little bias as possible to avoid making assumptions (Birks, Hoare & Mills, 2019), I felt that if I were to research any topic that I was interested in, some bias was inevitable. I am using my experience in this topic to find out more information. I feel that my experience of secondary schools and self-harm as a whole has been so varied, that instead of invoking a bias or strong opinion on the topic, it has instead sparked a curiosity. Dey, 1999, states that the research should be entered with '*an open mind, not an empty head*'.

As already indicated, I did not complete a literature review before collecting my data as I did not want previous research to steer my own. What I decided to do initially was to delve into the legislation and statistics around mental health support for children and young people, particularly in schools, and a more in-depth literature review will be completed after the data has been analysed.

The initial literature review was broad and included information that I already had some knowledge of from my previous roles, but was not something that I had researched in depth. As well as further clarifying the knowledge I had before data collection, this also helped to set the scene for the current guidelines around self-harm occurring in schools across the UK.

1.5 Initial literature review

1.5.1 Self-harm

Defining self-harm is in itself a challenge and different researchers have chosen to use different phrasing, this largely includes; self-harm, self-injury, deliberate self-harm and non-suicidal self-injury (NSSI). Lee (2016), writes that the *'only consensus about the definition of self-harm is that there is no consensus'* (p. 2). NICE (2013), describes self-harm as *'any act of self-poisoning or self-injury carried out by an individual irrespective of motivation'*. The Samaritans (2020) define self-harm as *'any deliberate act of self-poisoning or self-injury without suicidal intent. This does not include accidents, substance misuse and eating disorders'* (p. 2). The term 'deliberate' alongside self-harm has also been disputed as it implies that the individual who self-harmed could stop if they chose to (Allen, 2007). The main issue in the many different definitions of self-harm is whether or not to include 'indirect' behaviours that could result in harm, such as reckless driving. The general response to this is to consider intent to harm (Simm, Roen & Daiches, 2008). Furthermore, the Samaritans (2020) use different terminology to highlight whether a self-harming behaviour is linked to a suicide attempt or not, by using the terms 'non-suicidal self-harm' and 'suicide attempt', although they determined that the two can be highly linked, of the 15 young people that they interviewed, eight felt the distinction of including intention towards suicide to be useful.

The definition used for self-harm within this research is *'a compulsion or impulse to inflict physical wounds on one's own body, motivated by a need to cope with unbearable psychological distress or regain a sense of emotional balance. The act is usually carried out without suicidal, sexual or decorative intent'* (Sutton, 2007 p. 23). This definition has been adopted by many researchers into young people's self-harm (McHale & Felton, 2010; Williams & Gilligan, 2011; Barton-Breck & Heyman, 2012). I feel that this definition is likely to encompass a wide range of individual beliefs and understanding of student self-harm.

Memo: Understanding of terminology

Before completing the research, I felt fairly confident in my understanding of self-harm; what it was, and what it was not. Discussing my research with other professionals has brought up many questions, such as 'if a child pulls their hair out in frustration, is this self-harm?', and I realised that the definition was not perhaps as straightforward as I thought. This led me to consider that if I, a psychologist in training, with experience in child mental health services, found it difficult to clearly

define self-harm. It will likely be an even bigger challenge for those without my training, but also for those who are expected to support self-harm, possibly on a daily basis.

I thought it was important for this research to take an inductive approach and therefore not play too large of an emphasis on the language used and my preferred definitions of self-harm. As detailed later in this paper, a GT approach was taken and it was important to follow the data provided by participants. Although important to discuss the difficulties with language when referring to the topic of the research, the phrase 'self-harm' is most commonly used in literature and the media. 'Self-harm' is a *'general term that refers to a range of more specific self-harming behaviours'* (Long, Manktelow & Tracey, 2012, p. 106). The research does not intend to focus too heavily on what self-harm is, but more so on how it is experienced by secondary school staff, their interpretation of the language may contribute to this, so the general term felt best suited for the research. Drawing too much attention to the meanings of the phrase would possibly add bias which could divert the research in a different direction.

Alarmingly, the UK has the highest rates of self-harm in Europe at 40 per 10,000 population (NICE, 2013), and rates are higher for young people than for any other age group (NICE, 2002; Muehlenkamp, Claes, Havertape & Plener 2012). Ogle and Clements (2008), report the rates of self-harm to be three times higher in adolescent populations when compared to the adult population. It is important to note that almost all self-harm figures are often an underestimation as not everyone who self-harms will seek support and self-harm figures are derived from those that are recorded by professionals (Turp, 1999; Madge et al, 2008; Hawton et al, 2012; Griffin et al, 2018).

Specific rates are not assumed to be accurate as not everyone who self-harms will be known to professionals, but also different studies will use different terminology, as discussed above, which can then impact the collation of the data. We do know that, before 1992, self-harm, was the reason behind 42,000 children and young people presenting at A&E departments, in England and Wales (Hawton & Fagg, 1992; Mayor, 2019), and we know that self-harm has only increased over recent years (Hawton et al, 2003). Research in the UK and Australia, however, both demonstrate that self-harm is more common in the community than in inpatient populations, and the majority of instances are not reported to medical professionals (Hawton, 2002; Hawton et al 2006; Meltzer, Harrington, Goodman & Jenkins, 2001).

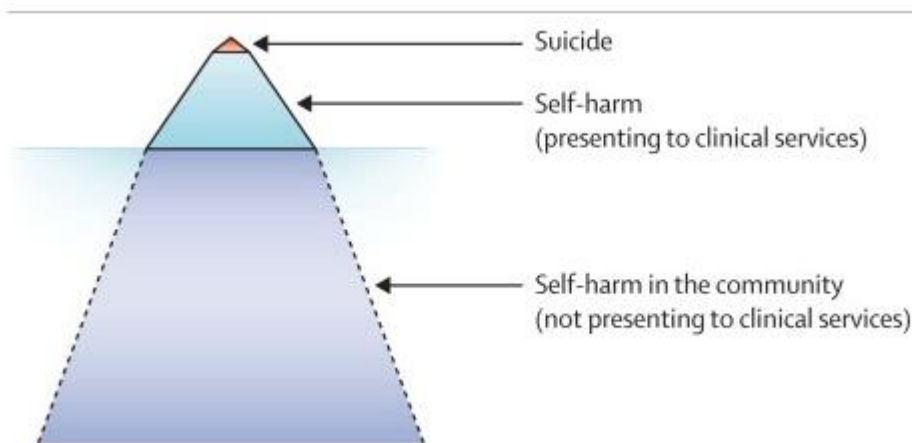


FIG 1: Representation of the relative prevalence of self-harm and suicide in young people (Hawton, Saunders & O'Connor, 2012)

In 2015, Mitchell reported that research concludes that self-harm affects between 10 and 12% of young people. 2016 data by Public Health England stated this figure to be 10% of young people. In 2017 this figure appears to have increased with Doyle, Sheridan and Treacy finding that one in eight adolescents, aged 15-27 years old, reported a history of self-harm.

Several studies have found that self-harm onset is typically between the ages of 11 to 15 years (Favazza, 1998; Heath, Toste, Nedechova & Charlebois, 2008; Ross & Heath, 2003; Jacobson & Gould, 2007). The peak age of self-harm is between 14 and 17 years (Whitlock, 2012). Although most commonly beginning as the student begins and is in secondary school, self-harm does occur in primary school populations (Bem, Connor, Palmer, Channa & Birchwood, 2017; Borschmann et al, 2020; Geulayov et al, 2019; Hawton & Harriss, 2008; Simm et al, 2008). It is also reported that female students engage in self-harming behaviours more often than male students (Hawton, 1986; Hawton, Hawton, Fagg, Simkin & Bales, 2000; Hawton, 2002), with Fox and Hawton (2004) reporting girls as being four times more likely to have experienced self-harm. In 2017, Morgan et al, reported that self-harm rates had increased by 68% among girls aged 13-16 from 2011 to 2014.

Recent research by Farooq et al (2021), reported that although we know there is a rise in self-harm among adolescents and it is unclear how self-harm, is seen among different ethnic groups and there is very little research looking into this information. Their research of 14,894 young people in England, who presented to the hospital with self-harm, found that rates were highest in white children and adolescents, but between 2009 and 2016, rates had increased for all ethnicities. The increase in rates was higher for Black groups, South Asian groups and other non-white groups when compared to white children and young people.

LGBTQ+ Youth are well established as having higher rates of mental health difficulties when compared to heterosexual adolescents, this includes an increased risk of self-harm (Miranda-Mendizábal et al, 2017; Jadva, Guasp, Bradlow, Bower-Brown & Foley, 2021). Research conducted from the Millennium Cohort Study (MCS) also found that children and young people who are in a '*sexual minority*' are more likely to experience depressive symptoms and to self-harm (Amos, Manalastas, White, Bos & Patalay, 2020). More specific research conducted by Jadva et al (2021) found that trans young people and those that labelled themselves as 'non-binary' had extremely high rates of self-harm when compared with their non-trans peers. It is important to add that at the time of the research, 'LGBTQ+' and 'trans' (Ryan, 2019) are currently preferred terms, and ones that young people I have worked with have used, however, LGBTQ+ terms have changed through history and different acronyms and phrases may emerge in the future (Thelwall, Devonport, Makita, Russell & Ferguson, 2022).

In 2021, after sharing an extensive report, the Samaritans stated that self-harm prevention is not a medical issue, but instead should take place in the community, and ideally, in educational settings, particularly secondary schools. Schools will, unavoidably, place a substantial influence on their student's personal and social development, placing them as an important arena for promoting mental health (Best & Galloway, 1990; Matthews, Kilgour, Mori & Hill, 2014; Weare & Nind, 2011). To focus directly on self-harm, schools have been found to be an influence on self-harming behaviours (Dow, 2004).

Since 2015, when Future in Mind was published, there has been a multitude of papers released by the government focusing on the mental health and well-being of children and young people (Department of Health & NHS England, 2015). Many of these papers have focused on schools' responsibilities to support children and young people, but also on other services that can also provide support. One of the most well-known documents is Future in Mind (Department of Health & NHS England, 2015), which highlights how there needs to be a focus on resilience and prevention and early intervention for young people's mental health. Not doing so is costly, both financially and for the outcomes of young people (Department of Health, 2014). This was followed by the 'Mental Health and Behaviour in Schools' document (Department for Education, 2015) which discussed how schools are key to promoting resilience and developing whole school approaches for prevention and early intervention of mental health difficulties. The green paper was published in 2017 (Department for Health and Department for Education, 2017), which detailed how mental health provision for children and young people will be transformed as a result of Future in Mind (Department of Health & NHS England, 2015) and the government's response to the green paper was published in July

2019. The green paper and its response specifically focused on the role that schools and colleges will play in supporting children and young people's mental health.

From this point, Local Authorities Clinical Commissioning Groups (CCGs) responded with how they would transform their local services from the guidelines set in the green paper (Department for Health and Department for Education, 2017). There have been many initiatives to help roll this out since this particular date, including the implementation of mental health leads in all schools and colleges across the UK (Department for Education, 2018). The area that this research is conducted in published their transformation plan, in response to the green paper, in 2019 when they were entering their final year of the five-year Future in Mind programme. At this time, 85 schools had appointed a mental health champion in school. It was only a few months after this document was published, however, that the world entered the COVID-19 pandemic. This will have undoubtedly caused some disruption and pauses in the implementation of mental health support in schools, the Department for Education has provided a deadline of 2025 for all schools to have a designated mental health lead in post.

1.5.2 Mental health in schools

In 2002, Flaherty and Osher wrote:

'The evolution of school mental health services has occurred over a long time span and reflects development outside of education, changes in dominant philosophies and approaches to public education, and developments in those professional friends that relate to school mental health' (p. 11)

Twenty years have passed since this statement and it continues to be true as knowledge and philosophies evolve, as do the systems within schools. Since this date, many more schools are also joining multi-academy trusts with a plan for all schools to have joined 'strong' academy trusts by 2030 (Department for Education, 2022). With these changes, mental health support and initiatives in schools continue to evolve within educational settings. Specific and targeted mental health support in schools is still relatively new with Greenberg writing in 2010 that the idea of embedding mental health support into schools had generated a great deal of interest in recent years prior to 2010.

The UK Millennium Cohort Study (MCS) provides detailed statistical information on 'some 19,000' individuals who were born in 2000-2001, giving an indication of the life experiences of a sample of the UK population (Joshi & Fitzsimons, 2016). The research highlights the possible disadvantage for children and young people from areas of high socio-economic deprivation which are representative

of the location of the school within this research. The millennium cohort study demonstrated that parental education and family income were the most important predictors of children's cognitive scores from the age of three to eleven (Brown & Sullivan, 2014). It was also found that child health outcomes were also correlated with socioeconomic risk (Connelly & Platt, 2014) which was found to be particularly true for child mental health needs where emotional and behavioural difficulties were significantly increased if the child has '*disadvantageous*' life circumstances (Kneale et al, 2016). When looking at ethnicity, the millennium cohort study found that by the time children reach the age of seven, there is no penalty to ethnic background that differs from any other social disadvantage (Sullivan, Ketende & Joshi, 2013; Taylor, Rees & Davies, 2013).

More recent data from the MCS demonstrates that social media use is linked to mental health difficulties in young people (Kelly, Zilanawala, Booker & Sacker, 2019). The research found that greater social media use is linked to higher depressive symptom scores, poor sleep, low self-esteem and poor body image.

The main way that mental health was talked about in schools before the introduction of universal and targeted mental health interventions, was through the Personal, Social, Health Education (PSHE curriculum). However, PSHE was not statutory until 2017, with many schools choosing to focus only on academic subjects (Bonell, Humphrey, Fletcher & Moore, 2014). Although not statutory, many settings chose to deliver the Social and Emotional Aspects of Learning (SEAL) programme which helped to develop children's social, emotional and behavioural skills within primary schools (Hallam, 2009). The programme was created in response to Every Child Matters (Department for Education and Skills, 2004) and was rolled out in primary schools in 2005 (Department for Education and Skills, 2005) and secondary schools in 2007 (Department for Education and Skills, 2007). Estimates in 2010 showed that although not statutory, 90% of primary schools and 70% of secondary schools, in the UK, chose to engage with the SEAL resources (Humphrey, Lendrum & Wigelsworth, 2010).

Personal, Social, Health Education (PSHE) is now, as of 2017, statutory and in terms of mental health, the topic covers emotional health and well-being with many schools adopting other mental health awareness programmes. Currently, whole-school approaches to mental health support are considered to be more effective than those that are targeted (Mackenzie & Williams, 2018; Rowling, 2009; Spencer et al, 2022; Weist & Murray, 2011). A whole-school approach involves a commitment to working in partnership with stakeholders, this includes Senior Leadership Teams (SLT), parents, all staff in school (both teaching and non-teaching) as well as the wider community (Critchley, Astle, Ellison & Harrison, 2018). The focus of a whole-school approach is to reduce stigma and raise awareness of mental health which can lead to changes in school culture. Deal and Kennedy (1983), describe school culture as the shared beliefs and values that knit the school community together.

This can improve outcomes for all students, particularly those that are showing or are at risk of, emerging symptoms of mental health difficulties (Fazel, Hoagwood, Stephan & Ford, 2014). The literature on whole-school approaches, however, is still in its infancy and there is a lack of peer-reviewed evaluations. Schools are also interpreting whole-school approaches in different ways which results in different implementations, making them difficult to compare and evaluate (Spencer et al, 2022). Although evidence is suggesting that whole-school approaches are the best way to support young people's mental health, there is still a need to work with young people to better understand what effective preventative school-based mental health support is needed so that support at the schools level can continue to be improved (Spencer, McGovern & Kaner, 2020).

Alongside a whole school approach, many educational settings are identifying a designated mental health lead or a mental health champion, in school. In my personal experience, this is often the Special Educational Needs Co-Ordinator (SENCO) but it is at the setting's discretion as to who they appoint. The role of the mental health lead has arisen from the recent mental health green paper (Department for Health and Department for Education, 2017) where the member of staff is responsible for mental wellbeing within the setting. The exact responsibilities of the role are unclear (Place2be, 2018) but in general, they are expected to ensure that mental health and wellbeing are taught within the school and to support staff in recognising signs and symptoms of mental ill health and have knowledge on how to refer children to specialist services. Alongside referring, the designated mental health lead should know how to support and manage students with mental health needs during their time in school and this information should be shared with other members of staff who are supporting the student (Place2be, 2018). The government is providing a grant for each school's mental health lead to attend '*Department for Education assured senior mental health lead training courses*'. This list was only released in August 2022 meaning that the impact and success of this training are yet to be seen (Department for Education, 2022). The role of mental health leads, even without the training, is still relatively new in most areas with the green paper providing a deadline for all schools to have appointed this role by 2025 (Department for Health and Department for Education, 2017).

There is a tiered approach to supporting children and young people's mental health. Tier one is universal mental health support that is made available to all children and young people, by adult professionals who do not specialise in mental health. This covers most of the adults in school which includes teachers and teaching assistants who are not only responsible for delivering the national curriculum, but also for tier one mental health support (Roth, Leavey & Best, 2008). Tier two is a mental health service that is provided by professionals who are specialists in mental health, this will likely include counsellors or therapists. Tier three is specialist Child, Adolescent Mental Health

Services (CAMHS) support, with tier four being professional services which are more specialists and provide inpatient support. As tiers three and four are often delivered by the same professionals, these are often combined into the same tier. Although some localities have been trialling different approaches to mental health support, the three, or four-tiered system is embedded in most localities across England (McGorry, Bates & Birchwood, 2013, Vaillancourt, Cowan & Skalski, 2016). Another way of describing the tiers is by the populations that will access each one. Tier one support is for entire populations of children and young people, tier two is typically for specific vulnerable populations, such as those who have experienced trauma or are demonstrating signs of mental ill health. Tier three is support for those who meet the criteria for a mental health diagnosis.

The school that took part in this study has a good source of tier one support in the school with students' mental health being a priority and access to the student support centre being embedded into many students' timetables. The school also has access to tier two support through art therapists, counsellors, and Educational Psychologists (EPs). The school, however, acknowledges that this support can be costly and is not as available to their students as they would like. The role of the EP within this school has historically been on supporting individual children and young people who have barriers to learning, assessing their needs and providing schools with strategies and interventions that they could use to reduce these barriers, as well as training. The school has worked alongside the EP to deliver training to their staff to equip them to further support their student's learning and their social, emotional, and mental health. The school also has some students who are accessing tier three support from CAMHS but also commented on how they have many more students on the waitlist for this support or some that were turned down for this support as they did not meet the required criteria.

Mental health teams that are a direct result of the green paper (Department for Health and Department for Education, 2017), are, in theory, available in the locality where the school is based. This is being rolled out to schools, but the project within this area is still in its infancy and the school had not yet accessed the support of this service.

1.5.3 COVID-19

It is important to also take note of the COVID-19 pandemic that was underway as this research began. The coronavirus disease (COVID-19) pandemic occurred when COVID-19 spread rapidly across the world and in March 2020, schools in the UK abruptly ended the majority of their face-to-face teaching and transitioned to emergency remote sessions (Marshall, Shannon & Love, 2020). COVID-19 changed living conditions effectively in all areas of life including education (Duran, 2021).

Due to the newness of this situation, there is not a lot of research on the effects of COVID-19 on self-harm. COVID-19 had a direct impact on the running of this research. It changed the means of data collection and resulted in some delays. Worldwide, COVID-19 affected the day-to-day life of everyone, of all ages. Research into COVID-19 is now beginning to emerge, but we are not, at the time of submitting this research, entirely out of the pandemic and its effects continue to be seen. From the limited research that does exist, the effects of the pandemic on mental health are being both predicted and evidenced.

Kumar and Nayar noted in 2020 that anxiety, depression and stress are common mental health consequences as a result of the pandemic. The closure of schools and separation from peers will also likely cause distress (Imran, Zeshan & Pervaiz, 2020). As well as the direct stress of COVID-19, Imran et al (2020) also listed the following as an effect of COVID-19 on young people's mental health; increased screen time, parental stress and heightened risk of child abuse, neglect and exploitation, Furthermore, Sahoo et al, 2020, stated that self-harm would be likely to increase during the pandemic due to the limited social interaction across communities, coupled with the anxiety that many people will be experiencing. Hawton et al (2021), found that in the first three months of the lockdown, fewer individuals were presenting to A&E with self-harm than is typical. They suggested that the reason for this may have been because of the avoidance of attending the hospital because of COVID-19 or the possibility that self-harm at the community level had been reduced. Research conducted by Hawton et al soon after the previous study found that of the individuals who presented to a hospital for self-harm, nearly half identified COVID-19-related factors as an influence on their self-harm (2021).

Thus far, research from Kapur et al, 2021, demonstrates that the pandemic (at the point of publication in December 2020) had not caused self-harm to increase across the UK, but this research also noted that the full effects of the pandemic were yet to be seen and that the rates may simply have not increased – yet. The well-being of many people is undoubtedly affected by the pandemic and as it continues to evolve, it could increase the risk of mental health problems worldwide (Moreno et al, 2020).

There is an ongoing emergence of research into the impact of COVID-19 on children and young people's education, yet the impact on teaching staff has not been a focus. Teachers typically experience some of the highest levels of occupational stress when compared to other professions such as prison officers, police and those in the nursing profession (Boyle, Borg, Falzon & Baglioni, 1995; Johnson et al, 2005; Markow, Macia & Lee, 2013; Schonfeld, 2001). There was a quick initiative to begin teaching remotely which would have resulted in a lot of uncertainty for teaching staff who had to navigate a new system, and it can be expected that at this time there would have

been particularly high levels of stress among teachers (Kush, Badillo-Goicoechea, Musci & Stuart, 2021; Marshall et al, 2020). The initial research that is beginning to be released is suggesting that during the pandemic, teachers reported greater mental health concerns than many other professions such as those in healthcare and office-based jobs. Mental health concerns were also reportedly higher for teachers that taught remotely during the pandemic (Kush et al, 2021).

1.6 Research question

When using GT, it is important to follow the data which may lead to the research question evolving and changing. GT research questions should be open and the researcher should not presume any information within the question (Strauss & Corbin, 1990).

The initial research question to begin the data collection, was:

How do secondary school staff experience student self-harm?

The initial question, which is explained further within the [methodology chapter](#) (page 25), aimed to carry as little assumption as possible. It is the school staff experience of student self-harm that the research was aiming to gain a greater understanding of. There is an assumption that secondary school staff would experience student self-harm, but this was not restricted to any particular experience, and instead would allow the participants to share their wide experience. At this stage of the research, I was utilising my previous career experience and knew that some members of staff will only have heard of the phrase, yet others will have had a very hands on experience. The research is interested in both of these types of experiences as well as others.

Chapter 2 Methodology

2.1 Method overview

The purpose of this chapter is to describe the philosophical underpinnings of the chosen methodology and to explain the different elements and stages of the research.

The research will include two phases which will make up the mixed-methods research. Phase one of the research will involve a mostly quantitative method largely using descriptive statistics and short content analysis, which will help to inform the second phase. Phase two will take a Grounded Theory (GT) approach and a qualitative method of data collection will be taken to further explore any data previously found.

2.2 Research design

The design used will be mixed methods with questionnaires, focus groups, interviews and memoing being implemented to provide data. GT states that *'all is data'* (Ralph, Birks & Chapman, 2014) with the primary forms within this research being transcripts from focus groups and interviews.

2.2.1 Mixed methods

I have decided to use a mixed-methods research (MMR) design for the study, which *'draws upon quantitative and qualitative methodological approaches to answer a particular research question'* (Jupp, 2006, p. 179). The use of a quantitative methodology being used to direct the qualitative element, suggests a *'sequential'* MMR (Creswell, 2002).

In its simplest definition, qualitative data differs from quantitative data as its raw form is ordinary language (Barker, Pistrang & Elliot, 2002). This language can be obtained in a variety of ways, which links to GT, in that data is found everywhere. This is a strength of the data and qualitative methods tend to be both richer and more complex than quantitative data (Barker et al, 2002).

The use of quantitative data will provide the researcher with some statistics that can then be further explored using qualitative methods. The use of the quantitative phase of the research will allow data from a larger number of participants to be obtained so that the voices of all staff members within the school can be captured. The research question, following the process of GT, will carry as few assumptions as possible and will aim to create a theory from the collected data which is systematically obtained (Chun Tie, Birks & Francis, 2019). The quantitative aspect of the study will allow more voices to be heard, which within the time limits, would not be possible with a qualitative

measure. Also, not all participants may want to take part in focus groups and a questionnaire allows participants to engage with the research anonymously and with a shorter time commitment than involvement in the second phase. It is important that the research aims to include the voices of members of staff who will not be able to or would choose not to take part in the second phase.

One difficulty with using MMR is the assumption of differing and conflicting viewpoints in terms of ontology and epistemology (Lincoln, Lynham & Guba, 2011). Quantitative methods are drawn from positivism and tend to take a realistic viewpoint that is often considered '*scientific*' (Johnson, Onwuegbuzie & Turner, 2007) and qualitative methods, drawn from Interpretivism, are often thought of as being more subjective and bounded by the researcher's interpretation (Damaskinidis, 2017). The flexibility of GT's ontological and epistemological viewpoints, suggests that it aligns well with MMR as it is suitable for researchers from a variety of epistemological approaches (Holt & Wash, 2016), with Walsh et al, 2015, describing Classic GT as '*epistemologically flexible*' (p.586).

Watts (2013), writes that scientific description is '*not a neutral value-free exercise*' and that this is true for both qualitative and quantitative data, but that this is more readily accepted with qualitative methods.

2.3 Epistemology and ontology

Walsh et al (2015), share that epistemological clarity leads to '*well defined and epistemologically congruent research outcomes*' (p. 587). When deciding on which type of GT to use, it was important to consider the epistemological stance as constructivist and classic grounded theory hold divergent views on their epistemological underpinnings, (O'Connor, Carpenter and Coughlan, 2019).

The potential opposing epistemological views of using an MMR design also need to be acknowledged. Quantitative research, as stated above, is generally underpinned by 'the philosophy of positivism' (Barker et al, 2002, p. 73) and the use of a questionnaire further suggests a positivist approach in that a higher number of scores deem something to be 'more true'. Qualitative research, however, tends to reject the idea of positivism and instead prefers non-realist epistemological positions which are grounded in the development of understanding as opposed to proving (Bryman, 1988).

I have chosen to work with classic GT due to the fact that its epistemological assumptions can be determined as '*flexible*' (Walsh et al, 2015). This is described as a limitation of GT, by Willig (2001) who states that the epistemological roots of GT are its '*most widely raised criticism*'. On the surface, GT is searching for a theory (Opie, 2004), which suggests that knowledge exists and can be captured, therefore implying a Positivist approach. Classic GT theorists state that its epistemological

assumptions are flexible and therefore suitable for researchers from a variety of epistemological viewpoints. It is also recognised that the resulting theory from GT would likely differ from one researcher to another on account of their epistemological viewpoint, as well as their previous training and life experience (Holton & Walsh, 2016). As such, this research takes a critical realist approach.

Critical realism is considered to be a paradigm position that covers a combination of differing views that are associated with positivist and interpretivist viewpoints (Haigh et al, 2019). Critical realism combines the realist ontology idea that there is something 'real' that exists and we can find information about it, with a relativistic epistemology where an individual's interpretation of the world affects their experience and their views (Stutchbury, 2021). Critical realism also details that our understanding of a phenomenon can change, our knowledge of the world is transitive and open to challenge and change (Haigh et al, 2019). The research will follow the data but it may be that a socio-political comment is made with the findings which further suggests a critical realism approach.

Memo: Critical Realism

I understand that classic Grounded Theory is epistemologically flexible (Walsh et al, 2015), but I feel that critical realism matches well with my understanding of the methodology. I have declared my knowledge of the research topic at the beginning of this thesis and enter it with curiosity and an open mind. I expect my knowledge to be challenged and to possibly change. I know that at the end of the research, I do not know the 'truth' as perceived by anyone else, but I will have more information about what exists in terms of school staff experience of student self-harm in the secondary school.

2.4 Research process

Strauss and Corbin (1990, p. 37-40) explain that an initial research question is needed when using GT, but that it must not make assumptions about the phenomenon that is being explored. This is almost impossible to achieve, but Willig (2001, p.37) gives further guidance that a question should remain at a descriptive level and should be open-ended. Taking this into account, the question at the beginning of the research is:

How do staff in secondary schools experience student self-harm?

The main assumption within this question is that secondary school staff will 'experience' student self-harm. I feel that this assumption is safe as experience should be interpreted from only hearing the phrase, in school our out, to working directly with students who self-harm. To be researching

self-harm in secondary schools means that there is already an assumption that it exists, meaning that the question carries the same level of assumption as the research itself.

Memo: Research question

I spent a lot of time reflecting on my research question as well as discussing it with my supervisor. I knew that it needed to be open and contain as little bias as possible, but to have none seemed an impossible task.

I considered that some members of staff would not be aware of any students who had self-harmed, but just knowing that people do self-harm was interesting for this research. I considered the other ways that self-harm may have an impact on secondary school staff, which included seeing the phrase in literature or on posters, supporting students directly who self-harm, being told by a colleague that they were supporting a student who had self-harmed or perhaps attending training with a big or small focus on self-harm. I was interested in all of these different things and so needed a word that encompassed each, including those that I had not considered.

I initially wondered about the word 'perceive', making my research question would be 'how do secondary school staff perceive student self-harm?', however, I felt that this did not capture physical experiences as well as thoughts and perceptions. I decided on the word 'experience' as I felt it captured both direct and indirect self-harm and was individualised to each member of staff. One member of staff's experience of student self-harm may just be hearing about it in the staff room or on a TV show, whereas another member of staff may have a more physical experience.

The word experience does carry some bias, but if a member of staff was to say that they had never heard of the phrase, this is an experience in itself. Therefore, I felt that although the word carries some bias, it is inclusive of all situations.

I also originally chose to have 'pupil self-harm' within my research question but found that as I was writing I would also use the word 'student'. I discussed this with some of my colleagues and while most agreed that pupil or student was acceptable language, most used 'pupil' when referring to primary school-aged children and 'student' when referring to those in secondary schools. I amended my question to include 'student' so that it matched the language being used within the local authority where the school was based.

As the research evolves, the research question will change as it is guided by the data that is collected (Strauss & Corbin, 1990). By using questionnaires as a part of phase one, the research will be steered towards self-harm in schools, but as participants are invited to take part in the data collection, the question may evolve and become more focused. By following the data, new, unexpected research questions may appear.

The order of action for the research can be found in [Appendix 11](#) (page 180). This includes both the planned time frames as well as the adjusted timeframes due to unforeseen delays with the research. It was also not possible, due to the GT methodology, to accurately predict how long data collection would take.

2.5 Participants

The focus of the research was on all members of staff within a secondary school. Children and young people who self-harm may disclose to any adult, and the fact that it cannot always be predicted who this may be meant that it was important for all adults within the school to be invited to take part in the research. The 'categories' of staff were discussed with the deputy head teacher, and the following descriptors were used as options in the questionnaire.

- Teachers
- Teaching assistants
- Business/administrative support
- Lunchtime supervisors
- Senior leadership team
- Cleaning staff
- Governors
- Site maintenance staff

To have a focus on self-harm meant that it was important to work within a population where this is likely to occur and although younger children do self-harm, the average age of the first incident of self-harming behaviour in the UK was found to be thirteen years when completing a meta-analysis of research into self-harm across 1990-2015 (Gillies et al, 2018). It was not necessarily important that the staff had directly worked with a child who had self-harmed, as the possibility of the occurrence was something they knew they may be faced with and this experience itself was useful for data collection.

To recruit a school, a letter explaining the research was written ([Appendix 3](#), page 151) and shared with the EPs within the service where I was based. They then sent this out to their secondary schools who were asked to contact me directly if they were willing to take part in the research. Five schools responded saying they would like to take part and they were responded to in order of interest shown. The first school contacted were unable to commit to the research due to upcoming staffing changes so the second school were contacted and a meeting was arranged with the deputy head teacher to discuss the research further.

It was agreed that the staff member would introduce the questionnaire to all staff members during each of their team meetings. As different staffing roles had different meetings, this meant that it would be rolled out over a period of two weeks. Of 120 members of staff, including governors and volunteers, 49 responses were gathered from the questionnaire.

The school has a 'Good' OFSTED rating and is located in an area of the East Midlands that has a particularly low socio-economic status according to 2011 census statistics. The school also has an on-site Pupil Support Centre where pastoral members of staff work to support student's social, emotional and mental health.

2.6 Phase one – Quantitative methodology

Phase one of the research was designed to create information and a starting point for phase two, but also to offer a realist standpoint to the research before delving into more detailed and objective data.

2.6.1 Rationale for questionnaire

The questionnaire was designed by the researcher to gather a large amount of information about self-harm and its occurrence in the secondary school ([Appendix 5](#), page 160). The main aim of the questionnaire was to gather information from all members of staff, which would not otherwise be possible via focus groups.

A critical realist stance is taken with the research, which accompanies an understanding that often decision-makers prefer to view numbers when deciding what action to take. The school were keen for the Governors to be made aware of the research so that they had a greater understanding of self-harm in their school. If any changes are to be made within the school, as a result of the research, statistics will be seen as 'evidence' of a need for change. Quantitative data alone, however, does not

give enough depth into how student self-harm is experienced in secondary schools and so the questionnaire was only used to gather initial data that was then further explored qualitatively.

The questionnaire was designed online and was sent to all 120 members of staff in the school (a copy of this can be found in [Appendix 5](#), page 160). The questions that were asked were then taken to the first round of focus groups and interviews as discussion points to generate further data.

2.6.2 Questionnaire development

The questionnaire provided quantitative data through the use of rating scales, a few open-ended but short, free text questions and radio buttons which give participants the option between two or more response, such as yes and no. I considered what information would be helpful for phase two of the study and implemented questions that would provide this data. Through research, I found there were no other questionnaires similar to what I was hoping to measure which meant I needed to develop one for the study.

The questionnaire was created on a website called Gorilla, which allows experiments to be made specifically for the social sciences and can securely hold sensitive data (Anwyl-Irvine, Massonnié, Flitton, Kirkham & Evershed, 2020). This platform also allowed participants to feel as though they are completing one questionnaire, which included the information and consent form, but for the researcher to separate this information to ensure anonymity.

The questionnaire had been piloted by three members of staff in a secondary school during a pre-test phase to test its usefulness. Their job titles were executive principal, head teacher and teacher. I received feedback from one member of staff who completed the questionnaire around the ease and clarity of the questionnaire and amendments were made accordingly. These included giving options for the year group the staff member worked with, as well as for their job title.

Memo: Considerations for focus groups (November 2020)

It is important that the participants feel assured that their questionnaire responses are anonymous but some demographic information is useful for data analysis. A balance needs to be found as well as the option for members of staff to not include their job title. They may be the only member of staff with that title. Giving a list of job 'levels' to choose from will help with the anonymity, and then the option

2.6.3 Administration of the questionnaire

The questionnaire was sent out to all school staff, in both teaching and non-teaching roles. A hyperlink was sent via email which led to a questionnaire on Gorilla where respondents were able to answer anonymously to all questions. Gorilla is an experiment design tool that has been designed for those conducting behavioural research within the realm of social science (Anwyl-Irvine et al, 2020). The university holds a subscription to the site and it is secure in holding sensitive data. It also provides the option for participants to complete consent forms and provide their names, and for this information to be stored separately from their questionnaire responses. Staff were given a ten minute time slot at the end of the team meeting to complete the survey to avoid adding more tasks to their workload. The pilot surveys provided information that the survey took, on average, six minutes to complete. After ten days had passed, the deputy head teacher sent staff members a reminder to complete the questionnaire if they had not already, this helped with the number of questionnaires that were completed.

2.6.4 Analysis of the questionnaires

Data from 49 respondents to the questionnaire were downloaded from the website anonymously. Participants were able to give their names to take part in phase two but this information was gathered and downloaded separately to question responses.

Data was analysed using SPSS software and content analysis (Krippendorff, 2018) for the qualitative questions that were included in the questionnaire. Descriptive statistics were largely used to analyse the data as this was the most helpful when looking at information to supplement phase two of the research. The analysis of the questionnaire was also kept separate to phase two initially so that the data could easily be shared with school governors.

For the first quantitative question, most participants provided a one or two word response. The question was immediately after a radio button question which provides the participant with a list of responses to choose from. The question was '*who should support students who self-harm?*' with the responses that the participant was able to choose from being '*adults in school*' or '*adults out of school*'. Once a response was given, participants were asked to provide further information on who these adults would be. Content analysis (Krippendorff, 2018) was used to analyse this data.

The second question was more open, and asked those that said they had responded to self-harm '*if yes, how and to what effect?*' A simplified version of the six-stage thematic analysis (Braun & Clarke, 2006) was used to draw themes from the data. The steps included were:

1. Familiarisation with the data
2. Initial list of codes
3. Identification of themes
4. Specification of themes

Content analysis was then used to quantify and analyse these results.

2.7 Phase two – Qualitative methodology

Once data was collected from the quantitative measures, GT methodology was used for phase two of the research. A total of four focus groups and four individual interviews were used as a part of the GT process where they were analysed through iterative cycles before the following set of data collection. In total, eight different members of staff took part in the qualitative phase of the research which took three months to complete.

2.7.1 Grounded theory

GT includes a repeated process of data collection and analysis until theoretical saturation is reached. Theoretical saturation refers to the stage in data collection when new data analysis no longer provides new information to the category, implying that the category is sufficiently explained (Birks & Mills, 2015). Theoretical components are constructed as they arise within the data. As such, there are no series of steps that must be followed to complete this methodology and the researcher must approach the data without 'perceptions or pet theories' (Willig, 2001). Grounded theory methodology is described as '*inherently flexible*' (Chun Tie et al, 2019).

2.7.2 Background to grounded theory

GT was developed by Glaser and Strauss in 1967 to demonstrate that qualitative data can be used to generate theory, and not just provide descriptions (Barker et al, 2002). There are several different types of GT, all of which originate from Glaser and Strauss' classic GT in 1967. When comparing the core feature of classic GT and constructivist GT, there are many similarities (Bryant & Charmaz, 2007). When comparing epistemological viewpoint, classic GT is more flexible with Urquhart (2013), stating that classic GT can be used by interpretive, positivist and critical realist researchers.

Classic GT '*involves a combination of induction, deduction and abduction to gain conceptual clarity about phenomena*' (Timonen, Foley & Conlon, 2018, p. 3). The data gathered is used to create new ideas. Unlike constructivist GT, classic GT also states that research questions should not be

developed before the data collection and only a broad question that allows the facilitation of discussion should be used (Glaser, 1998), this is in direct contrast to constructivist GT where a research question is decided before data collection. Classic GT follows the direction of the data meaning that it must remain flexible in its viewpoints as the research could be steered in new and unpredicted directions.

The questionnaire was designed for phase one of the research but was not a part of GT, and instead created prompts for phase two of the research. Two focus groups, one with three participants and one with two, as well as two 1:1 interviews, were then used to explore the questions from the questionnaire in more detail, and the following focus groups were used to explore theories that were beginning to emerge across two rounds of data collection.

2.7.3 The process of grounded theory

Grounded theory is compatible with '*a wide range of collection techniques*' (Willig, 2009) and a deep understanding of GT will likely result in the researcher being more flexible in their use of the method (O'Connor et al, 2019). Semi-structured interviews, participant observation, focus groups, and diaries are qualitative methods that are often used within GT (Berker et al, 2002).

Urquhart, Lehmann and Myers (2009), state that there are four core aspects of GT, although other researchers have suggested more principles. The main themes that occur across these principles is that the research design and outcomes are a direct result of the data that is collected and should not be predetermined. It is also important to consistently analyse and compare the data that is being collected alongside the use of memoing.

1. There must be theoretical sampling, meaning that the search for data is based on the emerging theory and continues until there is a saturation of concepts and categories.
2. The aim of grounded theory is to build and develop theory.

It is important for GT researchers to '*document carefully and in detail, each phase of the research process*' (Pidgeon & Henwood, 1997). Memo-writing helps the researcher to be aware of the possible effects on the data itself (Backman & Kyngas, 1999).

Memos were created throughout the research and then included in the write-up in the relevant sections. Those that did not fit into the thesis structure are included in [Appendix 10](#) (page 175).

The structure of GT meant that after each round of data collection, the information was analysed and compared to previous sets of data, searching for emerging theories and to begin to saturate

categories. This is described as theoretical sampling and means that the search for data is based on the theory that is emerging from the data, it should continue until theoretical saturation (Glaser & Strauss, 1967) is reached. The aim of GT is to build and develop a theory and this aim should be considered throughout data collection. The idea of what a theory looks like is critiqued by Charmaz (2014) who highlights that there are different meanings of 'theory' among grounded theorists.

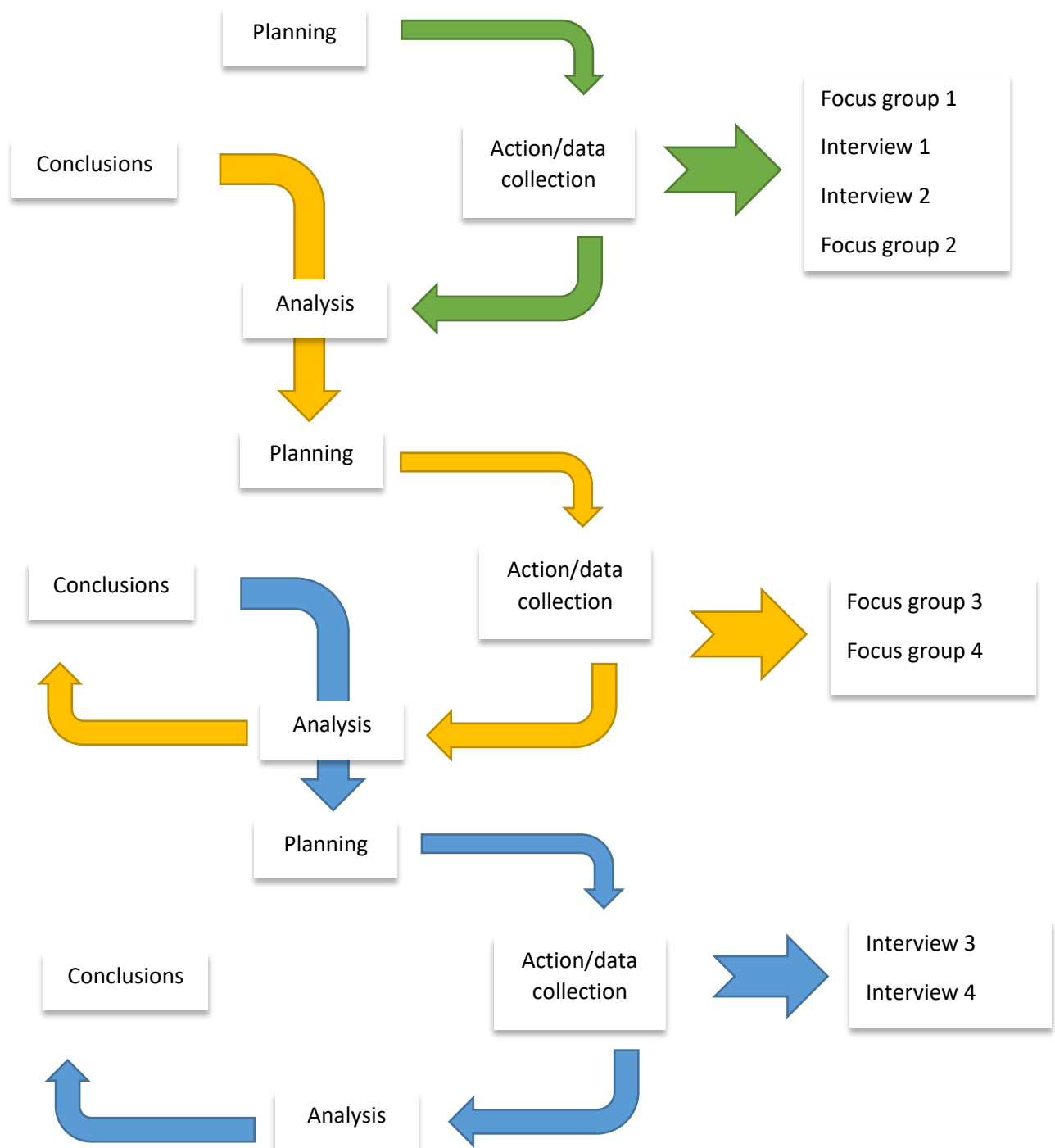


FIG 2: IMAGE DEMONSTRATING THE ITERATIVE CYCLES THAT TOOK PLACE IN THE SECOND PHASE OF THE RESEARCH

The above image demonstrates the iterative cycles that occurred during the second phase of the research alongside the means of data collection that occurred during that round. Each set of data collection was analysed and the findings were used to support the next round of data collection. Three iterative cycles occurred in total.

2.7.5 Coding

When using GT, *'the coding process begins with open coding of empirical data'* (Holton & Walsh, 2017, p. 81). The coding takes a line-by-line process where codes and concepts are collated (Strauss 1987; Strauss & Corbin, 1990). During this process, the researcher should write memos on any reflections or considerations that arise.

Following the information from Holton and Walsh (2017), coding began with open, *in vivo* coding (Strauss, 1987) which is used to identify 'incident' in the data. This is followed by selective coding which identifies *'properties and dimensions of the core category'* (p.87).

Coding and memoing occur concurrently and the process of writing memos helps to find patterns in the data. Once categories become saturated, which is further detailed below, theoretical coding can begin which will guide the data into a theory. Theoretical coding is used in classic grounded theory (Glaser, 1978) and is used to identify codes which is essential to develop a substantive theory. Although several theoretical codes will emerge, only one will be chosen as the theoretical code for the research to focus on (Hernandez, 2009).

This was completed with transcripts spread across the floor with different coloured highlighters being used to highlight any new concepts that could then be merged into categories. Different lines of the transcripts were cut up so that they could be placed where I felt, at this stage, that they best fit. Thirteen different categories emerged from the data collected in focus group one. *In-vivo* examples are provided below for each category to facilitate cross-checking.

2.7.6 Data saturation

When using GT, data is continuously collected until a point of theoretical saturation is reached. Theoretical saturation is used as a criterion for discontinuing data collection (Glaser & Strauss, 1967). Barker et al, 2002, describe the point of theoretical saturation as *'one or more categories, which capture the essence of the phenomenon'* (p. 80). Holton and Walsh (2017) share that *'core categories should be saturated as completely as possible'* (p. 103). It can be argued that if the process of data collection was to continue, eventually new data would be collected with Hallberg (2006) stating that

once data collection has been completed, you would never know if further data collection would result in new information. The research focused on reaching the point of saturation.

2.8 Focus groups and Interviews

2.8.1 Participants

In the first phase of the research, participants were given the option to add their name at the end of the questionnaire and told that doing so meant they may be contacted to take part in the second phase of the research which would include focus groups. Fifteen participants left their names and a random cell generator was used to decide which participants would be invited to each focus group. Eight different participants took part in the second phase of the research.

Memo: Reflections on GT

I found the writing up of my research to be very similar to that of GT. It is possible to keep going, to keep making amendments, to keep reading different journals until I find something new. But like most things, an end has to be reached, and I find myself reflecting on Winnicott's 'good enough' (1960), as well as the considerations of what I may have found if I had a year, perhaps decades to continue data collecting.

2.8.2 Rationale for focus groups and interviews

Focus groups are conducted similarly to semi-structured interviews, but also allow participants to respond to one another's contributions also, which can result in a deeper discussion (Barker et al, 2002). The interactions themselves can also be a source of data (Willig, 2001). Although gathering data in groups have these benefits, it is also important to consider the impact of group dynamics which can affect engagement and discussion. Focus groups should provide an open and honest environment, where possible, which will help promote engagement. Richer discussions also tend to occur when the participants attending the focus group are interested in the topic being discussed (Jupp, 2006). Participants who took part in the second phase of the research had put their names forward voluntarily, which could indicate that they are interested in discussing student self-harm further.

It is also important to note here the impact of COVID-19 on this research. Due to the pandemic, EPs were working from home and using technology to conduct the majority of their work. At the time of completing ethics, it was important to ensure that research could be conducted online given the

possibility that conducting focus groups face to face may not be an option. I did go into the school face to face to discuss the research with the link worker, but focus groups were conducted online. This was for safety reasons, as the research was not deemed 'essential' for a visit but also at this point, staff were comfortable with online video software and this also allowed for ease of audio recording the focus groups.

Unfortunately, there were some barriers in recruiting for the focus groups as there were staff shortages due to illness, which meant that some members had to cover others' duties. Alongside this, many schools had adopted a staggered timetable to help keep students safe, but this meant that it was difficult to find a time when all participants could be available. This meant that focus groups had to occur flexibly, as well as adding in the option for individual interviews.

Memo: Group dynamics (September 2020)

I need to be aware that if I have (for example), a member of SLT in the room, a TA may feel they need to be more positive and confident in their conversation about managing self-harm. I imagine I cannot avoid this entirely but I need to consider how to lessen these effects. Also perhaps this is suggesting questionnaires shouldn't be anonymous. Group dynamics can be considered (to a degree) and interested participants could be invited.

2.8.3 Recording focus groups

I audio recorded each of the focus groups and individual interviews that were conducted using Google Meet, a video-communication service developed by Google. Participants were made aware before the focus group that only audio would be recorded and that using their video camera was their choice. I kept my camera on throughout the focus groups but did mention prior that if the connection drops, I would turn it off to save on bandwidth. Fortunately, this did not need to occur and my camera remained on throughout all individual interviews and focus groups. Although optional, seven of the eight participants kept their cameras on throughout the interviews and focus groups. This option also meant that participants could join as an audio call on their mobile phones, allowing those without computer access to attend, which was the situation for the participant who joined via audio only. This will be discussed within the [discussion chapter](#) of this research (page 96).

The recordings were saved locally on a password-protected and encrypted computer. Participants were asked to give a pseudo name so that conversation could flow more easily and allow the

participants anonymity, whilst also feeling 'human'. The only demographic information asked for was job title but this was optional. The recording began after the briefing to allow participants to ask anonymous questions. The script used to support the focus groups can be found in [Appendix 6](#) (page 164).

2.8.4 Outline of focus groups

Focus groups one and two, and interviews one and two occurred in round one of data collection and followed the format of the questionnaire which allowed participants to give more detailed answers than what was given in the first phase of the research. I took the role of a participant observer where possible within the focus groups but also used probing questions when participants responded with something that I felt needed to be explored further. Glaser (1978), noted that probing questions during data collection will assist in theoretical saturation. This felt necessary to reduce the role of double hermeneutics but it is important to also note that this involvement may mean that the researcher affected the data.

The first round of data collection used the questions from the questionnaire to allow participants to elaborate or give further information to their responses in phase one. Participants were made aware that their responses in phase two were not directly connected to those in phase one as all questionnaires were anonymous. Questions were asked in a similar way to the questionnaire and a script was used to support consistency for the researcher ([Appendix 6](#), page 164)

For round two, I wrote a working thesis title which was created from round one of data collection followed by a discussion with my supervisor. I decided to share with the participants on a shared screen ([Appendix 8](#), page 167).

Counting the sharpeners: A Grounded Theory study exploring school staff experience of student self-harm.

The working research title was embedded into a grand tour question (Simmons, 2010), based on the results from the previous round of data collection. A grand tour question helps to open a group up with just one overarching question that leaves the discussion open to take any direction that the participants choose. You can use probing to delve deeper into any particular responses which may result in new concerns emerging (Holton & Walsh, 2016). The final round of data collection aimed to check the findings of the research.

Round two comprised of two focus groups. The first had two participants and the second had three. Four of the five participants had attended a previous focus group or interview. One participant had

hoped to join round one but had to unexpectedly cancel. For this round, as a grand tour question was being used, I felt it would not be suitable to use 1:1 interviews for data collection as a grand tour question heavily relies on discussion.

The final round of data collection aimed to check the findings of the research with the participants. Similarly to rounds one and two, a script was used and can be found in [Appendix 7](#) (page 166). The participants were first asked again if they had any further thoughts on the working thesis title. Participants were then asked two questions:

- *When we think of counting the sharpeners, do we think that's enough?*
- *What is the biggest barrier to doing more?*

2.8.5 Description of focus groups and interviews

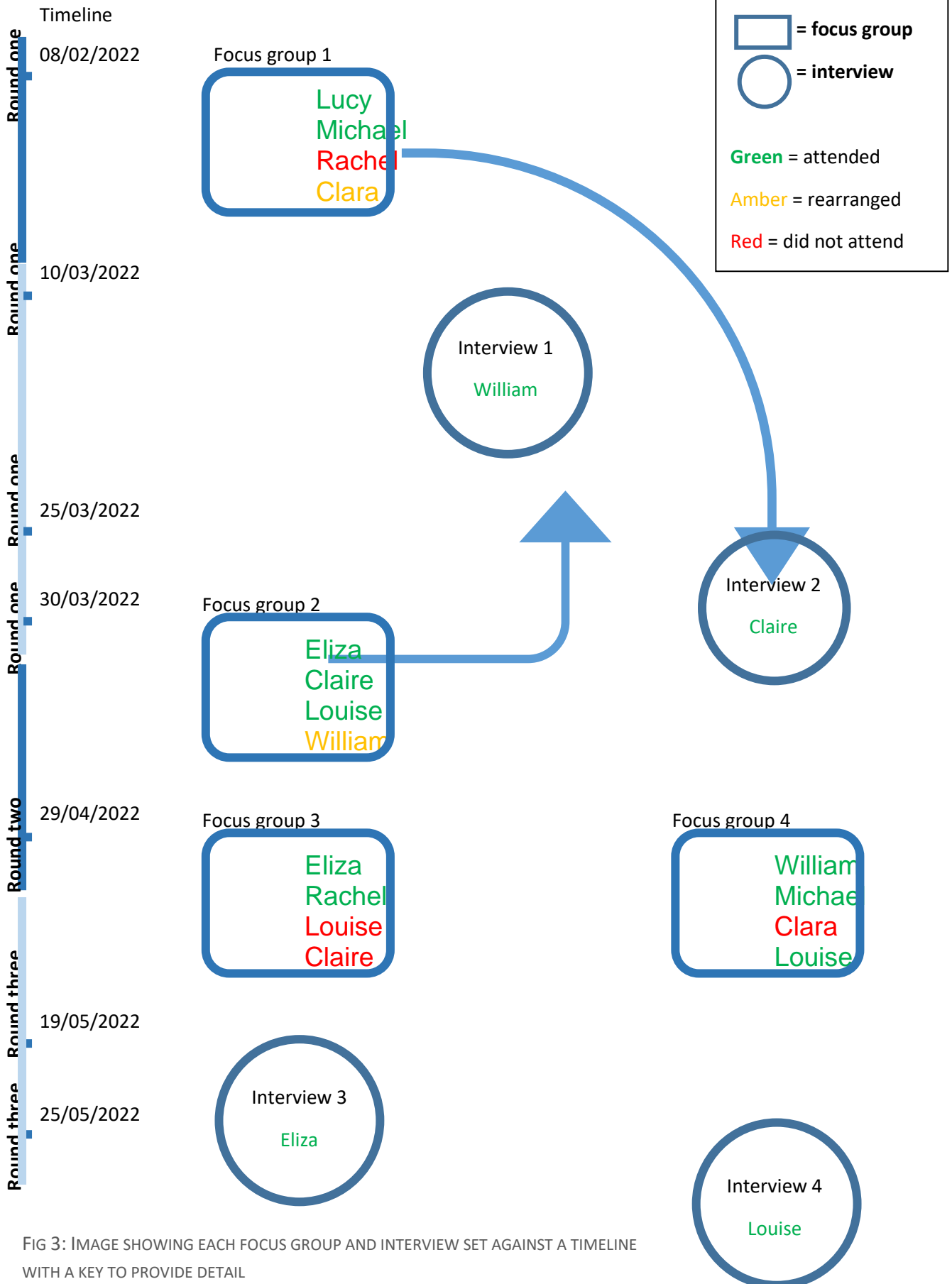


FIG 3: IMAGE SHOWING EACH FOCUS GROUP AND INTERVIEW SET AGAINST A TIMELINE WITH A KEY TO PROVIDE DETAIL

2.8.5.1 Focus group one

Four members of staff were invited to the first focus group. Unfortunately, it was only possible to find a slot where three participants could be available. The fourth participant was contacted and stated they would like to be invited to a future focus group.

On the day of the focus group, I received an email from another participant saying that due to staff illness they needed to cover a lesson and would not be able to make the focus group. After discussion with my research supervisor, I decided that these difficulties are likely to arise and that the focus group should continue with two participants.

The focus group was online and ran at the end of the school day and lasted for 25 minutes.

The group consisted of a female core subject head and a male technician. The department head had a teaching role, whereas the technician described his role as 'not student facing'. Throughout the focus group, the core subject head answered each question first, and the technician responded after. This was not a pre-determined structure but seemed to occur naturally as the department head often had longer responses.

Both participants were asked at the end if they were okay to be contacted regarding further interviews once the data was analysed and was deemed helpful. Both participants agreed to be contacted.

2.8.5.2 Interview one

A focus group was arranged with three participants, but two were unable to attend due to unforeseen circumstances. The participant that was still able to attend was invited to keep the timeslot but as an interview, or to be invited to the rescheduled focus group. The participant chose to meet in an interview format.

This interview took place after the school day and lasted for 30 minutes. The participant was male and had a pastoral leadership role within the setting. The participant worked regularly with young people who self-harmed and was detailed with his responses.

2.8.5.3 Interview two

Interview two was with the participant who was unable to attend focus group two due to illness. She had emailed and said she would be happy to participate and was invited to interview as she could also not make the following focus group timeslot.

The interview took place at 10:30 am on a day when the participant was working from home. The interview lasted for ten minutes. The participant was a technician.

2.8.5.4 Focus group two

Focus group two included three members of staff and took place at the end of the school day. This slot was decided by the participants and the focus group lasted for 30 minutes. It was intended for four participants to attend but due to timings, this participant took part in interview two instead.

The participants included a teacher, a teaching assistant and a 1:1 tutor. As well as responding to the interview questions, the participants discussed some topics among themselves.

During this focus group, probing questions were used to gain more detail from participants' responses. Glaser (1978) states that probing questions help to assist the densification of conceptual properties. Probing questions included: 'What would you do?' (Transcript 2, page 5, line 110) and 'would anyone do anything different?' (Transcript 2, page 6, line 116).

2.8.5.5 Focus group three

Focus group three was the first set of data collection of round two that was grounded in the data that had previously been collected. The data had been analysed and a key theme had been drawn out to be explored in focus group three. All seven participants and one participant who was unable to previously attend were invited to take part in focus groups three and four.

Focus group three included two participants, one of whom had not been in previous data collection due to illness but was keen to take part in the research. This focus group lasted for eight minutes and was attended by a female 1:1 tutor and a female SEND lead.

This round of data took the format of a 'grand tour question' (Simmons, 2010) which is intended to open the discussion up. Participants were presented with the thesis title and asked their thoughts ([Appendix 8](#), page 158).

2.8.5.6 Focus group four

Focus group four lasted for 17 minutes and was attended by three members of staff, each of which had attended previous focus groups. This group included a female teaching assistant, a male science technician and a male pastoral lead.

The grand tour question (Simmons, 2010) was also used in the focus group and took the same format as focus group three where the researcher shared a computer screen which displayed the research question in large font ([Appendix 8](#) , page 158).

2.8.5.7 Interview three

Interview three offered the opportunity to check in with participants who had been less vocal in previous focus groups, to explore the emerging theory. The participant in interview three was a female 1:1 tutor and the interview lasted for seven minutes.

2.8.5.8 Interview four

Interview four was set up in the same way as interview three. Participants were invited to attend together, but it was nearing the end of the school half term so everybody had limited availability.

Interview four lasted for nine minutes and was with a female teaching assistant.

Memo: Reflection on recruitment

Recruitment was far more difficult than I expected, in terms of arranging days and times to meet. Due to COVID 19, participants were working on a staggered timetable which meant there were no times in the day that everyone was likely to be free. I was very mindful of their time and very appreciative when participants would meet with me outside of their school day.

2.8.6 Coding

Coding began once round one of data collection had been completed, although memos were written throughout the process. The process began with open coding which is the process used to identify emerging concepts and similarities within the data (Chun Tie et al, 2019). The initial coding step begins the process by looking for similarities and differences in the data and creating as many codes

as possible from the early data by identifying important groups of words (Charmaz, 2006). This was completed one data set at a time. For example, focus group one was coded and categorised before adding interview one. The following data set would be added to the previous categories as well as the emergence of new ones. This was continued for all of round one of data collection.

Once data from round one was collected, it was important to check whether any of the categories were mutually exclusive. If found to be so and not merged, this could result in problematic interpretations (Weber, 1990). Krippendorff (2018) adds that for coding to be reliable, it must be mutually exclusive and exhaustive. All categories that emerged from round one of data collection were checked for mutual exclusivity with the support of my supervisor. It was also important to only pursue categories that were fully represented by both interviews and focus groups that had taken place in round one. This ensured that the nature of GT was adhered to where the main principle is to follow the data. As all participants were to be invited into the second round of data collection, only fully represented categories were kept.

Before round two of data collection began, I met with my supervisor and we spent time checking for mutual exclusivity, combining categories and removing those that were not fully represented. They were provisionally titled as:

- Adult self-harm
- Parental support
- Self-harm is a financial problem

The most saturated category was chosen as the category to follow further and round two allowed for theoretical sampling, which allows the researcher to follow leads from their data by gathering further information (Chun Tie et al, 2019).

Data from rounds two and three was analysed similarly to the initial coding and axial coding was used to group the data into themes. Axial coding occurs after open coding and involves reassembling coded data into categories, this leads to the researcher constructing deeper theoretical meaning in the data (Williams & Moser, 2019).

Round three of data collection was used to test the saturation of the core category and again the process of drawing themes from the data using *in-vivo* and axial coding was repeated.

In-vivo coding, also known as verbatim coding, literal coding and natural coding (Saldaña', 2016) is the literal record of participants' responses in their original form (Strauss, 1987). Charmaz (2014) details that in its earliest form, *in-vivo* coding is used to assist in the development of grounded

theory. After *in-vivo* coding is completed, axial coding is used to develop more complex or nuanced categories (Manning, 2017).

2.9 Ethics and consent

2.9.1 Ethical approval

Before data began to be collected, ethical approval was requested and approved through the University of Sheffield's ethics panel ([Appendix 1](#), page 149). The ethics application described focus groups as being the main means of data collection. As the after-effects of COVID-19 became more apparent, it arose that it would be helpful and perhaps necessary to also conduct individual interviews. It was difficult to find times that all participants were able to meet for a focus group, and on a number of occasions, participants were no longer able to attend due to illness or a change in their timetable. On these occasions, it was easier to continue and meet with participants independently rather than to create a new time they were able to meet together. Participants were always told prior to the meeting whether it was a group or individual format so that they had the option to attend. The interviews would occur in the same format as the focus groups but as these would now be on a 1:1 with the researcher, further ethical approval was sought and granted ([Appendix 2](#), page 150).

2.9.2 Ethical considerations

The first phase of the research was an online questionnaire ([Appendix 5](#), page 160), and information about taking part was included within this on page one before any questions were asked ([Appendix 4](#), page 153). At this point, participants were asked not to continue with the questionnaire if they did not feel happy to do so, once reading the information sheet. As such, the software used to create the questionnaire meant that if the participant did not sign and agree to the information provided, they were not able to proceed. As the questionnaire was anonymous, participants were unable to withdraw their data unless they opted to include their name at the end of the questionnaire, this was made clear in the information sheet. Participants were also signposted to sources of mental health support as the research questions could potentially be triggering for some. At the end of the questionnaire, there was a question where participants were asked to include their names if they were happy to be contacted regarding the second phase of the research. Participants were made aware that if they had opted in and their name was randomly selected, this would be passed on to the executive vice principal and/or his assistant, both of whom were referred to within the questionnaire by name. This meant that the researcher was not storing the participants' email

addresses. Fifteen of the 49 respondents chose to add their name, indicating they were happy to be contacted regarding the second phase of the research.

Before taking part in phase two of the research, participants were sent a link to Gorilla, an online experiment design tool intended to hold sensitive information (Anwyl-Irvine et al, 2020), where they could electronically sign and read through an information sheet and consent form for the next phase ([Appendix 4](#), page 153). Focus groups and individual interviews were audio recorded so that the researcher was able to remain present, and specific consent was gained for participants' voices to be recorded. This information was then stored safely, in line with GDPR. All ethical considerations were in line with the British Psychological Society Code of Human Research Ethics (2014; 2021) and the HCPC Standards of performance and conduct ethics (2018).

One consideration of the data collection was to not inconvenience participants. For the questionnaire that was distributed to all members of staff, time was given to them during their respective team meetings to complete the questionnaire if they wished to do so. This ensured that this did not come out of their own time. It was also important to make sure that the focus groups ran at times that were suitable for the participants. Each focus group and individual interview took place online and could be completed at a location where the participant felt comfortable either on their phone, a tablet or a computer. To arrange the dates for focus groups, participants were asked to share their availability. Each focus group took no more than 45 minutes.

Before each focus group participants were reminded of what to expect and were given the opportunity to ask any questions prior to the recording beginning. Key information from the consent form was also reiterated, including the fact that they were able to leave at any time if they chose to, and a reminder of who they could speak to for support if they felt this was needed. At the end of each focus group, participants were asked if they would be happy to be contacted regarding the next cycle of data collection. They were assured that this does not mean they have to take part, but only that they give consent to be contacted again.

On two occasions, a date and time could not be found for a participant to take part in a focus group, so an individual interview was used. The participants on these occasions were made aware before their timeslot that they would be the only participant and they were given the option to continue or to be invited to the following focus group. On both occasions, the participant was happy to continue in an interview format.

In both the focus groups and interviews, participants were asked to provide a pseudo name. This provided the participants with anonymity, but also allowed the conversation to flow and for both myself and other participants to direct a question to a particular participant within the recording

without breaking anonymity and also allowing for the interaction to feel more natural, than if a participant number was used. Participants were also given the option to withdraw their data within one month of it being recorded, providing this pseudo name would have made the process simple. As such, no participants in either the first or second phase requested for their data to be withdrawn.

At the end of each focus group and individual interview, participants were reminded of who they could contact for support and signposted to the Samaritans. This information was given at the beginning of the focus groups and individual interviews but I was conscious that by the end of the sessions, some time had passed with a lot of discussions so felt it was important to remind participants about this information after a sensitive topic has been discussed.

Chapter 3 Analysis and findings

3.1. Chapter overview

This chapter will break down the findings from both phases of the research. Phase one considers descriptive statistics from the 49 completed questionnaires. Two of the questions within the questionnaire were more open and allowed free text responses as opposed to choosing an answer from a pre-determined list, so a thematic analysis was used to analyse the findings (Braun & Clarke, 2006) alongside content analysis (Krippendorff, 2018) to quantify the results. Phase two takes a Grounded Theory (GT) approach and analysis was completed after each round of data collection. The process taken is detailed within the methodology chapter, and the below will delve into the research findings.

3.2 Quantitative data: Phase one

The first phase of the research was a questionnaire ([Appendix 5](#), page 160) that was distributed to all members of staff in the school, via their work email addresses. The first part of this chapter will focus on the analysis of the questionnaires.

3.2.1 Summary of quantitative analysis

The below section details the scores and analysis of the self-harm questionnaire. The summary of the questionnaire findings were:

- The majority of participants felt comfortable talking about self-harm with a mean rating of 6.9
- There was no correlation found between job title and years spent in the job role at the school with comfortability in talking about self-harm
- 23 participants felt that self-harm occurred weekly in their school
- Only two of the 49 participants had previously attended training on self-harm within the last academic year
- 55% of the 49 participants had responded directly to student self-harm
- 69% of participants felt that self-harm is always indicative of a mental health problem
- 71% of participants felt that adults in school were best placed to support student self-harm, and the safeguarding team was the most common response as to who this should be

- 57% of participants said they had responded to self-harm. The most common action taken was to report the information to the safeguarding team, student support centre or log the incident on the schools safeguarding database

3.2.2 Quantitative analysis of self-harm questionnaire

49 members of staff completed the questionnaire. They had a mix of job roles with the majority (n=20) being teachers.

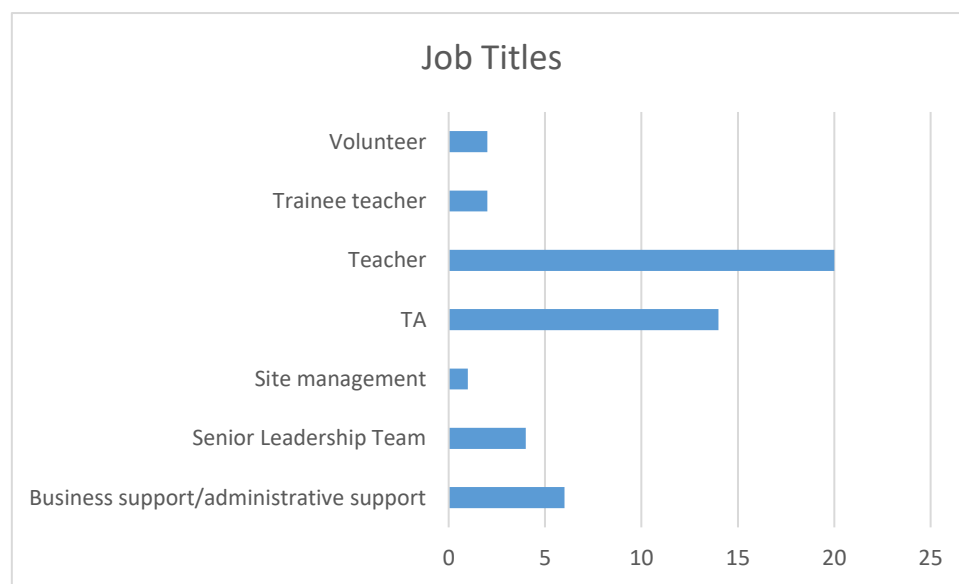


FIG 4: CHART DETAILING THE DIFFERENT FREQUENCIES OF JOB TITLES

Participants were asked how comfortable they were talking about self-harm on a scale of one to ten, where one was not at all comfortable, and ten was extremely comfortable. The mean result was 6.9 and results ranged from three to ten. A Pearson correlation coefficient was computed through SPSS to assess the linear relationship between job title and comfortability in talking about self-harm. No significant correlation was found ($P = 0.195$, $p < 0.05$).

Job Title	'how comfortable are you talking about self-harm?'
Business Support/administrative support	7
Site management	7
Teaching assistant	6
Trainee teacher	6.5
Teacher	7.4
Senior Leadership Team	7
Volunteer	7.5

TABLE 1: MEAN SCORES FOR 'HOW COMFORTABLE ARE YOU?' BY JOB TITLE

Time in post	N	'how comfortable are you talking about self-harm?'
0-3 months	2	7
3-6 months	4	5.25
6-12 months	-	-
12-18 months	6	7.25
18-24 months	-	-
24-36 months	5	8
3-6 years	8	7.5
6 years+	22	6.5

TABLE 2: MEAN SCORES FOR 'HOW COMFORTABLE ARE YOU?' BY YEARS IN CURRENT POSITION

Participants ranged in their experience and understanding of how often self-harm as defined by Sutton (2007, p.23) ([page 13](#)) was being identified in their school. The majority of participants (n=23), believed that self-harm was identified weekly. One participant understood it to be identified yearly, and three participants considered it to be identified on a daily basis.

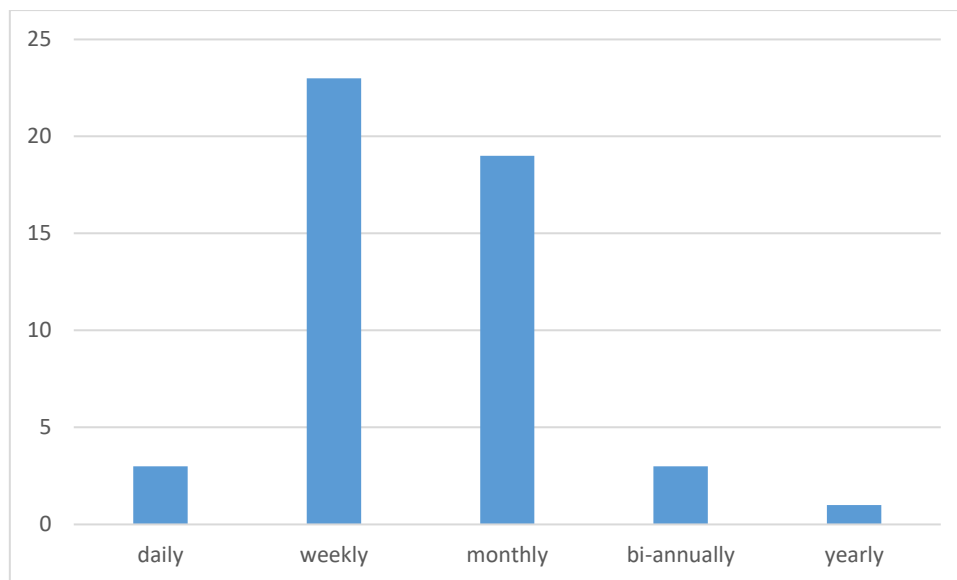


FIG 5: CHART DETAILING STAFF RESPONSES TO HOW OFTEN SELF-HARM IS IDENTIFIED

When looking at participants' job titles, there was also no significant correlation between job title seniority and understanding of how common self-harm is with the Pearson correlation coefficient being 0.811 ($p < 0.05$).

Only two participants (a technician and a teaching assistant) said that they had attended self-harm training.

Participants were also asked if they thought self-harm always indicated that there was a mental health problem. 69% of respondents said that 'yes' self-harm is always a sign of a mental health problem, 26% responded with 'no' and 4% (2n) responded with 'I don't know'.

Of the participants asked, 55% had experience in responding to self-harm and 45% had not.

Participants who had responded to self-harm had an average score of 7.1 for 'how comfortable are you talking about self-harm', compared to 6.6 for those who had not.

Participants were also asked 'who is best placed to support' and given the option of 'adults in school' and 'adults out of school'.

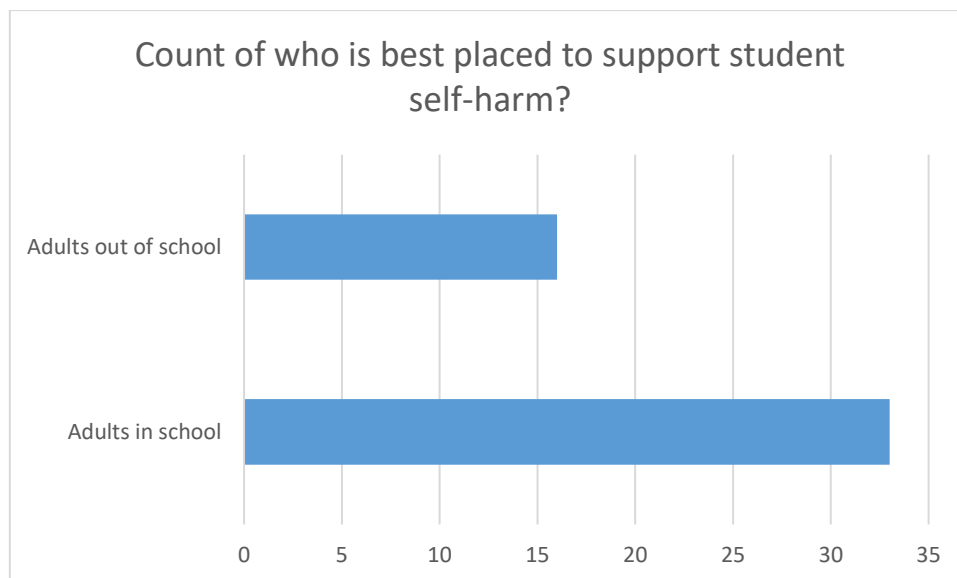


FIG 6: CHART DETAILING STAFF RESPONSES TO WHO IS BEST PLACED TO SUPPORT STUDENTS WHO SELF-HARM

The majority of adults (35n) felt that adults in school were best placed to support students who self-harm, 14 respondents felt the adult best placed was outside of school. Participants were asked who these adults were. A quantitative approach to the qualitative data was taken as all answers were only a few words long and direct with the language used, so there was no need to specify the themes used.

3.2.2 Qualitative analysis of self-harm questionnaire

There were two questions in the questionnaire that were not multiple choice or on a Likert scale (Likert, 1932), instead, a free text box was provided for responses. These questions were:

- The first question links on from the question above of '*who is best placed to support*' where once a choice of '*adults in school*' or '*adults out of school*' was chosen, participants were asked who these adults were
- The second question asked participants who said that they had responded to self-harm '*if yes, how and to what effect?*'

When responding with '*adults in school*', the below table shows which adults the respondents were referring to. Although this was an open question, most responses were only one or two words long so their frequency was collated.

Adults in school	No of responses
Pastoral Team	8
All adults in school	2
Safeguarding officer/manager/team	16
Someone who is trained in self-harm	4
Early Help*	2
Someone the students trusts/is comfortable with	4
Teachers	1

TABLE 3: PARTICIPANT RESPONSES TO WHICH ADULTS IN SCHOOL ARE BEST PLACED TO PROVIDE SUPPORT

*Early help is also known as early intervention and is support given to a family when a problem first emerges. It can be provided at any stage in a child or young person's life. The service is for the family, is optional and a referral is made through social care.

When participants responded with 'adult out of school', their clarified answers were as below.

Adults out of school	No of responses
CAMHS/mental health professionals	6
Counsellors	2
Trained professionals	1
Parents/family	3
Support workers	2
Doctors	1
Social Workers	2
Outside Agencies	1
Health professionals	1

TABLE 4: PARTICIPANT RESPONSES TO WHICH ADULTS OUT OF SCHOOL ARE BEST PLACED TO PROVIDE SUPPORT

One participant added to their response of 'adults out of school' that they did not feel that an adult who has a relationship with a student through supporting their self-harm, should also have another relationship, such as being their teacher. The participant likened this relationship to that of a

counsellor where the role and boundary should not be blurred but should be explicit in supporting only one thing, education or self-harm.

Of the adults in school 28 participants (57%) had an experience of responding to self-harm and all gave some information on how this has occurred. Content analysis (Krippendorff, 2018) was used to count the instances of each theme to continue with the quantitative analysis method of phase one of the research.

The themes that arose from the data (see [Appendix 12](#), page 182) were:

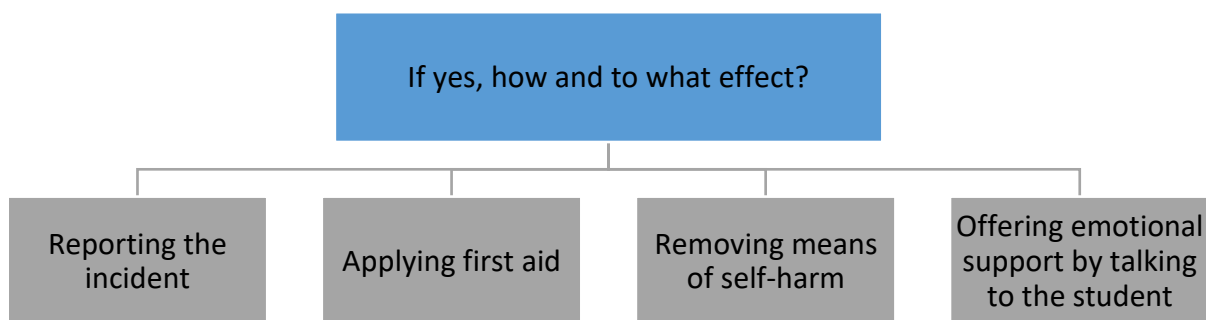


FIG 7: SPIDER DIAGRAM SHOWING THE FOUR DIFFERENT THEMES THAT EMERGED FROM THE QUESTION RESPONSES

- Reporting the incident
19 responses to this question included that either the only action or a part of their response would be to pass this information on to someone who is '*relevant*' or to someone who is '*more equipped than myself*'. Typically reporting included logging the incident on MyConcern (the school's online safeguarding database), speaking to the pupil support centre or the safeguarding lead
- Applying first aid
Three responses of the 19 respondents made note of administering first aid as a first response and making sure '*the wound appeared clean and not infected*'. Only one participant only noted the first aid response whereas the other two responses ended with reporting the incident once first aid had been applied
- Removing means of self-harm
Once identifying the self-harm, four participants described discrete actions that they took as a result. This included '*not allowing certain pupils to have equipment which they may use to self-harm*' and '*not allowing them to use the toilet without supervision*'
- Offering emotional support by talking to the student

Seven participants wrote that they offered the student support through talking to them as '*initial emotional support*'. Some participants recorded this as simply '*talking*' to the student and for all seven of these responses, there was also a comment on the next step being reporting the incident.

3.3: Qualitative data: Phase two

Phase two used classic GT methodology (Holton & Walsh, 2016) as detailed within the [Methodology](#) chapter. The data gathered in phase one of the research, the quantitative phase, was useful for the first round of phase two as it initially helped to guide the focus groups. Participants were invited to add an expression of interest to phase one of the research if they were happy to be contacted regarding phase two. A list of first names was collated and exported to Microsoft Excel where a random cell generator was used to identify which participants would be invited to take part. A random cell generator provides a random selection from a given list with each item in the list having an equal probability of being selected. At the end of each round of data collection, participants were asked if they were happy to be contacted to take part in round two.

When analysing the data at the end of the GT cycles, phase one's data was also relevant. Each 'round' of data was collected and analysed before moving on to the next round using an iterative learning cycle method (Kolb, 1984). This allowed me to immerse myself into the inductive nature of GT, as defined by Glaser (1967), and to follow the data by using the saturated categories of each 'round' as the initial focus of the next.

The purpose of the qualitative data of phase two was to add deep and rich meanings held for secondary school staff around pupil self-harm by speaking with members of the school staff.

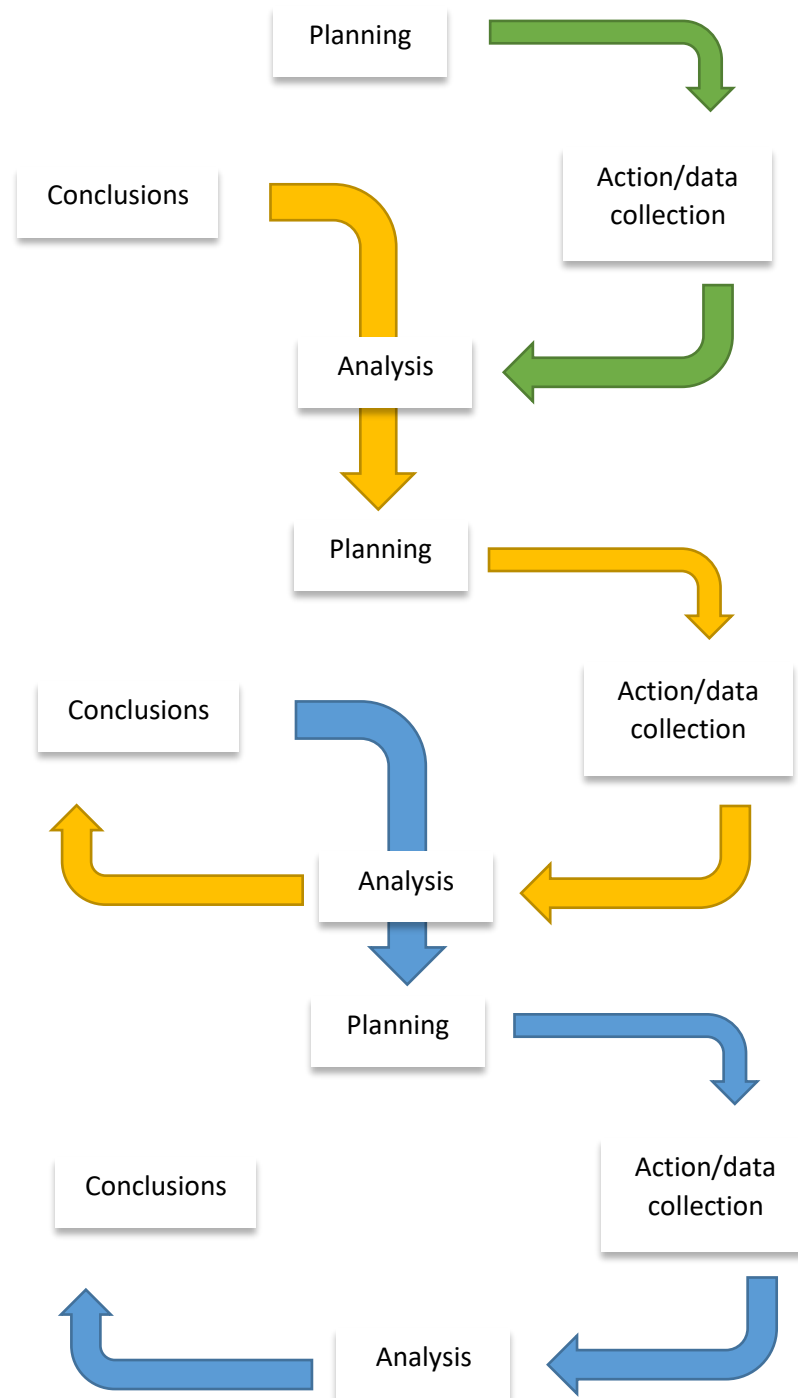


FIG 8: IMAGE DEMONSTRATING THE ITERATIVE CYCLES USED TO GATHER DATA

Figure 8 demonstrates the iterative cycles of data collection that formed the second phase of the research. The first cycle used questions from the questionnaire used in phase one to gather data. This cycle fed into the second by generating a theme to be further explored. Data from the second

cycle was analysed and then the third cycle was used to check in with participants on what was found through the first two cycles.

	Means	Name	Job title
Round one	Focus Group 1	Lucy	Core subject head
		Michael	Technician
	Interview 1	William	Pastoral lead
	Interview 2	Clara	Technician
	Focus Group 2	Claire	Teacher
		Eliza	1:1 tutor
		Louise	Teaching assistant
Round two	Focus Group 3	Eliza	1:1 tutor
		Rachel	SEND lead
	Focus Group 4	Louise	Teaching assistant
		William	Pastoral lead
		Michael	Technician
Round three	Interview 3	Eliza	1:1 tutor
	Interview 4	Louise	Teaching assistant

TABLE 5: TABLE DETAILING THE PARTICIPANTS FOR EACH FOCUS GROUP AND INDIVIDUAL INTERVIEW

Job titles have been slightly adjusted to account for anonymity and all the names appearing here are pseudonyms

Table 5 shows the three rounds of data collection that occurred in the second phase of the research. Each round was made up of focus groups and/or individual interviews and the table demonstrates who attended. The majority of the participants were teaching staff but a mix of job roles took part in the research.

3.3.1 Round one

During Round one, the questions from the questionnaire in phase one were given to participants. As previous responses were anonymous these were not linked to the participants in the focus groups.

The questions were also open-ended instead of closed as they had been previously. This was to give participants the space to elaborate on or explain their previous closed responses. The purpose of this phase was to gather richer information than the quantitative questionnaire had found to further understand how secondary school staff experienced student self-harm.

Round one began with Lucy and Michael. Their experiences were very different from one another. Lucy stated that *'because I used to have a pastoral role in a previous school, erm and also from personal experience, I've dealt with self-harm a lot'* (transcript 1, page 1, line 21-23). However, Michael felt less comfortable, stating *'I think I'm the opposite end of the spectrum. Probably not as comfortable. Erm Just because my role is not student facing'* (transcript 1, page 2, lines 2-3). The two participants took turns answering each of the questions from the questionnaire in phase one of the research.

A sample transcript can be found in [Appendix 9](#) (page 168).

Concepts were drawn from the data and grouped using open and *in-vivo* coding. *In-vivo* coding places emphasis on the actual words that were spoken by the participants and is often used to assist data analysis with GT (Charmaz, 2014).

Category		In-vivo examples	Location
1	Who self-harms?	<i>People that do self-harm aren't always the people that you'd expect.</i>	Transcript 1, Lucy, page 9, line 209
2	Self-harm is a secret – not everyone should know	<i>I wouldn't say that staff are aware of all students who do, it's only those with the severest risk assessments</i>	Transcript 1, Lucy, page 8, line 174-175
		<i>I am aware of certain students, but I think there's probably a few that I'm not aware of</i>	Transcript 1, Michael, page 2, line 43
3	What to do when initially being made aware of self-harm	<i>Deal with the initial disclaimer</i>	Transcript 1, Lucy, page 6, line 125
		<i>Not approaching the student directly</i>	Transcript 1, Lucy, page 6, line 122

Category		In-vivo examples	Location
4	How to help a student who has self-harmed	<i>I know the different pathways that I need to take and how to approach it</i>	Transcript 1 , Lucy, page 6, line 127-128
		<i>I don't think that I know that off the top of my head. But I've got a rough idea as to who I'd go and speak to to seek, you know, guidance from them</i>	Transcript 1, Michael, page 6, line 130-131
5	Self-harm is common and increasing	<i>I would say that, that there is a higher proportion than there was only 10 years ago, of students who do self-harm or exhibit self-harm characteristics</i>	Transcript 1, Lucy, page 2, line 36-38
		<i>Probably more common than I think it is</i>	Transcript 1, Michael, page 2, line 41
6	Training on self-harm is helpful	<i>Training would be useful</i>	Transcript 1, Michael, page 6, line 118
		<i>I think all staff need that knowledge and awareness</i>	Transcript 1, Lucy, page 5, line 105
		<i>If you can spot those signs, and you can intervene at that early stage, then it's less likely to develop into the more severe forms of harm</i>	Transcript 1, Lucy, page 5, line 107-108
7	Why do students self-harm?	<i>Probably at least 80% of them. It's, it's a coping mechanism.</i>	Transcript 1, Lucy, page 4, line 83
		<i>Sometimes it's stress, and it's learning to deal with different coping mechanisms of stress</i>	Transcript 1, Lucy, page 3, line 62
		<i>Could be there is something else going on in the background that needs to be dealt with</i>	Transcript 1, Michael, page 4, line 77
8.	Being confident and comfortable with responding to self-harm	<i>I don't find it something that I become uncomfortable when I need to talk about</i>	Transcript 1, Lucy, page 1, line 22
		<i>Probably not as comfortable, erm just because my role is not student facing</i>	Transcript 1, Michael, page 2, line 24-25
9	Self-harm is emotive and can be personal	<i>There's one student that kind of sticks in mind</i>	Transcript 1, Lucy, page 6, line 142
10	Self-harm as a mental health problem	<i>I don't mean it's indicative... but I think it's something that you always it's something that you need to have in the back of your mind</i>	Transcript 1, Michael, page 4, line 79-80

Category		In-vivo examples	Location
		<i>don't think that it necessarily is down to an issue in terms of mental health</i>	Transcript 1, Lucy, page 3, line 61
11	There are different levels of self-harm	<i>We have students with individual risk assessment plans, who I would say are on a higher level of half harm than others</i>	Transcript 1, Lucy, page 8, line 170-171
		<i>Sometimes it can start mild and get more extreme</i>	Transcript 1, Lucy, page 10, line 215-216
12.	Being scared of self-harm and suicide	<i>The reason people are scared of it is because they can't relate to it</i>	Transcript 1, Lucy, page 10, line 229
		<i>Sadly, she's no longer with us as a result of that self-harm that took place later on.</i>	Transcript 1, Lucy, page 7, line 152-153

TABLE 6: CATEGORIES EMERGING FROM PHASE TWO, ROUND ONE, FOCUS GROUP ONE

This table shows the first twelve categories that emerged from the data that was gathered in the first focus group. There were two participants in attendance, Lucy, a core subject head and Michael, a technician. In-vivo examples were used to demonstrate the quotes that helped to form the category title.

To continue with round one, William, a pastoral worker, was then interviewed. There was no time that William was able to attend alongside other members of staff so he was invited to do the focus group in an interview format instead. The same questions were used in focus group one. By coding William's transcript, the categories above were further filled as well as new ones were created. William was confident in responding to questions and discussing self-harm within his school. Seven new categories were added to the list.

Category		In-vivo examples	Location
13	Impact on staff wellbeing	<i>Really sometimes you take it home with you as well</i>	Transcript 2, William, Page 2, line 31
		<i>I just sometimes feel we don't there's not enough hours to be able to do it within a day.</i>	Transcript 2, William, Page 12, line 275
14	Getting it 'wrong'	<i>I think we need to tread carefully, because obviously you don't, we're not we're in school and non-medical professionals</i>	Transcript 2, William, Page 4, line 91
		<i>Something I personally feel sometimes the more you draw attention to it, the more self-harm happens</i>	Transcript 2, William, Page 9, line 215
15	Parental support	<i>We've got a lot of parents I'm working with a parent at this moment, and she's an incredibly supportive parent</i>	Transcript 2, William, Page 5, lines 102-103
16	Self-harm is a financial problem	<i>We need more funding to help provide either train or in house more people who can be a counsellor</i>	Transcript 2, William, Page 11, lines 258-259
17	Safeguarding against self-harm	<i>Making sure we remove any harm to them immediately</i>	Transcript 2, William, Page 8, lines 178-179
		<i>Want to let parents know if they can remove any sharp items, for example, within the bathroom razorblades</i>	Transcript 2, William, Page 8, lines 191-192
		<i>What we see a lot is razors from pencil sharpeners</i>	Transcript 2, William, Page 8, line 173

TABLE 7: ADDITIONAL CATEGORIES EMERGING FROM PHASE TWO, ROUND ONE, INTERVIEW ONE

This table shows an additional five categories that emerged from the data that was gathered in the first interview that was with William, a pastoral lead. The rest of William's data was able to fit into the prior twelve categories that emerged in focus group one and are shared in Table 6 above.

At this stage, using open coding, a large number of categories were created with the goal of reducing them once round one of the data collection was completed.

Clara, a technician was also unable to meet at the same time as other participants so she also completed a 1:1 interview that was again structured the same as the previous interview and focus

group. When Clara was asked if she was comfortable talking about self-harm, she said '*obviously, it's not a nice thing to talk about. But I'd rather they did talk about it than bottled it all up.*' By pulling out different concepts within Clara's transcript, previous categories were further added to, and only one new category was created. This indicated that this round of data collection was coming to a close as fewer categories were being added to the list suggesting saturation. The new category is below.

Category		In-vivo examples	Location
18	Effect on staff	<i>that's really difficult to deal with, especially when you're in a busy, practical classroom</i>	Transcript 3 (Clara), page 5, line 89

TABLE 8: ADDITIONAL CATEGORY EMERGING FROM PHASE TWO, ROUND ONE, INTERVIEW TWO

This table shows one additional category that emerged from interview two, with Clara, a technician. The rest of Clara's data was able to fit into the prior 17 categories that had previously emerged and are shared in Table 6 and 7 above.

At this stage, using open coding, a large number of categories were created with the goal of reducing them once round one of data collection was completed.

One last focus group was delivered to complete round one of data gathering to further saturate the categories before following the data to focus in on a shorter list of categories. This focus group only introduced one new category, bringing the total to 19.

Category		In-vivo examples	Location
19	Adult self-harm	<i>It's not just students that self-harm. It's we've got to support our colleagues as well</i>	Transcript 4, Claire, page 5, line 93-94

TABLE 9: ADDITIONAL CATEGORY EMERGING FROM PHASE TWO, ROUND ONE, FOCUS GROUP TWO

This table shows one additional category that emerged from focus group two. In attendance was Claire, a teacher, Eliza, a 1:1 tutor and Louise who was a teaching assistant. The rest of the focus group's data was able to fit into the prior 18 categories that had previously emerged and are shared in the tables above.

I took this initial set of 19 categories to supervision and with help from my supervisor, we condensed the categories further into ten (see table 10 below). Some of the previous categories overlapped and it was only as more data was collected that this became clear so these were merged using mutual exclusiveness. As GT follows the data, which was analysed as it was collected, the condensing of categories was more useful to occur at the end of round one. The titles of the categories were also amended if needed based on the following data that fell into that category.

Category		In-vivo examples	Location
1	Who self-harms and why?	<i>You can be brought up in the most loving, caring, supportive family, and yet still feel that everything you do isn't good enough, and that you need to punish yourself for that. And as a result of that self-harm can come</i>	Transcript 1, Lucy, page 9, line 204-206
		<i>I feel schools who, within in more deprived socio economic deprivation areas will see an incredible lot more</i>	Transcript 2, William, page 11, line 251-252
2	Only certain people need to know about student self-harm	<i>I think it's important letting staff know but giving a PG version</i>	Transcript 2, William, page 8, line 197
		<i>You log your concern and then you for protection. You don't hear anything else</i>	Transcript 3, Clara, page 4, line 66-67
3	How adults respond to and think about student self-harm	<i>The main thing I would do would be to pass that on into log it on my concern</i>	Transcript 4, Louise, page 2, line 24-25
		<i>It's very, you need to be very clear in saying, well, I'm now going to, I can't keep this to myself, because we need to, we need to help, we need to help here</i>	Transcript 2, William, page 7, line 165-167
4	Supporting students who self-harm in the medium/long term	<i>She went down the route of needing CAMHS, and having full CAMHS support while she was at school</i>	Transcript 1, Lucy, page 7, line 151-152
		<i>We've got a quite a big support centre. So we've got people that come in every week anyway, so there's always going to be support around for them.</i>	Transcript 3, Clara, page 4, line 80-81

Category		In-vivo examples	Location
5	More student are self-harming now than before	<i>We're seeing more and more risk assessments now being put in place quite a lot for mental health and self-harm now</i>	Transcript 2, William, page 9, line 210
		<i>It's part of my normal day</i>	Transcript 4, Eliza, page 1, line 16
6	Training is important in supporting self-harm	<i>The teaching staff are sort of they see people more all in class, so I think they could be given some advice on how to potentially see them to see the first point of how it starts.</i>	Transcript 2, William, page 6, line 126-127
		<i>It'd be good for the whole school to be trained on something like self-harm</i>	Transcript 4, Louise, page 8, line 175
7	Self-harm is scary and links to suicide	<i>Sadly, she's no longer with us as a result of that self-harm that took place later on</i>	Transcript 1, Lucy, page 7, line 152
		<i>They've said that they've had potential suicidal thoughts</i>	Transcript 2, William, page 6-7, line 146-147
8	Parental support	<i>Hopefully there will be support available for them at home so that when they're at home, and perhaps that might be time when they're more vulnerable to, to self-harming</i>	Transcript 4, Eliza, page 8, line 162-164
		<i>We've got a lot of parents I'm working with a parent at this moment, and she's an incredibly supportive parent</i>	Transcript 2, William, page 5, line 102-103
9	Self-harm is a financial issue	<i>I feel it could come down to a point of monetary value being placed on the school to give extra funding to actually help</i>	Transcript 2, William, page 11, line 252-253
		<i>If the money's not there, unfortunately, we just cannot physically afford it</i>	Transcript 2, William, page 12, line 285

Category		In-vivo examples	Location
10	Adult's self-harm too	<i>It's not just students that self-harm. It's we've got to support our colleagues as well</i>	Transcript 4, Claire, page 5, line 93-94

TABLE 10: SET OF CATEGORIES FROM PHASE TWO, ROUND ONE OF DATA COLLECTION

Table ten details ten categories with *in-vivo* examples across all four transcripts. The categories were condensed from those found across round one of data collection. Categories that were not fully represented were removed

Ten categories were created from the original 19 by condensing the data. This was still a large number of categories that would need to be further condensed to be able to effectively explore the data in round two. To help decide which categories to develop further, any categories that were not fully represented by all participants in round one of data collection were removed with the suggestion that these can be picked up for future research (see [Discussion](#), page 91). This left the research with five categories which are shown in table eleven. The titles of the categories were also amended if needed based on the following data that fell into that category. An *in-vivo* example is listed from each focus group or interview to demonstrate how the category was fully represented across round one.

Category		Examples	Location
1	Only certain people need to know about pupil self-harm	<i>I wouldn't say that staff are aware of all students who do, it's only those with the severest risk assessments</i>	Transcript 1, Lucy, page 8, line 174-175
		<i>It's just liaising in such a way that everybody is aware. But sometimes people don't need to know</i>	Transcript 2, William, page 9, line 204
		<i>You don't hear anything else. So it all goes quiet because it's confidential</i>	Transcript 3, Clara, page 4, line 67-68
		<i>Others are a lot more they want to keep it hidden</i>	Transcript 4, Louise, page 4, lines 71-72

Category	Examples	Location
2 How adults respond to and think about student self-harm	<i>I think there are cases where it's not indicative that there is a mental health problem</i>	Transcript 1, Michael, page 4, line 76
	<i>really sometimes you take it home with you as well</i>	Transcript 2, William, page 1, line 31
	<i>it's not a nice thing to talk about</i>	Transcript 3, Clara, page 1, Line 17
	<i>the main thing I would do would be to pass that on into log it on my concern</i>	Transcript 4, Louise, page 4, lines 24-25
3 Supporting students who self-harm in the medium/long term	<i>I think it's very much down to why the student is health self-harming in the first place as to what support they need to put in place</i>	Transcript 1, Lucy, page 8, line 183-184
	<i>The waiting list for CAMHS is ridiculous</i>	Transcript 2, William, page 10, lines 241-242
	<i>It tends to be the Support Centre because they're the ones that do all the pastoral care</i>	Transcript 3, Clara, page 4, lines 73-74
	<i>If they are being supported by outside agents? Well, that's, that's better. In my opinion</i>	Transcript 4, Eliza, page 8, lines 166-167
4 More students are self-harming now than before	<i>I would say that, that there is a higher proportion than there was only 10 years ago, of students who do self-harm or exhibit self-harm characteristics</i>	Transcript 1, Lucy, page 2 line 36-38
	<i>I feel it's becoming a lot more, a lot more mainstream now</i>	Transcript 2, William, page 13, lines 300-301
	<i>It's still alarmingly high compared to when I first started in education</i>	Transcript 3, Clara, page 2, lines 25-26
	<i>We've not even reached a peak yet I don't think</i>	Transcript 4, Claire, page 2, line 39

Category		Examples	Location
5	Training is important in supporting self-harm	<i>Training would be useful</i>	Transcript 1, Michael, page 6, line 118
		<i>I think all staff could do with a basic on it</i>	Transcript 2, William, page 6, line 125
		<i>It's important that everyone's aware of it, and everyone can see and help.</i>	Transcript 3, Clara, page 3, lines 49-50
		<i>We need to know how to deal with it.</i>	Transcript 4, Claire, page 9, line 185

TABLE 11: FULLY REPRESENTED CATEGORIES FROM PHASE TWO, ROUND ONE OF DATA COLLECTION

One category which was based on a theme that was repeatedly represented '*how adults respond to and think about self-harm*' was chosen to move forward with the research. The most saturated category at this stage, supported by 99 individual comments across round one's two interviews and two focus groups, was: '*How adults respond to and think about student self-harm*'.

This category encompassed many different subcategories which were difficult to pull apart, but before looking at the data again to gain further understanding, I considered the themes that were already emerging and tried to capture the '*essence of the phenomenon*' (Berker et al, 2002). At this stage, the themes that I was identifying and wished to explore further are detailed in the image below. These themes were emerging from the transcripts and each made me consider the impact of the theme, the 'so what?' My curiosity, as a researcher, into these themes suggested that there would be more information to collect and more discussion that could help to build these themes further.

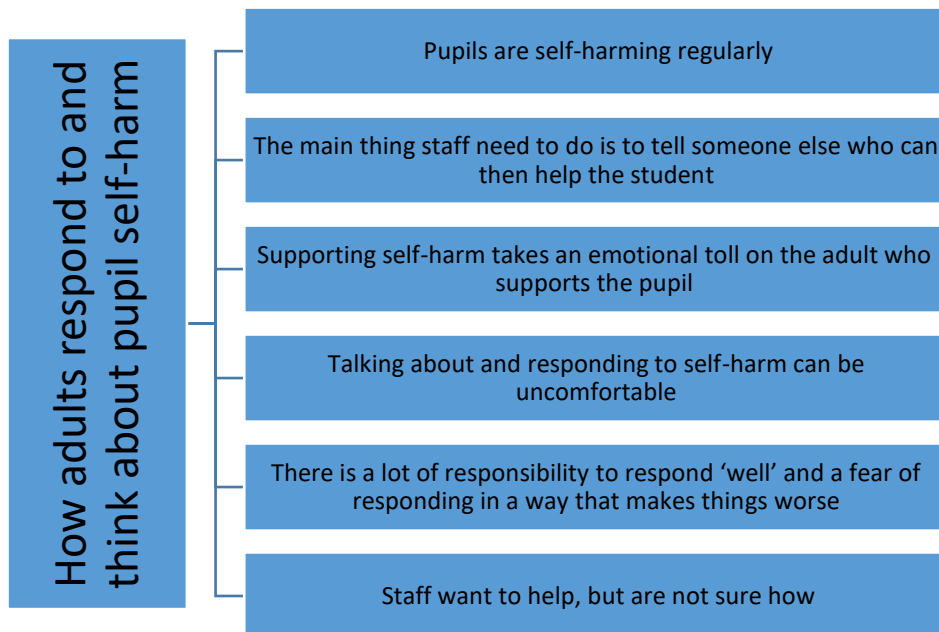


FIG 9: IMAGE DEMONSTRATING THE SIX DIFFERENT THEMES THAT WERE EMERGING FROM THE 'HOW ADULTS RESPOND TO AND THINK ABOUT STUDENT SELF-HARM CATEGORY'.

After re-listening to the recordings and re-reading the transcripts, with the above themes in mind, I created a list of questions to help decide what to do with the next steps and discussed this in supervision. This list of questions that were not used can be found in [Appendix 14](#) (page 191).

I was keen to use a 'Grand Tour' question (Simmons, 2010) which focused on a smaller range of categories. This would result in my question still being open and broad, alongside honing in on one of the categories. A grand tour question allows the group to open up discussions in a way that does not preconceive the direction that the conversation will take (Holton & Walsh, 2017).

One particular comment that struck me in round one of the focus groups was how staff in schools, count in scissors and sharpeners as a part of their risk assessment to help prevent self-harm.

Can we just be mindful of when handing scissors out? Can we please count them back in? Can we not give pencil sharpeners out? Can we just give them a new pencil (Transcript 2, page 9, line 206-208)

Memo: Counting the sharpeners

I found it particularly interesting that this information was shared with me as though it was just an everyday and obvious step in keeping students safe. However, I also found it to be a contradiction.

Many participants spoke about how self-harm is a means of coping, and then they spoke about removing this means of coping as though that was the end of the support required. This evidently means it is a short-term preventative tool.

Alongside this, most of the self-harm cases I have supported with all involved young people bringing blades into school, even though they were searched on arrival. The blades were hidden and not found by the members of staff who searched them. So as well as being short-term, I wonder about the effectiveness.

It seems that perhaps counting the sharpeners or scalpels or not allowing students to be unsupervised, helps the member of staff to feel better and that they have taken steps to prevent self-harm. Yet the action is likely to either remove the student's means of coping, or they will find another means – so although seen by the school as an essential step, I wonder about its effectiveness.

At this stage, to remain true to the GT approach, only a [shorter initial literature review](#) had been completed but although counting the sharpeners could be seen as a proactive step, it is not something I have heard mentioned before. I also felt that it encompassed the chosen category. I decided to take this forward to round two.

3.3.2 Round two

For round two, the working thesis title was shared with participants as a grand tour question (Simmons, 2010) (see [Appendix 8](#), page 167). Using a grand tour question (Simmons, 2010) allowed me to capture elements of all six of the themes outlined in figure 9 with just one question which results in less direction from the researcher during the focus groups. This helps to limit the amount of researcher bias alongside covering each of the previous themes.

Counting the sharpeners: A Grounded Theory study exploring school staff experience of student self-harm

Memo: Reflection on grand tour questions

Having collected the data for round two, I am glad that I took the position that a grand tour question would not be suitable for an individual interview. The focus group with three participants ran more smoothly than the one with two. It was not a difficult focus group, but there was a long silence at the beginning which I imagined felt uncomfortable for the participants, I broke this silence after around two minutes and discussion began, but I imagine this may have been more intense on a 1:1 with the participant perhaps feeling pressure to answer 'well'.

Data gathered from round two was analysed in the same way as previously but with the main category being 'how adults respond to and think about student self-harm' with subcategories being created. Four sub categories were created from focus group three. The subcategories were nested in the six themes detailed in figure 9 (page 65) which suggests that the data is working toward saturation.

Sub-category		Examples	Location
1	Actions taken to remove risk of self-harm	<i>I never have any pencil sharpeners in my room</i>	Transcript 5, Eliza, page 2, line 21
		<i>Count them in, count them out, count them out, then count them in. You know, just to ensure that students aren't getting hold of something that they can use, for self-harm</i>	Transcript 5, Rachel, page 3, line 57-58
2	Removing means to self-harm is done without thinking	<i>It's just having that almost sort of subconscious it's, it feels like a sort of subconscious awareness of pencil sharpeners</i>	Transcript 5, Eliza, page 3, line 51-52
3	Having to prevent self-harm is new	<i>There would have been a time when we would have had a block of scissors in a classroom or a drawer of scissors</i>	Transcript 5, Rachel, page 3, line 56-57
4	Student's will self-harm regardless of staff actions	<i>Students will, you know, utilise anything really, if they want to self-harm</i>	Transcript 5, Rachel, page 3, line 67

TABLE 12: SUBCATEGORIES EMERGING FROM PHASE TWO, ROUND TWO, FOCUS GROUP THREE

Focus group four lasted for 23 minutes which was longer than focus group three which only lasted for 12 minutes. Within focus group three, participants engaged in dialogues with one another which helped to facilitate a discussion. The grand tour question (Simmons, 2010) felt like a good fit for this group and lots of data was collected with further themes added to the table above.

Sub-category		Examples	Location
5	Risk assessments	<i>The actual volume of risk assessments that we've got, try and actually remember, which, which student has the risk assessment, but then also, what each individual has, for their specific needs</i>	Transcript 6, William, page 2, line 45-47
6	The effect on staff of student self-harm	<i>Sometimes that panic that you have, in a classroom thinking, making sure that no one could have anything that they could harm themselves with.</i>	Transcript 6, Louise, page 2, line 38-39
		<i>It sometimes can really, really hit you, you sort of freeze</i>	Transcript 6, William, page 3, line 62-63
7	Are preventative actions taking it too far?	<i>Over protecting and sort of not allowing for the children and young people their own experience of what the classroom are like if we're getting to a point where we're thinking like, gosh, you can't even have a ruler</i>	Transcript 6, William, page 4, line 76-78
		<i>Are we not allowing students to actually get on with their day to day</i>	Transcript 6, William, page 4, line 76-77
		<i>If we're targeting too a bit too much, and over protecting them, it could then actually lead to a bit more of a detrimental effect on them</i>	Transcript 6, William, page 5, Line 106-107
8	Why are the students self-harming?	<i>I know self-harm can sometimes be a bit of a shout for help</i>	Transcript 6, Michael, page 4, line 82-83

TABLE 13: ADDITIONAL SUBCATEGORIES EMERGING FROM PHASE TWO, ROUND TWO, FOCUS GROUP FOUR

Memo: Helping students?

It is interesting that staff recognise that pupils are self-harming because they need help, or cannot cope, but the support provided to them removes the means of self-harm and therefore removes their means of coping. From The staff's understanding of why pupils self-harm, their actions of removing or reducing the risk, does not 'help' the pupil, but instead reduce the incidents of self-harm.

From round two of the second phase of data collection, I had learnt that all members of staff who took part (including a teaching assistant, pastoral worker, technicians, 1:1 tutor and teacher) were familiar with removing items in the classroom that students could use to self-harm. Most had added that they now remove the risk of self-harm without even thinking about it and that it is just a part of their role.

Furthermore, when a student is known to self-harm, they are given a risk assessment that all adults who work with them are made aware of and will know which actions need to be taken that are detailed in the risk assessment. This generally includes removing sharp objects and ensuring they are supervised at all times. Although staff members will know which steps to take from the risk assessment, they do not know, generally, how to support students who self-harm. Members of staff follow the risk assessments but they are unsure if they are effective.

School staff are worried about 'getting it wrong' when they speak with a student who is known to self-harm. They do not want to say the wrong thing or increase the likelihood of self-harm by giving access to sharp objects. This is something that they worry about.

Memo: Thesis title

I also received comments directly relating to the use of the title. This was positive and assured me that I was on the right track but also that I should use the title for my thesis. The participants have made the research so I feel positive about the idea that they helped to create and gave feedback on the title itself.

'I think it's quite a grabbing thesis title' – Transcript 6 (Louise, William & Michael), page 2, line 24

'It's a good open title' – Transcript 6 (Louise, William & Michael), page 2, line 44

3.3.3 Round three

Round three of data collection was used to check in with what I had found. Eliza, a 1:1 tutor and Louise, a teaching assistant who had taken part in both round one and round two, took part in individual interviews. I decided to again ask the same grand tour question to the participants in case they had further reflections since they were previously asked. I then asked two extra questions. These were:

- *When we think of ‘counting the sharpeners’, in terms of preventing and supporting self-harm, do we think that it’s enough?*
- *What are some of the barriers to doing more than ‘counting the sharpeners’?*

At this stage, participants were getting to the end of the school year so it was becoming more difficult for them to become available. Round three included two 1:1 interviews. The interviews were both fairly short. The data was looked at combined, as the interviews were conducted on the same day. The responses iterated that my interpretation and analysis of what I was learning was similar to what the participants were thinking.

When we think of ‘counting the sharpeners’, in terms of preventing and supporting self-harm, do we think that it’s enough?

Categories	In-vivo example	Location
Counting the sharpeners is not enough	<i>No, definitely not</i>	Transcript 8, Louise, page 1, line 21
	<i>No, not at all.</i>	Transcript 7, Eliza, page 1, line 22
	<i>No, I don't think it's enough</i>	Transcript 7, Eliza. page 1, line 23
Counting the sharpeners is a good starting place	<i>It covers, you know, what we think is potential harm for the student</i>	Transcript 8, Louise, page 1, line 21-22
	<i>I think it's a practical starting place</i>	Transcript 7, Eliza, page 1, line 22

Categories	In-vivo example	Location
Counting the sharpeners does not 'treat' a problem, it prevents an action rather than helping a problem	<i>But it doesn't look at the deeper issues of why the student is doing that, and what support there is to help them to find other strategies to deal with whatever, you know, ever what they're going through, you know, be it anxiety or whatever other mental health issue</i>	Transcript 8, Louise, page 1-2, line 22-24
	<i>It's like treating what they what they could potentially do to themselves, but it's not helping, you know, what, what is triggering it in the beginning</i>	Transcript 8, Louise, page 2, line 24-26
Taking actions to remove items that could be used to self-harm is not preparing young people for adulthood when this safeguarding will not be present	<i>In the long run, it's not going to help students who then become adults, it's not going to help them further down the line is it.</i>	Transcript 8, Louise, page 2, line 31-33

TABLE 14: CATEGORIES EMERGING FROM PHASE TWO, ROUND THREE, INTERVIEW THREE

Table 14 shows the categories that emerged from the two individual examples with in-vivo examples when responding to the question of 'when we think of 'counting the sharpeners', in terms of preventing and supporting self-harm, do we think that it's enough?

The second question that was asked in the interview was 'what are some of the barriers to doing more than 'counting the sharpeners'?'

Barriers	In vivo examples	Location
Time	<i>There's not enough hours in the day at school</i>	Transcript 7, page 2, lines 42-43
	<i>It's a big job</i>	Transcript 7, page 3, line 59
Resources	<i>There's not always the time and, you know, resources to enable us to deal with all of those things</i>	Transcript 7, page 2, lines 29-90
Priority is education	<i>During that time, we've also got to educate them as well</i>	Transcript 7, page 2, lines 44-45
Difficult to access services	<i>I know obviously, there's long waiting lists for, you know, for young people to see mental health professionals</i>	Transcript 7, page 2-3, lines 47-48
No way out	<i>And there's nothing. There's nothing we can do about that as a school really</i>	Transcript 7, Eliza, page 2, lines 51-52
Financial	<i>Always comes down to funding</i>	Transcript 8, Louise page 2, lines 31
Understanding of self-harm	<i>Training, education across the whole school</i>	Transcript 8, Louise, page 2, lines 31
	<i>I think all members of staff should be fully trained, fully aware, there's sometimes discrepancies between people's understanding of why young people self-harm.</i>	Transcript 8, Louise, page 2, lines 31-33
	<i>I think that there are varying ideas about why some people self-harm, and I think sometimes sometimes staff can think that it's a attention seeking thing, or not really understand how it reflects on mental health</i>	Transcript 8, Louise, page 2, lines 42-44
	<i>I think it's about educating people</i>	Transcript 8, Louise, page 3, lines 50
Family support	<i>It's about educating parents as well, so that as parents are working together with us, it's working with the young people themselves.</i>	Transcript 8, Louise, page 2, lines 34-35

TABLE 15: CATEGORIES EMERGING FROM PHASE TWO, ROUND THREE, INTERVIEW FOUR

Table 15 shows the categories that emerged from the two individual examples with *in-vivo* examples when responding to the question 'what are some of the barriers to doing more than counting the sharpeners?'

Staff within the school are aware that the actions they are taking to prevent self-harm, are not enough and do not provide the student with the support that they need. However, they also feel positive that they are doing something, and feel that there are many barriers to prevent them from doing more.

Chapter 4 Literature Review

4.1 Chapter overview

This chapter is based on themes of the data gathering in [Chapter 3](#) (page 49). The below literature review considers the contributory factors to the findings, in addition to how to support children and young people who self-harm, including consideration of teacher stress.

4.2 Introduction

Staff in education settings have been given the responsibility, for many years, to implement universal mental health interventions and to refer those students who may need more targeted support (Adelman & Taylor, 1993; Moore et al, 2015; Reinke, Stormont, Herman, Puri & Goel, 2011; Rones & Hoagwood, 2000; Wells, Barlow & Stewart-Brown, 2003). This responsibility has only increased, and evidence consistently suggests that mental health in young people is a rising concern (Sharpe et al, 2016). Alongside this increasing concern, there have been cuts in specialist mental health support with a report in 2018 declaring both a crisis in funding and staffing when comparing 2013 to 2018 (Trades Union Congress, 2018). Although on the surface this is not evident, as the amount of money given to mental health trusts in England has risen. The disparity occurs when inflation is also taken into account and in 2018 it was reported that mental health trusts received £105 million less than in 2011-2012 (Royal College of Psychiatrists, 2018). The direct consequence of this that we see for children and young people is the limited provision and long waiting lists, which act as a barrier to young people receiving the support that they need. A larger responsibility for supporting young people's mental health has been placed on schools as a result of Future in Mind (Department of Health & NHS England, 2015) and the response via the green paper (Department for Health and Department for Education, 2017).

4.3 What is self-harm?

Evans et al, describe adolescent self-harm as a 'major public health concern' across England and Wales (2018). Their research, which included responses from representatives of 153 schools, found that student self-harm is a major concern for senior leadership teams. To summarise the information found within that section of the research, self-harm is a rising concern for children and young people in secondary schools. The statistics appear to be increasing and schools have a role in supporting these students.

Rethink (2002), an organisation to help improve the lives of those severely affected by mental illness, have an online self-harm factsheet, which describes self-harm as not being a mental illness, but as often being linked to mental distress. Within the DSM-V, self-harm is not listed as a mental health problem in and of itself, it is, however, a common symptom or indicator of many other mental health difficulties. (Turp 1999; 2002) suggests that self-harm is a type of self-care and instead it would be preferable to view self-harm as being on a continuum, with good enough (Winnicott, 1960) self-care at one end of the scale, and severe self-harm at the other. To assume that self-harm is always related to a mental health problem also suggests a one-size-fits-all approach. Adopting Turp's continuum view will help to avoid pathologising young people who self-harm. Doyle et al, (2017) add that '*self-harm should be understood as a meaningful behaviour rather than a symptom of an illness*' (p. 134).

4.4 Risk factors

A systematic review by Edmondson, Brennan and House (2016), found when reviewing literature that reported first-hand accounts of the reasoning behind self-harm, that most participants responded with '*multiple reasons for self-harm as applying to them*' (p. 112), demonstrating that there is not only one set of circumstances which will result in a young person self-harming. There is, however, a vast amount of research that collates the different risk factors which may result in a young person self-harming. Although not helpful for identifying every young person that will self-harm, the fact that there are common characteristics of young people who self-harm, is helpful when looking at prevention and developing support and interventions.

Memo: Identifying self-harm

It is important to highlight the risk factors of self-harm as it can support staff who do not feel competent or confident in identifying and supporting self-harm to be more aware of those pupils that are, statistically, more likely to self-harm and to also develop interventions and strategies of support. This is the information that I think school staff want as it helps to improve their confidence in 'what to look for'. Although likely helpful, the idea that a young person can be broken down into a list of 'risks' that has made them more likely to self-harm than their peers, is something I am very uncomfortable with. This idea is extremely limiting and does not detail the complexities that are taking place. I think this is a dilemma in many fields, but speaking from an educational psychology view, I am torn between a humanistic paradigm that would not reduce anyone to a list of 'risks', but also an awareness that by simply increasing staffs' confidence in

identifying self-harm, could help more children and young people. Statistics mean nothing to an individual but schools are working with often large populations and this information could be helpful in the prevention and identification of students who self-harm.

Young girls aged 15-19 years are one of the largest groups of people that are likely to self-harm (Hawton et al, 2007; Marchant et al, 2020). Young people living with one parent were also found to have higher rates of self-harm, as well as those who had experienced bullying (Hawton, 2002). Students who were worried about their sexual orientation were also found to have higher rates of self-harm, as well as those experiencing, mental health problems (such as anxiety and depression), difficult family circumstances and a disrupted upbringing (Hawton, 2002; Fox & Hawton, 2004). Farooq et al (2021), found, in an observational study where data was collected from five general hospitals in Manchester, Oxford and Derby, that an increase in self-harm rates was higher for those aged ten to nineteen years old in minority ethnic groups. They suggested that this was likely linked to the fact that they were more likely to live in areas of high deprivation. However, it is important to note that not all people who occupy such characteristics will self-harm.

Risk factors and the reasons why people self-harm will be highly interlinked, for example, a young person who experiences high levels of anxiety and low mood is more likely to self-harm (Hawton 2002; Fox & Hawton, 2004) but also young people who self-harm have also expressed that feelings of anxiety resulted in them self-harming. School staff need to be aware of both the possible risk factors as well as the individual reasons why a young person has self-harmed. The reason being that risk factors can give professionals the means to develop interventions and preventative tools at a more general and whole-school level, whereas the individual reason why someone is self-harming will help to create targeted intervention, and/or support for that particular student. There are many different reasons why young people tell us, either during adolescence or retrospectively as adults, why they self-harm. One thing that is apparent across research, and the experiences of most adult professionals who work with young people, is that there is no one 'type' of person who will self-harm. There is now an increasing understanding that self-harm is in response to emotional distress and that it is used to cope. Fox and Hawton (2004) add that self-harm rarely begins as the result of one isolated difficulty or event, but instead is more complex and a result of multiple different experiences.

4.5 The cycle of self-harm

There is some biological information which can help to explain why some people may self-harm. For some individuals, research suggests that neurochemicals can play an important role in self-harming behaviour (Bresin & Gordon, 2013; Smith, Cox & Saradjian, 1999; Sandman & Hetrick, 1995). The neurochemicals involved are endogenous opioids and serotonin and they are released when both humans and animals perceive they are in danger or if the body is hurt (Bigliardi, Sumanovski, Büchner, Rufli, & Bigliardi-Qi, 2003; O'Benar, Hannon, Peterson & Bossone, 1987). When they are released, the individual will unlikely feel any pain but instead are likely to feel calm. For some people, it may be that this feeling is what they are seeking when they self-harm. The role of neurochemicals and the biological effect of self-harm is not regularly seen in the research around self-harm but could be a contributing factor to why self-harm is described as an 'addiction' for some (Brown & Kimball, 2012; Harvey & Brown, 2012; Sandman & Hetrick, 1995).

The idea that self-harm is an addiction is also contested and seen as controversial (Strong, 1998; Sutton, 2007). To describe it as such is to pathologise the process unnecessarily (Babiker & Arnold, 1997) which, as previously discussed, could prevent an individual from reaching out for help. Regardless of whether self-harm should be described as an 'addiction', the behaviour does often predict future instances (Spirito & Esposito-Smythers, 2006; Hawton et al, 2007).

Memo: Educational Psychology

Working in the field of educational psychology, a pathologising model is rarely used when describing difficulties that a young person may be experiencing, so the idea that self-harm is a biological addiction, feels very deterministic and I would worry that if described as such, it could become a self-fulfilling prophecy where we entirely undermine the individual's ability to make decisions and to break out of the 'cycle'.

However, the fact that the language feels uncomfortable to me and others within the research, does not mean that every young person who self-harms would agree and perhaps to some, it would help them to make sense of their behaviours.

Once an individual has begun to engage in self-harming behaviours, they can become embedded in a 'self-harm cycle' (Sutton, 2007).

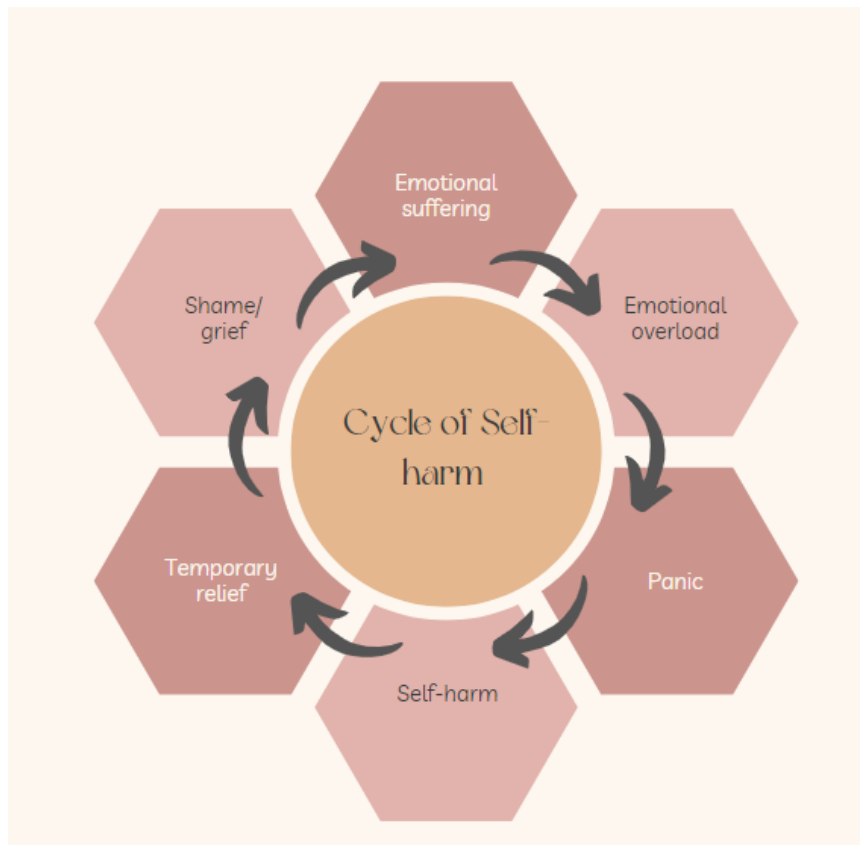


FIG 10: CYCLE OF SELF HARM – IMAGE ADAPTED FROM SUTTON, 2007. P. 187

The image above visually demonstrates a self-harm cycle (Sutton, 2007). The cycle suggests that someone will self-harm if they are experiencing emotional suffering which can lead to a feeling of being overwhelmed. At this stage, the individual may panic and then engage in self-harming behaviours. Whilst this provides temporary relief, it then leads to feelings of shame and grief, which then contributes to the emotional suffering that they were already feeling, which can then result in an emotional overload. The cycle will continue unless it is broken at one of the stages.

The self-harm cycle, as shown in the picture depicts how the feelings that self-harm can evoke can then lead to further self-harm. Research does show that one incident of self-harm is a strong predictor of future incidents (Spirito & Esposito-Smythers, 2006; Hawton et al, 2007). It can be difficult to break out of this cycle and a replacement behaviour will likely be needed.

4.6 The role of social media in contributing to self-harm

Self-harm has become more prevalent in public life, with celebrities and public figure sharing their stories of overcoming self-harm (Biernesser et al, 2020), as well as self-harm becoming a regular

topic in documentaries and on TV shows that are often targeted at young people (Hawton et al, 2002). Social Media is also a part of most young people's everyday life, with 96% of young people using at least one social media site (Office for National Statistics, 2017). Exposure to self-harm on Instagram, a social media platform which in 2018 was reported to have over one billion monthly users (Instagram, 2019), may lead to a triggering effect of imitating self-harm behaviours (Arendt, 2019; Brown et al, 2017). Arendt, Scherr & Romer found in 2019, that when following 729 young adults, aged 18 to 29, in America, exposure to self-harm, specifically on Instagram, predicted self-harm behaviours one month later. It is important to note, however, that participants were all recruited from gaming websites and were told that they would be taking part in an anonymous survey regarding media content that features suicide.

The impact of social media on young people who self-harm is often considered a social contagion effect. This is the idea that seeing others' self-harm could increase the risk of the viewer also engaging in the behaviour. This topic has been researched in real life interactions with Hawton, Rodham and Evans (2006) finding that young people who have a friend that has self-harmed in the previous year, are more likely to engage in self-harming behaviours themselves. The same has been found in social media and observing self-harm online has been discussed as a contributing factor to self-harm and suicide (Daine et al, 2013; Hawton et al, 2012; Seong et al, 2021). Molly Russell was a fourteen-year-old living in Harlow, who died from self-harm in November 2017. This particular case made national news (Hardy, 2022). The inquest into Molly's death found that social media content played a role in Molly's self-harm and resulting death with the official statement reading that her death was a result of:

'An act of self-harm while suffering from depression and the negative effects of online content'

It was following Molly's death, alongside other events that also generated significant news coverage, that addressing self-harm online was seen to be a critical issue (Smith & Cipolli, 2021). Many of the hashtags that Molly searched for have consequently been blocked from Instagram, but the national news of Molly's death demonstrates the possible dangers of social media and its impact on young people's self-harm. Furthermore, the Millennium Cohort Study (MCS) found links between social media use and depressive symptoms, which was a stronger link for girls than boys (Kelly et al, 2019) again demonstrating the link between social media and mental ill health.

There is also research suggesting the benefits of social media for young people who self-harm. Social media allows young people the space to share their experiences (Rodham, Gavin & Miles, 2007), gain a sense of belonging (Baker & Fortune, 2008; Jones et al, 2011; Dyson et al, 2016) and reduce

feelings of isolation (Ziebland & Wyke, 2012; Daine et al, 2013). Daine et al, 2013 also suggest that a sense of belonging, intimacy and community online, may reduce and stop destructive desires.

Furthermore, Sedgwick, Epstein, Dutta and Ougrin (2019), concluded that when looking at suicide attempts and problematic (also defined as pathological) social media use, the direction of causality, if any, remains unclear. This suggests that it is not a black-and-white topic to determine whether social media and the media in general, have a negative impact on self-harming behaviours.

Marchant et al (2018) completed a systematic review of the relationship between self-harm and internet use and similarly concluded that although there is significant potential for harm from online behaviours, the internet, particularly social media, also provides the opportunity for some young people to reach out for help, reduce social isolation and communicate their distress.

Young people who engage in self-harm are generally impacted by these behaviours throughout their day-to-day life. Self-harm is shown to have an impact on the individual's relationships, wellbeing and mental health (Hawton et al, 2003; Knorr et al, 2016; Muehlenkamp, Xhunga & Brausch, 2019; Townsend et al, 2016). Young people who self-harm generally do so in secret, and the pressure of keeping this secret can cause stress in itself (Doyle, Sheridan & Treacy, 2015; Favazza, 1992; Fox & Hawton, 2004; Rowe et al, 2014). In a simple, perhaps more obvious way, young people will go to great lengths to hide their self-harm (Chandler, 2017) including wearing clothing that covers their body. By going to great lengths to hide the self-harm, young people may avoid intimate and/or physical relationships and activities through fear of exposing their 'secret'. Young people who do self-harm will often report feelings of isolation (Endo et al, 2017; Hawton, Saunders & O'Connor, 2012; Johnson et al, 2002). In terms of an emotional impact, guilt is a common by-product of self-harm (Hicks & Hinck, 2008; Lindgren, Wikander, Marklund & Molin, 2022; Long et al, 2013; Ross & Heath, 2003).

Other items that have been linked to self-harm, although it is not clear if they are a causal effect or a by-product of self-harm, include poor educational attainment, mental health difficulties, lower employment prospects and an increased likelihood of substance misuse (Mars et al, 2014; Mars et al, 2019).

4.7 Supporting young people who self-harm

Research by Morgan et al (2017), found that schools frequently feel that counsellors and mental health services are best placed to support students who are self-harming, yet accessing this support is difficult due to high thresholds and long waiting lists due to limited capacity (Rice, Eyre, Riglin & Potter, 2017; Sharpe et al, 2016). Young people themselves tell us that the main sources in

preventing their self-harm, are family, friends and school, they add that they are more helpful and more important than external agencies (Fortune, Sinclair & Hawton, 2008). However, not only is there a reduction in the numbers of staff members within mental health services but there is currently a record number of children being taught in classes of over 30 students, ultimately also reducing their access to the class teacher (Department for Education, 2019). As well as difficulties in accessing services, the majority of people will not present to professionals (Ystgaard et al, 2008). Only 12% of young people who self-harm will seek any support (Bailey, Wright & Kemp, 2017). There are many reasons why, and again, there is no 'one size fits all', but when asking young people why they did not seek support, there are common themes within their responses.

Research shows that many professionals will make assumptions about individuals who self-harm and feel they are provocative, angry and attention-seeking (Batterham, Calear & Christensen, 2013; Dickinson, Wright & Harrison, 2009; Hasking & Boyes, 2018; Turp, 2002). Self-harm was previously reported as being an issue for white, middle-class, educated women (Sandoval, 2006; Strong, 1999) but as awareness has increased it is now better understood that anyone can be affected by self-harm. Although awareness has increased (Saunders, Hawton, Fortune & Farrell, 2012), there is still stigma and assumptions made about those who self-harm and if young people are aware of this information, this could act as a direct barrier to them disclosing their self-harm to an adult through fear of being stigmatised. Seemingly this is occurring in school populations and Fortune et al, 2008, found from a representative sample of 41 secondary schools, that when completing anonymous questionnaires, some young people stated that concerns of stigma acted as a barrier to seeking support for self-harm. Self-harm behaviours in those aged 13-26 years old are generally kept secret and often, parents are entirely unaware that their child has self-harmed (Chandler, 2017; Green, McGinnity, Meltzer, Ford & Goodman, 2005).

Long et al (2012), reported that although there has been an increase in self-harm incidence, stigma and misunderstanding still surround the issue, which often adds to the distress of those who self-harm. More recently it is reported that stigma around self-harm is a major barrier to overcoming the problem (Aggarwal, Borschmann & Patton, 2021; Burke, Piccirillo, Moore-Berg, Alloy & Heimberg, 2018). Long et al (2012) adds that the social stigma, in particular, around self-harm is extremely complex. Many people think that an individual's self-harm behaviours are manipulative and focused only on gaining attention (Fox & Hawton, 2004; Hogg & Burke, 1998). This is not the same as describing the behaviour as attention needing or a cry for help, but often results in the behaviour being ignored. This myth is largely dispelled by the fact that many people who self-harm, do not tell anyone and actively try to hide their behaviour (Fox & Hawton, 2004; Mental Health Foundation, 2006; Turp, 2002). Not only untrue, but this myth can be a dangerous one. It can help to perpetuate

the cycle of self-harm (as shown above) as well as prevent young people from asking for help, through fear of being ignored or told they are attention seeking.

Turp (1999) described self-harm as a '*multi-professional issue*' (p. 307) as those who self-harm may seek support from a wide variety of professionals. This suggests that all of the professionals that an adolescent may turn to, including (but not limited to): social workers, GPs, EPs, teachers and teaching assistants, psychiatrists and community mental health workers, will all need an understanding and knowledge of self-harm in young people, and also how to best support them, or who they can refer onto.

Schools are well placed to act as a hub to support students and in a survey of teachers in 1997, Roeser and Midgley found that 99% of teachers felt that managing student's mental health is a part of their role, demonstrating that this responsibility, although now increasing, is not new. There are people in schools that work pastorally, and in an ideal world, young people would disclose to these adults that they are self-harming, and very quickly receive the support that they need. This is not realistic, however, and young people are most likely to disclose to an adult that they trust (Fox & Butler, 2007; Howieson & Semple, 2000; Pope, 2002; Roose, Yazdani & John, 2003). This could be any adult in their lives, most of which will have had no experience or training in supporting young people who self-harm.

As written earlier, teaching staff often feel unprepared to support student self-harm, but they are not the only profession and research suggests that many frontline professionals do not know how to respond to children and young people who self-harm, including General Practitioners (GPs) (Mental Health Foundation, 2006). Research conducted in 2015 found that GPs tend to underestimate the prevalence of self-harm in young people, particularly those under the age of fourteen. Twenty eight GPs took part in this research and findings also showed that similar to those in education, GPs would also welcome further training in self-harm to provide guidance on how to talk to young people about self-harm as well as practical information (Fox, Stallard & Cooney, 2015). Furthermore, GPs report that they are unsure of what language to use when talking to children and young people about self-harm due to the sensitivity of the topic which causes concerns about miscommunication (Young Minds & Cello Group, 2012).

4.8 School staff

The term '*teacher stress*' first appeared in the title of a paper in 1977 (Kyriacou & Sutcliffe, 1977), now, 45 years later, teacher stress is a major topic of research worldwide (Kyriacou, 2001). Teaching is known to be a profession that carries some of the highest levels of occupational stress (Bauer et

al, 2006; Botwinik, 2007; Johnson et al, 2005; Markow et al, 2013; Pithers, 1995). The effect of occupational stress on teachers is causing them to leave the profession (Brunsting, Sreckovic & Lane, 2014; Schlichte, Yssel & Merbler, 2005), in fact, 25-50% of teachers reportedly leave the profession within the first five years of teaching due to high levels of stress, and an alarming number are leaving in their first year (Algozzine, Wang & Violette, 2010; Schlichte et al, 2005). Kyriacou (2001) notes that sources of teacher stress are unique to the individual and are based on the interaction between the individual's personality, values, skills and circumstances. Greenberg, Brown and Abenavoli (2016) documented four main causes of teacher stress. These were:

1. School organisation (e.g. impact of school culture, lack of administrative support and negative working conditions; Ingersoll, 2012; Skaalvik & Skaalvik, 2007).
2. Job demands (e.g. high teaching loads, high stakes testing, insufficient time and excessive paperwork; Adera & Bullock, 2010; Billingsley, 2004; Shernoff, Mehta, Atkins, Torf & Spencer, 2011).
3. Work resources (e.g. limited autonomy and decision-making powers; Miller, Brownwell & Smith, 1999).
4. Personal resources and social and emotional competence (e.g. lack of collegial relationships; Kilgore & Griffin, 1998).

These are day to day stressors that many individuals who work in educational settings will be experiencing which have possibly increased given austerity and negative world events such as the pandemic. Adding the responsibility to support self-harm will add to the already highly stressful situation many teachers find themselves in. The result of the stress that teachers face, as well as leaving the profession, includes physical symptoms (such as fatigue and illness) as well as mental health problems that are typically associated with stress, such as anxiety and depression (Herman, Hickmon-Rose & Reinke, 2018; Kyriacou, 2001; Maslach & Goldberg, 1998; Maslach, Schaufeli & Leiter, 2001). As well as this, teachers who experience occupational stress have been associated with a minimalist coping response, where they spend less time preparing for teaching and take less responsibility for student learning as well as distancing themselves from their students and their work (Dworkin, Haney & Telschow, 1988; Hughes 2001; Maslach & Goldberg, 1998). The impact of occupational stress on teachers then results in negative impacts on student behaviour (Hoglund, Klinge & Hosan, 2015; Skaalvik & Skaalvik, 2007) and student achievement (Braun, Roeser, Mashburn & Skinner, 2018; Roberts, LoCasale-Crouch, Hamre & DeCoster, 2016; Tsouloupas, Carson, Matthews, Grawitch & Barber, 2010). Furthermore, teachers who were experiencing stress were less likely to refer students to school-based support services when compared to school staff who experience less stress (Pas, Bradshaw, Hershfeldt & Leaf, 2010).

4.9 The responsibility of the school

With the introduction of Future in Mind (Department of Health & NHS England, 2015), and the ‘transforming children and young people’s mental health provision: a green paper’ (Department for Health and Department for Education, 2017), schools were noted as a key part in the response to children and young people’s mental health. As such, there is a growing expectation for teachers to have an understanding of mental health difficulties that students within their school could face (Shelemy, Harvey & Waite, 2019). Relatively few young people with mental health needs will gain access to timely evidence-based treatments and support from specialist services (Education Policy Institute, 2021; Essau, 2005). Many young people have received support for their mental health needs from their educational setting (Hoagwood, Olin, Kerker & Kratochwill, 2007; Stormont, Reinke & Herman, 2009). Support from schools is shown to be effective in supporting young people’s mental health and wellbeing, with research demonstrating reductions in ‘*behaviour problems and depressive symptom scores*’ alongside the implementation of increased emotional support by teachers (Way, Reddy & Rhodes, 2007; Joyce & Early, 2014).

4.10 Staff confidence in supporting young people who self-harm

Education staff are currently on the frontline of identifying and supporting young people who self-harm, however many members of staff took employment in a school at a time when mental health and self-harm were not openly discussed and were therefore unaware of this responsibility or did not feel that it was a part of their role. Most, if not all, however, will enter the profession aware of their role of supporting student’s well-being *in loco parentis* (Power, 1996) but seemingly self-harm is not something that comes to school staff’s minds when they consider this responsibility (Best, 2007). The perceptions that these members of staff hold on self-harm will impact their responses to self-harm (Long et al, 2013). Time and time again, research tells us that school staff members want training on self-harm to improve both their knowledge of self-harm but also their confidence in responding to it (Best 2005; Roberts-Dobie & Donatelle, 2007).

Memo: Role of the teacher

Speaking with friends and colleagues who do or have previously worked in schools, I find that we all have the same story, of a Geography teacher (or a teacher of any subject), stating that they are not there to support mental health/challenging behaviour/self-harm etc. and that they went to university to qualify and teach their chosen topic.

From an outsider's perspective, I can look at this and feel that it is naïve and that anyone working with children and young people, in any capacity, needs to support the whole person, however, I am speaking as a millennial. Mental health has become far less taboo over the past decade or two, teachers who qualified many years ago may not have covered mental health in their training, they almost certainly would not have looked at self-harm in the same way that we are doing now. So to expect them to now do so, almost feels like a change in their job role. It is important that we reach these people and teach them the skills they need to support the whole person, but it is also important that we understand where they are coming from and what has led them there.

4.11 The case for training and support

A study conducted in Canada by Heath, Toste and Beetham (2006), surveyed fifty teachers in high schools and graduate-level courses. The participants were asked about their knowledge and attitudes towards self-harm. Results found that 78% underestimated prevalence and only 20% of the respondents said that they felt 'knowledgeable' about self-harm, however, 74% responded that they had a direct encounter with a student who self-harmed. This highlights that having experienced a student disclosing self-harm does not necessarily then help the member of staff to feel equipped for a similar situation in the future. Furthermore, adults in school rarely have access to support or supervision from others that have expertise in mental health (Sharpe et al, 2016).

There is some evidence, from North America, to suggest that teaching staff who have been in their posts for many years have higher levels of knowledge and confidence about student self-harm and are less likely to hold negative attitudes towards self-harm than newer members of staff (Carlson, DeGeer, Deur & Fenton, 2005; Heath, Toste, Sornberger & Wagner, 2010).

Berger, Hasking and Reupert (2014), state that adults in school who encounter students who self-harm experience strong reactions. Mitchell (2015), wrote that teachers feel '*hopeless and unsure about what to say*' in regards to student self-harm. Further research tells us that schools can struggle to identify and respond to self-harm and that seeing the behaviours can be overwhelming (Berger et al, 2014).

The tiered response to mental health difficulties expects all members of staff within a school, namely teachers and teaching assistants, to have the skills to deliver tier one support (NHS Digital, 2017).

Tier one support is described as universal mental health support that should be available for all children and young people. The difficulties lie when teachers and other educational professionals are expected to deliver tier two support which is more targeted mental health support. Adults in schools

are not adequately trained to respond to mental health difficulties and provide this higher level of support (Byrne et al, 2015).

4.12 Preventing self-harming behaviours

In schools, self-harm is typically responded to through a process that is similar to responding to any safeguarding concern. The school with whom this research is conducted, details within their safeguarding policy that safeguarding is everybody's responsibility, this includes all staff members, governors, and volunteers. The policy also includes the idea that multi-agency work should take place as and when needed. Students who self-harm may disclose to any adult in school and when responding to self-harm, often other agencies are included in providing support. The ultimate goal of any safeguarding policy is to keep people safe. Responding to self-harm in schools reflects this directly and can take different approaches similar to any other safeguarding concern. The initial safety of the child should first be assessed, this can be through examining the physical self-harm, through to providing students with the support that they need to remain safe. The same decisions will be made through any safeguarding concern such as; who needs to be told, whether or not to include the young person in each step and deciding what to do next.

Often the result of a safeguarding query will be a risk assessment, designed to ensure the safety of a student. When considering self-harm, a common action is likely to be providing social, emotional, and mental health support. Students who are known to self-harm within the school are often given support by the student support centre staff and at times, when following safeguarding processes, a referral may be made to outside agencies.

Supporting young people who self-harm is one means of action, however, another key part of the resulting risk assessment is to actively try to prevent self-harm from occurring by limiting access to sharp objects or by supervising a student more closely. This approach would be based on prevention rather than 'cure'. Removing access to objects that could be used to self-harm, does not require training and does not require direct contact with the young person. Prevention, alongside identification and appropriate management, is seen as an important element in suicide prevention (Prince et al, 2007). Many schools have a self-harm policy and risk assessments are created for young people who are known to self-harm. When a young person is known to professionals to be self-harming, one of the first steps is to remove sharp objects from their reach. Cutting the skin is described as the most common method of self-harm, so it is only logical to conclude that removal of the item used to cut the skin, will reduce self-harming behaviours. This is advice that both schools and specialist mental health services, such as CAMHS, would share.

4.13 Self-harm and suicide

For many, the topic of self-harm instantly leads to concerns about suicide. Self-harm is determined to be a key predictor of completed suicide (Hawton, Houston & Shepperd, 1999) with Geuylov et al, 2019, reporting that self-harm is the strongest predictor of suicide. International studies have found that self-harm in some young people can indicate repeated self-harm and can lead to completed suicide (Joiner, 2002; Muehlenkamp et al, 2012). The same results have been found in the UK with Owens and House finding in 1994 that a quarter of suicides are preceded by self-harm within the previous twelve months. This research was updated in 2002 when Owens, Horrocks and House again found a link between self-harm and suicide that suicide risk among self-harm patients to be *'hundreds of times higher than in the general population'* (p. 193). It is important to note that this research is within patient populations and will therefore not include individuals who have not disclosed their self-harm. Furthermore, Hawton and van Heeringen (2009) found in their UK based research, that a history of self-harm is an important risk factor for completed suicide. These are just a few examples of statistics and research that show the link between self-harm and suicide, there is a wealth of evidence linking the two.

Ultimately, suicidal intention is usually absent in self-harm and the majority of young people who self-harm do not attempt to complete suicide (Klonsky, Victor & Saffer, 2014; Suyemoto, 1998). The narrative that they are linked causes fear and concern about responding to a young person in a way that may then contribute to self-harm and potential suicide.

Skegg (2005), explains that part of the reason why health professionals are often ambivalent towards those who self-harm is that medical services are typically focused on helping people who are *'inflicted by illnesses beyond their control'*. When their patients deliberately harm themselves, the contract between health professionals and patients is tested. Although teachers do not sign up for the same contract as doctors, there may be similar feelings in supporting students who self-harm, which is not something they expected to do in their role as a teacher, administrator, teaching assistant etc.

House, Owens and Storer (1992), however, found that with adult inpatients who self-harmed, there was a favourable attitude towards supporting those whose motives were related to suicide, than those whose behaviour they deemed to be *'manipulative'*. Although this study is old and was completed with an adult inpatient population, it demonstrates my personal experience of 'big' reactions to those that were deemed not to be self-harming for attention, as opposed to those that

were. Assuming that a young person is not self-harming as they 'want to die', could therefore act as a barrier to receiving support from others.

Furthermore, when looking at nurses providing 'treatment' for individuals who self-harm, Patterson, Whittington and Bogg (2007), stated that the only way this can be delivered is through a relationship between the individual and the professional. Yet, it was also found that hostile attitudes and antipathy were common attitudes towards repeat self-harmers by healthcare professionals (Watts & Morgan, 1994; Mental Health Foundation, 2006). This attitude can directly act as a barrier to a young person receiving help, but also the likelihood of them confiding in an adult about their self-harming behaviours.

In the 2021 Samaritans report, where self-harm was determined to be best prevented in schools, it was recommended that teachers should be trained in recognising students who may be self-harming. This was followed by Best's 2006 pilot study that found teachers' knowledge and awareness of self-harm was limited. The idea of students self-harming invoked feelings of '*alarm and panic*' and of '*cared, repulsed and freaked out*' (Timson, Priest & Clark-Carter, 2012). The result of this research was a call for education, training and supervision for adults in school. This call for training is echoed by school staff who have highlighted the need for '*in depth and specialised*' mental health training (Graham, Phelps, Maddison & Fitzgerald, 2011; Moon, Williford & Mendenhall, 2017; Walter, Gouze & Lim, 2006). Since this call for training in 2006 and 2012, research continues to tell us the same thing that school staff continue to not feel skilled in responding to students who self-harm, as well as fear that through addressing self-harm they may encourage the behaviour (Evans et al, 2019; Meinhardt, Cuthbert, Gibson, Fortune & Hetrick, 2022; Te Maro et al, 2019).

Evans et al (2018) found that of the 153 secondary schools in their research across England and Wales, only 52% had received any training on self-harm and only 22% felt that the adequacy of the training was high. Of this figure, only one person from each school completed the questionnaire so it is unclear whether the training had only been attended by the representative or all members of staff within the school.

For the training that has been made available, which was unnamed and referred to as '*mental health related training*', school staff expressed concerns about the realistic use of the training alongside working in a busy school schedule and transferring what they learn into the classroom setting (Roth et al, 2008). Teachers have also reported that the interventions that they are trained on, often fail to take into account the pressures that the staff members face within their role as well as the lack of flexibility to implement the work (Taylor et al, 2014). This suggests that alongside school staff

needing and asking for mental health training, this needs to be specific and realistic for them to use the skills learned within their role.

When looking at the importance of how professionals react to those who self-harm, training and education may *'hold the potential for bringing about attitude change'* (Patterson et al, 2007, p.100). Consequently, Townsend, Gray, Lancaster and Grenyer, (2018), did find that within their research where they implemented a self-harm training programme in 18 secondary schools when looking at 400 teachers, attitudes towards students who were self-harming, were significantly more positive after training. Furthermore, education in self-harm and an increased in understand of self-harm are seen to improve the quality of care (Jeffery & Warm, 2002; Friedman et al, 2006; McAllister, Creedy, Moyle & Farrugia, 2002; Wilstrand, Lindgren, Gilje & Olofsson, 2007).

There is a need and want for training in the education profession, however, this does come at a cost, but to staff members' time, as well as a financial cost. In 2017, 2,780 constituents responded to a Department for Education survey and stated that funding was a *'major barrier'* to setting up mental health support in schools (as reported by Camden, 2017). Even if training is funded outside of the school's budget, the implementation of the delegates learning, even just providing the members of staff time to be available, is costly. Camden (2017) also reported that nine out of ten responders to the survey stated that they were paying for school counselling services or other mental health provisions out of their budget. This meant that schools are having to decide whether to spend money on supporting academic needs, special educational needs, or students' mental health.

4.14 Implications for the role of the Educational Psychologist

Research conducted by Sharpe et al, in 2016, found that when 341 schools across England completed a survey about the provision of specialist mental health support in their school, EPs were found to most often provide support for young people who were self-harming, with 81% of schools stating that EPs provide them with specialist support. This response was followed by counsellors. Lee (2016) wrote that Educational Psychologists are well placed to support schools with self-harm as they are *'equipped with applied psychology, research skills, training in therapeutic approaches, understanding of pedagogy and educational systems'* (p. 118).

EPs can and do work directly with young people. However, their primary role is supporting young people to access education and it may often be that schools are having to prioritise the children and young people who receive support from the EP. This means that although the EP may work with a young person who self-harms, they are more likely to provide support to the adults in school who can then support the student, which is seen as a more efficient use of time. Many Educational

Psychology Services currently work within a traded mode (Schulze, Winter, Woods & Tyldsley, 2019). This means that the work that can be offered to schools is often ring-fenced and also time limited. It also means that the work completed within schools is often decided through a collaborative conversation with the school, alongside the likely time and contract restraints. As such, if support is needed directly with the child, from what is deemed a specialist in mental health, this is typically through specialist mental health services such as Child and Adolescent Mental Health Services (CAMHS). These services have extremely long waiting lists and many young people are waiting for over 6 months to be seen by the specialist service, and 25% of referrals are rejected as *'inappropriate'* (Kirby, 2020). Long waiting list times are seen to be barriers to help-seeking (Camm-Crosbie, Bradley, Shaw, Baron-Cohen & Cassidy, 2019; Crouch, Reardon, Farrington, Glover & Creswell, 2019).

EPs are well placed to work at organisational and strategic levels by providing training for schools in supporting young people who self-harm. Berger et al (2014), reported that education in self-harm does improve both knowledge and confidence in responding. A study conducted by Lee (2016), however, raised the issue of EPs needing to be prepared to deliver self-harm training. Similarly, to professionals who work in schools, EPs may also experience similar feelings of discomfort and a lack of confidence in working with young people who self-harm.

The effectiveness of Continued Professional Development (CPD) has been disputed, with a key factor being that the effects of CPD are highly individualised and there will be different outcomes for each participant (Harland & Kinder, 1997). Coincidentally, this brings about the argument of whether self-harm training would be 'enough'.

CPD is seen to be extremely important in improving teaching and learning (Lydon & King, 2009) and *'well structured'* CPD can positively impact teacher's practice, school improvement and student achievement (Bolam, 2008). The quality of CPD is found to be inextricably linked to any resulting change and improvements in the setting (Schostak et al, 2010). The success of CPD within education is dependent on many causal processes and Opfer and Pedder (2010), describe that at a minimum, teachers must learn something by attending the CPD and possibly have a change in belief. They then need to engage in new practices in the educational setting, but this will also be dependent on beliefs, practices and relationships within the systems of the setting itself. Opfer and Pedder (2010), add that this is further complicated by adding in the beliefs and orientations to learning of the students that attend the educational setting. To avoid these complexities, the success of CPD is often determined by an increase in knowledge and research suggests that teacher participation in CPD does result in improved knowledge (McLinden, McCall, Hinton, Weston & Douglas, 2006; Miller &

Glover, 2007). There is also research to suggest that CPD can result in a change in teachers' attitudes and beliefs (Cordingley, Bell, Rundell, Evans & Curtis, 2003; Pedder, James & Macbeath, 2005).

EPs are well placed to facilitate CPD sessions for school staff due to their knowledge of psychological theory and practice relating to supporting children and young people (Frederickson, 2002). CPD is found to be more effective when provided by people with expertise in the topic (Cordingley et al, 2003; Armour & Makopoulou, 2012). Educational Psychologists are also likely to have built positive relationships with local schools which can support the delivery of CPD.

EPs are also in a unique position where they can offer direct supervision to school staff or support supervisory processes through consultation (Dunsmuir, Leadbetter & Lang, 2015). Throughout the Educational Psychology Doctorate, EPs are taught different models for supervision and reflection which may be beneficial for adults in school who are working directly with young people who self-harm. This can be directly related to supporting teachers to support young people who self-harm but also to provide teachers with supervision for the general day-to-day pressures that the job brings.

Through all of the different ways and methods that an EP may work with a school, such as training, consultation, direct 1:1 work and supervision, the goal is often to change the narrative and to look at the 'problem' from a different perspective. EPs, through their training, are equipped with psychology that they can use to bring people together, work collaboratively and change narratives. If an EP is able to support a school-based professional who is, in turn, supporting students who are self-harming, shared goals can be agreed upon, with the possibility that the member of staff will feel better equipped to support the students within their school.

Chapter 5 Discussion of findings

5.1 Main findings

This study explores the experiences and understandings of student self-harm in a secondary school in the East Midlands. A Grounded Theory (GT) methodology was used which aims to create a theory from the collected data (Chun Tie et al, 2019). As with Charmaz (2014), a set of narratives concludes the research.

Self-harm is common in secondary schools and in this study, the staff feel that it has significantly increased over recent years. It is something they see regularly and they know of many students in the school who self-harm and have a risk assessment based on their self-harming behaviours.

The staff in this secondary school are aware that they are expected to support young people's mental health and wellbeing and this includes supporting students who self-harm. Although school staff are responsible for supporting these students, they are not sure how to and they often lack the training and confidence to do so. They want to attend training and they want to know how to better support the students who self-harm.

Students who are known to self-harm are given risk assessments in school, these include actions such as not allowing the young person to go to the toilet unsupervised and accounting for all sharp objects at the beginning and the end of lessons. The staff in the secondary school do not feel that this is enough, but there are barriers to them doing more. They feel that there is not enough time to teach alongside offering support for self-harm and that to be able to do more, there would need to be funding. This funding could help to employ more specialist staff or be used to upskill staff already in school. As well as this, staff have some fear around supporting students who self-harm which comes from a place of uncertainty and a lack of confidence. They acknowledge that this could also be improved with training. They feel that everyone needs to access some level of self-harm training due to its prevalence in school.

The barriers to secondary school staff doing more to support students who self-harm are discussed in further detail within this chapter. It is also important to add that as well as school staff recognising that what they are currently doing as a whole staff team is not enough, but that it is also not preparing the students for adulthood when these safeguarding steps cannot be taken.

5.2 Limitations of the study

This research took place in one secondary school in the East Midlands and to enrich the data collected, the same research would need to occur in multiple settings (Holton & Walsh, 2017). Although the findings as a whole cannot be generalised to other populations, it would be expected that some of the findings can be transferred to similar settings, such as the conclusion that staff members across the school differ in their confidence in talking about, and responding to student self-harm. When comparing the results of the research to the literature review, it appears that many of the findings are similar to previous research, suggesting further that the results are not unique to the secondary school used in this research. This is discussed further throughout this chapter.

A GT approach was taken for the second phase of the research. The method allowed for topics to arise that were not predetermined by the researcher and as such, allowed the participants to guide the direction of the research. My personal experience of this was positive and I do not think I would have reached the same conclusions had I used a different methodology. The constant comparison of the data that takes place in GT also allowed me to see patterns in the data that may not have been seen if I had used a different method.

The use of GT, however, can also be seen as a limitation of the research. If a different method had been used, it would have been possible to focus the research on a smaller topic meaning more data and information could be gathered about the subject. Another limitation of GT, which is also embedded in the restrictions of the research as a whole, was that not every individual who agreed to be contacted about taking part in a focus group was able to participate. This was partly due to the time restrictions given for this particular research, but also due to the nature of GT. Fifteen individuals agreed to be contacted regarding focus groups, however, only eight voices were heard, three were unable to attend round one of data collection and four were not 'chosen' by the randomised cell generator. As the eight participants took part in the first phase of the GT data collection, it was important to continue with these participants to be able to reach data saturation. The solution to this would have been to invite all fifteen participants from the beginning of the research, however, this would have resulted in the challenge of reaching data saturation within the time limit. Although steps were taken to randomise the participants that took part, and as such providing anonymity in phase one of the research but also removing bias on focus group attendance, it is possible that had other participants been invited to take part, different data would have been found. Due to the anonymity given to participants in phase one, it is not known which job titles were not heard within the research.

When following a GT approach, this also meant that categories of data had to be chosen, based on theoretical saturation, at each step. Although this is a key component of GT and has resulted in rich

data, it also means that some data was lost. Typically this data can give an opportunity for future research, however, it is not known what the research may have found if one of the other ten categories were chosen to explore further.

I started the second phase with pre-determined questions and encouraged discussion, but switched to a GT question for round two of the second phase by using a grand tour question (Simmons, 2010). I think this was helpful to allow the discussion to take a direction chosen by the participants but also, at times felt as though, for some participants, it was a difficult question to answer. By having the mix of the two different formats, I felt that all participants were able to engage well with the data collection. This also meant that although the topic had already narrowed down from the first round, the grand tour question allowed for discussion to be as open as possible, given that there was a question to answer.

The research focused on how school staff experienced self-harm with the unsaid assumption that this would impact student experience also. Although the staff experience most likely will impact student experience, without speaking directly with students and gathering data from their experiences, it is not possible to know how. If the research was to be replicated, it would be insightful to look at how students understand their experience of self-harm in school, particularly when speaking with and working with adults in school.

Meeting with members of staff in small focus groups may have also impacted their experience and resulted in differing responses. For example, one participant stated that they felt quite confident about self-harm in one group, but in the other focus group, they said that they were not confident. This may have been because the participant had reflected on their confidence between the two groups, but it also may have been a result of the group dynamics and relationships that I would not have been aware of. Each focus group included members of staff with different job titles that sit at different levels when considering the hierarchy found within schools. Due to the heterogeneous groups, which were a result of randomising the participants who were invited to take part, it was possible that power dynamics played a role in each focus group. Furthermore, some participants were more vocal than others and this may have impacted the response of other, quieter participants (Willig, 2009).

In-vivo coding was initially used to analyse the data and focus groups and interviews took place remotely, with all participants and the researcher attending from different locations. One participant was unable to have their camera on so only attended verbally. This needed to be an option in the research so that the focus groups and individual interviews were accessible for all participants but also meant that any visual information, such as body language, could not be collected. This can also

be said for participants who attended with their cameras on. The situation of attending a focus group or interview online is not the same as attending in person which can also impact body language. Although the research would have possibly revealed more information if completed in person, face to face, it is also important to note that at the time of the focus groups and interviews, the pandemic had begun two years prior, meaning that participants, particularly those in schools, were used to conducting meetings and teaching lessons online, so the format was likely more familiar to them than it would have been before March 2020.

Another limitation is the bias that I hold as a researcher. This is something that I feel is impossible to avoid entirely, but it is important to note the impact it will have made on the research. Namely, the research would not exist if I did not hold an interest, and therefore some knowledge of the topic of self-harm.

5.3 Barriers to supporting students who self-harm

I began the research by asking participants about their experience of student self-harm, and by following the data, a lot of the information gathered was linked to the barriers to supporting students. Participants would often talk about how their response was to pass the information on, and when speaking to the members of staff to who the information was passed on, these staff members also spoke about the barriers to supporting the students. There was a clear message from all participants that although they could do something – someone else could do better. Participants believed that someone was better equipped to support the students than themselves because of the barriers that they faced.

Although external agencies were mentioned as being a good source of support, all participants in the research felt that support could also be provided in school so most of the data found was related to self-harm within the secondary school.



FIG 11: IMAGE DETAILING THE DIFFERENT BARRIERS TO SUPPORTING SELF-HARM BASED ON PHASE TWO OF DATA COLLECTION

The image above demonstrates the main barriers that participants in the research detailed as being barriers to supporting students who self-harm. They are arranged with the main barriers being training and support. If training and support are given to members of staff in secondary schools, this will likely have a positive impact on their confidence and competence in supporting students, ultimately removing the fear associated with supporting students who self-harm. This research suggests, by the responses within the data, that the answer to supporting students who self-harm, is to provide the staff that work with them with training and support. When considering the possible actions that a school and the school's community could take to support their students who self-harm, providing training and support is a barrier they will have more control over reducing within their school.

A larger emphasis is therefore placed on this theme, but it is also important to draw attention to the other barriers that they feel they are facing which are time and funding. Below further details are given for each of the barriers shown in figure 11.

5.3.1 Training

This research supports a vast amount of previous research where members of staff are asking for specialised and specific support in mental health training (Best, 2006; Graham et al, 2011; Moon et al, 2017; Walter et al, 2006). It is not uncommon for no members of staff in a school to have received training on self-harm (Evans et al, 2018). It is also recognised that training needs to be for everyone, and not just the school's mental health lead or a small number of pastoral workers. Staff recognise that in any role, a student may disclose their self-harm or a member of staff may witness it

without a disclosure being needed. This could be any member of staff, although it is more likely to be someone that the young person trusts (Fox & Butler, 2007; Howieson & Semple, 2000; Roose et al, 2003). Students form relationships with all of the adults that they interact with in their school and it would be impossible to predict which members of staff they prefer or feel that they can trust.

When looking at who attends training, it also appears that those we may expect to support self-harm, such as pastoral workers, are not more likely to have attended any training about self-harm and in this research, the participants that had attended self-harm training in the previous year were a technician and a teaching assistant. Participants who dealt with self-harm on a more regular basis, as discussed in the focus groups and interviews, had not attended any self-harm training. Instead what participants spoke about was more based on a 'learning on the job' approach, where the two members of staff that said they supported self-harm daily, had not had any formal training. The participants who had attended self-harm training, were not in the Senior Leadership Team so it can be argued that it would have been more difficult for them to roll out the information that they received with the rest of the staff. Furthermore, it was not clear if the training that they had attended was arranged by the school or something they had completed externally. When considering the content of self-harm training, school staff are keen to have training that helps them to identify which students could be self-harming, e.g. spotting the signs, but also to know what to do next. At the moment, they are typically referring the student on, which feels within their skillset, but does not feel as though it is enough.

Without any training to know what to do, staff members are doing the obvious, removing the means of self-harm. If a student is known to self-harm with razor blades, it is a logical step to remove access to blades within the classroom. School staff know that this is not enough, and they also consider whether this will be detrimental to their future when these safeguarding practices will not be possible, yet they do not know what else to do.

Alongside the direct benefit of knowing what to do, by attending training on self-harm, perceptions of the behaviour will also likely change (Jeffery & Warm, 2002; Friedman et al, 2006; McAllister et al, 2002; Wilstrand et al, 2007). Participants in this research commented that part of the reason why people are not confident in responding to self-harm is that they do not relate to it, and they do not understand it. Similarly to previous research, this suggests that by providing that insight, attitudes may also change across the staff.

If more members of staff are trained to respond to self-harm, this will also reduce the need to refer the student to someone else whom they feel is better equipped to support the student. This is not to say that other people in school will not be made aware of the self-harm and concerns, but one of the

barriers to students reaching out for support is the fear of being stigmatised and labelled (Fortune et al, 2008). Reducing the line of referring to others, may help students not feel that they need a specialist to work with them, indicating that there is something wrong, that many adults in school cannot deal with themselves.

Increasing knowledge and an understanding of self-harm will also help to dispel the myth that students who self-harm are attention-seeking and manipulative (Batterham et al, 2013; Dickinson et al, 2009; Hasking & Boyes, 2018; Turp, 2002). Again, this perception can be a barrier to students disclosing their self-harm (Fortune et al, 2008). If it is shared among the school staff that this is not true, this barrier could also potentially be broken down and result in more students asking for help when they need it. As well as this, students simply being aware that they may be perceived as attention-seeking if they self-harm, can add to their distress (Long et al, 2012). Reducing this message should also help to reduce the distress that some students will be experiencing.

Memo: Reflection on adult support

This reminds me of a time when I was working in the pupil referral unit with a young person who was presenting with a low mood. I spoke with the student, who I had never met before, and we talked about how it was important to develop coping skills and that perhaps someone in school could help him to do so, and I asked who his favourite teacher was. His response was the school's behaviour lead who worked with all the students. I spoke to this member of staff to set up a weekly session where they could work together and the member of staff told me that he was shocked that the student had identified him and that he had barely interacted with him.

The intervention was successful. The student had identified this member of staff as someone who he felt he could build a good rapport with, rather than someone he already had this with.

I felt this short story demonstrated how it is not possible to predict who a young person may disclose to, or who may be the best person to support them.

5.3.2 Clinical Supervision

Providing schools with high-quality training will be a positive step in helping to support staff confidence and competence when responding to self-harm, however, there will still be scenarios where further support is needed through the form of clinical supervision. This particular supervision model allows professionals to discuss cases of children and young people they are working with and does not generally extend to those working in education. Previous research has shown that staff in

schools are asking for both training and supervision to respond to self-harm (Graham et al, 2011; Moon et al, 2017; Walter et al, 2006). Although high-quality training can help to change narratives around self-harm and provide prompts and ideas on how to respond to student self-harm, it is not possible to predict the complexities of each individual response that is required. At times, staff may feel able to respond to student self-harm, however, in other instances, schools want to be able to speak to someone who has a higher level of training, and therefore expertise, in student self-harm. This is not something that schools typically receive (Sharpe et al, 2016).

Students who do self-harm have reported within the research, retrospectively, that the person they want to be supported by is someone that they trust (Fox & Butler, 2007; Howieson & Semple, 2000; Roose et al, 2003), which likely means the young person will disclose to an adult that they know. This is unlikely to be an adult with a high level of mental health training and experience. Simply knowing that there is an individual with more knowledge about self-harm that the adult can reach out to, can help to alleviate some of the fear associated with responding to self-harm. This reduction in fear, alongside the support of a professional, can help when having to respond to serious self-harm, which is of critical importance when the goal is to safeguard children and young people.

The challenges arise when considering who can provide this clinical supervision. Typical clinical supervision is provided by a direct line manager who plays both a professional and an ethical role in supporting the young person. Typically, the supervisor and supervisee will work for the same organisation, but at different hierarchical levels. When considering who would be best to provide reflexive clinical supervision to members of staff within a school, this is likely to be through psychologists, either educational or clinical, however, these individuals do not directly work with the same population of children and young people as the school. The professional providing clinical supervision would ethically be involved in providing safeguarding for the young person in question. The solution to this challenge is for clinical supervision to be formalised and provided to schools as essential support which is protected by both policies and contracts. This is not likely to be a quick or smooth implementation and also links directly with the concerns around funding, but the support is necessary to provide students with adequate support. The implementation of school mental health teams that bridge the gap between schools and specialist mental health services may provide some of this support, however, it will be important to consider the ethical concerns of who will hold the safeguarding responsibilities for each child or young person.

5.3.2.1 Fear

Addressing participants' fear of supporting children who self-harm can be addressed through training so is detailed under the umbrella of training. The theme of fear and worry around providing this support was a theme found in the literature and current research and is therefore described as a separate category.

Research does show that there is a link between self-harm and suicide (Geuylov et al, 2019; Hawton et al, 1999; Joiner, 2002; Muehlenkamp et al, 2012 Owens et al, 2002). Although the statistics and research are there to demonstrate this, it is also true that the majority of people who self-harm do not attempt or complete suicide (Klonsky et al, 2014). Simply knowing that something you are aware of a young person doing could lead to an increased risk of suicide, could then act as a barrier to providing support for that young person. The member of staff is aware that the student needs support, but they feel that they need the 'right' support, and they feel that not providing that can lead to worsening self-harm behaviours or an increased risk of suicide. It is difficult to dispute this as the statistics do tell us that self-harm and suicide are linked, however, it is also true that having a strong support system in school is a preventive tool for mental health difficulties (Fortune et al, 2008).

It is also important to note the emotional toll that working with young people who self-harm can take on the adults around them and the possible fear of supporting students who self-harm can have an impact on staff stress. The assumption is made that adults in school have the resilience every day to manage their own emotions and support these students, but there will undoubtedly be days, for all of us, where this is difficult and it is not possible to put your own emotions to one side. There are already an alarming number of teachers leaving the profession (Algozzine et al, 2010; Schlichte et al, 2005) and teaching is a stressful job (Bauer et al, 2006; Botwinik, 2007; Johnson et al, 2005; Markow et al, 2013; Pithers, 1995), adding something very emotive to a teacher's already challenging workload can have a huge impact. Unlike many other professions, where children and young people are provided with support, teaching is not a job that typically benefits from any supervision (Sharpe et al, 2016).

Seeing that a young person has physically harmed themselves can be distressing, and participants talked about the moment when they realise that what they are seeing is evidence of self-harm and that there is a moment of panic. This panic is likely linked to knowing how to respond, appropriately, to the situation. Participants also talked about how responding in a way that is not helpful to the student may make the self-harming behaviour worse. This is linked to the idea that the young person who self-harms may have a stronger likelihood of suicide and adults in school are scared that they may contribute to this.

5.3.3 Time

Although schools are seen as well placed to identify and support young people's mental health difficulties, due to the amount of time they spend in contact with young people, not everyone will enter the profession with the awareness or confidence and competence to do so. Many teachers begin their career because they have a passion for their chosen subject, and ultimately they will be employed within a school to teach that subject where they are then likely to be scored based on their performance based on the grades and scores of the students in that topic. Promotions and therefore pay rises are often based on student academic performance. If a member of staff sees one group of thirty children, for one or two lessons per week and they are responsible for their grades, their time is needed for teaching.

Alongside the funding cuts to specialist mental health services (Royal College of Psychiatrists, 2018), there is also a reduction in the number of teachers in schools (Department for Education, 2019). As reported previously, the significant increase in teacher/pupil ratios and the number of children being taught in a classroom will impact the class teachers' ability to recognise mental health concerns and also their ability to respond to them. When members of staff are identifying a mental health concern, namely self-harm, they do not have the time to respond which is why they are then referring that young person to someone else.

5.3.4 Funding

With the cuts to mental health services (Royal College of Psychiatrists, 2018), the responsibility of schools to support students' mental health has increased, but they have not been given the extra funding to do so. Schools are having to make decisions on what to spend their budget on, taking into account all areas in which students may have needs. Ultimately, children and young people attend school to learn, and the majority of the school's budget will be spent on access to learning.

When considering the barrier of time, training and fear, all solutions to these problems would require funding, whether this is training or employing new members of staff. School staff spoke about how they wanted to have counsellors and other mental health professionals be a part of their school staff, but that this was not possible within their current budget when they have to prioritise learning.

5.4 COVID-19

Conducting research after March 2020 is to collect data from participants who have lived through the COVID-19 pandemic. It is evident in practice that the after-effects of COVID-19 are beginning to be seen and will continue to appear in the education system. It has been predicted that instances of self-harm will likely increase during the pandemic (Sahoo et al, 2020) and this was seen in reality as COVID-19 related factors were identified as an influence on individuals who presented to A&E with self-harm injuries (Hawton et al, 2021). This, alongside the fact that self-harm figures are continuing to rise (Farooq et al, 2021) will result in more young people needing support for their self-harm in school. All participants within the school talked about how they felt self-harm was increasing in instance and it is something that they see regularly.

We are still learning about the after effects of COVID-19 and its impact on mental health (Kumar & Nayar, 2020), but whilst this is happening, the impact on secondary school staff is that these young people are likely to be met with the barriers that are preventing schools from doing more to support students from self-harming. With an increase in incidence, this will be a bigger draw on staff's time and resources, as well as impact specialist mental health services that already have long waiting lists (Rice et al, 2017; Sharpe et al, 2016).

5.5 Additional insights

Although the research only took place in one secondary school in the East Midlands, through working in different schools and Educational Psychology Services over the past decade, my insight is that the results from this research are not unique. Although never formally measured and only observed, without the eye of a researcher, the response to self-harm has rarely included confidence and almost always included letting someone else know – perhaps passing along the responsibility.

I also think that the comments that participants and previous research have made about the training needing to be 'right' and of high quality (Graham et al, 2011; Moon, Williford & Mendenhall, 2017; Walter et al, 2006) are key. Self-harm is present in a lot of training, namely Mental Health First Aid, but, in my experience, it is simply mentioned as a potential symptom of a mental health difficulty, rather than as a distinct behaviour. It is important that schools are given more information than just an add-on and it is also important that it is not just given to one or two members of staff who are then required to roll the information out across the school when they are not given the time or resources to do so. Self-harm is predicted to affect one in eight (Doyle et al, 2017) to one in ten young people (Public Health England, 2016), with Farooq, Tunmore, Ali and Ayub reporting in 2021 that these numbers continue to increase. This suggests that school staff will continue to need to

support a larger amount of their students who self-harm. They need to be equipped to do so appropriately.

5.6 The original contribution of the research

A vast amount of the information found in this research is not dissimilar to what was later found in the literature review, for example, adults in school are still not trained in supporting their students who self-harm, and they are still asking for self-harm training and the time needed to provide the support. Teachers' jobs are highly stressful and they are predominantly assessed on their student's academic progress.

What needs to be noted, and what the research adds, is that secondary school staff still want and need the same things that they did throughout previous self-harm research. Since this time, they have been given high levels of responsibility to support students, but their knowledge and confidence in doing so, have not changed. This mismatch will affect the students directly.

5.7 Future research

One of the main steps for future research would be to look further than one secondary school and to see if similar results are found in other secondary schools, as well as other educational settings including primary schools and colleges.

With the use of GT, different categories had to be excluded to develop further data in other areas. The result was four categories from the original ten. This does not mean that the other categories created would not be useful for future research, and if they had been chosen, different information and a possible theory may have been found. These categories included:

1. There are different levels of self-harm which are responded to differently depending on their severity or links to mental ill health
2. There is an impact on the young person when self-harm is responded to in the 'wrong' way
3. Self-harm impacts the whole family and family support is necessary
4. Adults also self-harm, so colleagues need to be supported as well as students

5.8 Implications for schools

Three main categories of barriers were identified in the research. The first is high quality training and clinical support where fear is a subcategory, the second is time and the third barrier is funding. Each

of these barriers will have implications for schools. It is important to focus on those that the school will have some control over. Although each school will have its' own budget, this will be limited and much will also be ring-fenced. It is possible that further funding could be accessed but in terms of this research, it is important to focus on the implications and possible actions that are more available and easier to access.

Adults in schools have been given the responsibility to support young people's mental health, and we know that we cannot always predict who a young person will disclose to. They will typically disclose to someone that they trust (Fox & Butler, 2007; Howieson & Semple, 2000; Roose et al, 2003), and this does not always mean that it will be the person that is trained to respond. This means that all adults in school need to attend high-quality training so that they are in a position to respond to and support these students.

The other implications for schools are more difficult to apply. Participants in this study felt that the other main barrier to supporting students was based on time, and providing teachers, and all adults in school, with the time to provide emotional support to students, would require a much larger change within the school system. Not only would this be difficult on a school level, but, for example, OFSTED inspections would also need to be taken into account as well as time to deliver the national curriculum.

Although this change is important, it is helpful to reflect on the changes that can occur short term and at the discretion of the schools themselves. It is also not necessarily helpful to note that schools need to access high-quality training, without knowing where or what this may be. Schools will also have a responsibility, if all of their staff members are equipped to support student self-harm, to provide them with the support and supervision that they made need after such an instance.

5.9 Implications for Educational Psychologists

This study has several implications for Educational Psychologists and the roles they can play in student self-harm. These include creating positive relationships with school staff, not limited to just the Special Educational Needs Co-coordinator (SENCO) as well as strategic work that can be completed with the school such as training and supervision as well as providing ad hoc support if queries arise or advice is needed.

Many adults in school felt that students who self-harm should be supported by adults that they trust, rather than immediately seeking support from outside professionals. The EP's role in this instance is not to directly support the student, which may increase their fear of being stigmatised or

diagnosed with a mental health problem, but instead would be to support the adults that already have positive relationships with their students.

Members of staff who worked in the secondary school wanted to attend self-harm training and to increase their knowledge and confidence in responding to students who self-harm. EPs are well placed to deliver training, due to their use of applied psychology (Lee, 2016). However this possibly requires more thought in that it will be important that EPs who do deliver the training feel confident and competent themselves in supporting children and young people who self-harm.

Mental health professionals, as a part of their role, receive clinical supervision. This is time that they have, typically once a month, to discuss their caseload, get advice and talk over what may have happened with previous cases. Supervision recognises that working in the mental health field can have an emotional toll and so this time to reflect and share is helpful. Alongside this supervision, which is typically with a senior member of staff who will have more knowledge and/or experience in the work that is being completed, there is also the option for peer supervision. Similarly, supervision with the supervisor, allows members of staff to talk through their cases, gain advice and support one another. This model of support is not what that school staff have, yet, similarly to mental health professionals, they are supporting the wellbeing of many different individuals each day.

Educational psychologists are trained in different supervision techniques and these can and should be shared with schools.

It is important that all of these things are not just delivered to a school for a fee, which can add further to the barriers to supporting students who self-harm, but instead knowledge and experience need to be shared so that the practice can become sustainable within the educational setting without the need for an educational psychologist or other professional. When participants talked about needing more people and more professionals to support their students, they did not mean externally, they spoke about how these members of staff needed to be in school so that they can build relationships with students. The same is true for supervision, and although it is likely helpful that initially, the educational psychologist could deliver supervision sessions in school themselves, it is important for this to later occur without the support of the EP. This then gives the staff the option to apply peer supervision tools reflexively.

Having access to support from someone with training in this particular area, is as important as high-quality training. Although training can help members of staff to feel more confident about supporting children and young people with mental health difficulties and those who self-harm, there is still a need to apply the training reflexively and reflectively, and at times this will require further support. This support is key for schools to be able to support their student's mental health and

wellbeing. Currently, without this support, school staff do not feel as though they have the skills to provide their students with adequate support. Furthermore, this is not school specific, but is, as Future in Mind suggests, a national problem, which needs to be responded to on a national basis. For children and young people to get the support that they need, it will need to become routine for schools to have access to professionals for supervision and training around mental health and self-harm.

5.10 Dissemination

Before the research began, I offered to provide the school governors with an executive summary of the research which I could share at a governor's meeting. I also intend to submit my abstract to the British Psychology Society's (BPS) Division of Educational and Child Psychology (DECP) conference in January 2023 to allow me to share my research further within educational psychology. I also intend to explore the possibility of publishing my research with my research supervisor.

I have also offered a CPD session on self-harm to the school that took part in the research. This was something that was important to me from the beginning of the research and was included in the ethical application. It did not feel ethical to potentially highlight that a school needed training in supporting students who self-harm without providing some support. This training will also be delivered to the staff members within the educational psychology service where I am based so that they too can deliver the training further.

My research has been presented to the current trainee EPs at the University of Sheffield and will later be shared at a service day within the Local Authority where I will begin employment in September 2022.

5.11 Conclusion

Over the years, particularly with the release of Future in Mind (Department of Health & NHS England, 2015) and the 'transforming children and young people's mental health' green paper (Department for Health and Department for Education, 2018), the responsibility placed on schools to support mental health difficulties has significantly increased. This, alongside the reduction of specialist mental health support services and the increase in waiting lists, as well as higher thresholds needing to be met (Rice et al, 2017; Sharpe et al, 2016) has only furthered that responsibility. Although the responsibility has increased for schools to support children and young people that self-harm, confidence and competence to do so have not changed. Staff in schools do

not feel they have the skills or resources to do more than follow risk assessments which include counting in and out the sharp objects used in the lesson. Staff do not think this is enough, but time and fear are barriers that they face in doing more. School staff identify that they would like support and training to improve their confidence and competence in supporting students who self-harm.

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Appendices

Appendix 1: Ethical approval



Downloaded: 04/10/2021
Approved: 03/06/2021

Lisa-Marie Forge
Registration number: 190117676
School of Education
Programme: DEdCPsy

Dear Lisa-Marie

PROJECT TITLE: How staff in secondary schools experience pupil self-harm
APPLICATION: Reference Number 038549

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 03/06/2021 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 038549 (form submission date: 28/05/2021); (expected project end date: 01/05/2022).
- Participant information sheet 1091736 version 1 (14/05/2021).
- Participant information sheet 1091735 version 2 (28/05/2021).
- Participant information sheet 1091734 version 2 (28/05/2021).
- Participant consent form 1091739 version 1 (14/05/2021).
- Participant consent form 1091738 version 1 (14/05/2021).
- Participant consent form 1091737 version 1 (14/05/2021).

If during the course of the project you need to [deviate significantly from the above-approved documentation](#) please inform me since written approval will be required.

Your responsibilities in delivering this research project are set out at the end of this letter.

Yours sincerely

David Hyatt
Ethics Administrator
School of Education

Please note the following responsibilities of the researcher in delivering the research project:

- The project must abide by the University's Research Ethics Policy: <https://www.sheffield.ac.uk/rs/ethicsandintegrity/ethicspolicy/approval-procedure>
- The project must abide by the University's Good Research & Innovation Practices Policy: https://www.sheffield.ac.uk/polopoly_fs/1.671066/file/GRIPPolicy.pdf
- The researcher must inform their supervisor (in the case of a student) or Ethics Administrator (in the case of a member of staff) of any significant changes to the project or the approved documentation.
- The researcher must comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
- The researcher is responsible for effectively managing the data collected both during and after the end of the project in line with best practice, and any relevant legislative, regulatory or contractual requirements.

Appendix 2: Change to ethics

 **Lisa-Marie Forge** <lforge1@sheffield.ac.uk>
to

10 Feb 2022, 19:05 ☆ ↶ ⋮

Dear

Thank you for the very quick response. I have added the below into the word document.

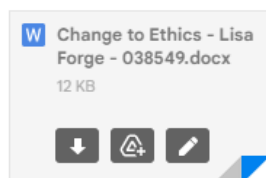
The interviews will be conducted via Google Meet and only audio will be recorded. Participants will have the option of having their camera on or off. Prior to the recording beginning, participants will be asked to give a pseudo-name to help facilitate conversation and maintain confidentiality.

Once the recording is made it will be stored locally on a local drive on a PC that is connected to a secure LAN. The drive in the PC is encrypted using XTS-AES 256 encryption and TPM validation. The user account is also password protected with a strong password. Data will be transcribed and anonymised before sharing with the research supervisor via the university drive.

many thanks

Lisa

⋮



sheffield.ac.uk> 11 Feb 2022, 08:12 ☆ ↶ ⋮

to me ▾

That's great. Thank you very much. I'll forward now to edu **ethics** and you can take this email as confirmation of approval.

Dr. University of Sheffield

Appendix 3: Recruitment letter



The
School
Of
Education.

Lisa Forge
Lforge1@sheffield.ac.uk
School of Education
241 Glossop Road
Sheffield
S10 2GW

To Whom it May Concern,

My name is Lisa Forge and I am a year 2 Trainee Educational Psychologist at Sheffield University and I'm also on placement at Derbyshire EPS.

I am about to begin my research for my thesis, and I was wondering if your school would like to take part. I've outlined the research below but please feel free to contact me with any questions you may have or if you would prefer for me to run through the research with you. I am hoping to recruit a school before the summer holidays so phase one can begin in the Autumn term. If you are interested, you can email me at: **Lforge1@sheffield.ac.uk**

My research question is 'how do secondary school staff experience pupil self-harm?'. With the introduction of mental health leads into school and the Government's focus on children and young people's mental health, there is a responsibility for schools to, at a minimum, respond to self-harm and I am interested in whether staff feel able to do this, and if so, why this may be, in the hope that we can identify areas of support that schools may need.

For my research I need one secondary school to commit to the below. At the end of the research (no later than May 2022) the school will receive training on how to respond to self-harm.

The research has two phases.

Phase 1: All staff within the school will need to complete an online questionnaire. This is optional and there are consent and information sheets prefacing the questionnaire so staff members can opt out, but it is important that it is sent to all members of staff within the school, including SLT, lunchtime supervisors, reception staff etc. At the end of the questionnaire, participants will have the option to add their name if they would like to take part in a focus group. The questionnaire is around ten questions long. I will be piloting it first so will be able to suggest how long it has taken others to complete, but it should not be more than ten minutes.

Phase 2: From the list of individuals who have put their name forward, three will be randomly selected for a focus group. The focus group will take place virtually via Google Meet and an invite will be sent to

each participant. The group will last around 30-45 minutes and can take place at a time that is convenient to the school. Questions in the focus group will be directly from the questionnaire and will be based on student self-harm. Participants will not need to have direct experience with student self-harm, nor will they need to discuss any students. The focus group will run at least two more times, with different participants for the same period of time with the same questions. I am using Grounded Theory for my research which means that the focus groups will need to continue to occur until data saturation is reached. I predict this will be around three focus groups, but this is subject to the data.

At this point I will take the data to analyse and we can book in your training at a time that suits you. Please let me know if you would like to take part in this research or would like more information by emailing LForge1@sheffield.ac.uk.

Kind regards,

Lisa Forge

Appendix 4: Information and consent form



You are being invited to participate in a research project called 'Understanding Secondary School Staff Experience of Self-Harm'. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Feel free to ask me if there is anything that you do not understand, or if you would like more information. Thank you for taking the time to read this Participant Information Sheet. The consent form can be found after the information has been displayed. Please read the information carefully and thoroughly before deciding on whether you would like to participate.

Participant Information Sheet

1. What is the aim of the project?

This research is being conducted as a part of the researcher's Doctoral qualification in child and educational psychology. The research aims to gain a greater understanding of how pupil self-harm is experienced by secondary school staff.

2. Why have I been chosen?

All members of staff within your school are being asked to complete the questionnaire.

3. Do I have to take part?

It is up to you to decide whether or not to take part. You will be given the option to add your name to the questionnaire. If you choose to do so, you will be able to withdraw your data prior to December 1st 2021. At this point, all the data will be anonymised and it will not be possible to withdraw your data.

If you choose to withdraw, you do not have to give a reason and there will be no consequences to your withdrawal. If you wish to withdraw, please contact Lisa Forge - Lforge1@sheffield.ac.uk

Please note that by choosing to participate in this research, this will not create a legally binding agreement, nor is it intended to create an employment relationship between you and the University of Sheffield. It is up to you to decide whether or not to take part.

4. What will happen to me if I take part? What do I have to do?

If you decide to take part in this phase of the research, once completing this form, you will be taken to a questionnaire which has eight questions. The majority of the questions have closed responses where you are able to select an answer, as well as a few open questions that will require short answers. This should take around ten minutes to complete. The questions are related to the research aims of creating an understanding of pupil self-harm in your school. The questions relate to your personal opinions and perspectives of how self-harm occurs in your school. You will not be asked to give specific examples. It is important that you answer the questions honestly.

You will be asked to include your job title in the questionnaire, this is optional, but is helpful for the research. Your data will be anonymous and even if you do choose to add your name, this will be stored separately to your other responses.

5. Will I be recorded, and how will my work be used?

There will be no recording through the questionnaire,

6. What are the possible disadvantages and risks of taking part?

The topic of self-harm can be triggering for some people. None of the questions will require you to speak about your personal experiences or that of others. If you feel this may be difficult for you, you do not have to take part. If you decide to take part and would like some support after, please speak to your school SENCO or contact the researcher, Lisa Forge - Lforge1@sheffield.ac.uk . If you would like support with self-harm or a mental health difficulty, please contact:

your GP

Samaritans - 116 123 or jo@samaritans.org

Next



7. What are the benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will help to gain a greater understanding of the education system's role and impact on children and young people who self-harm. This greater understanding could help to support schools and their students.

8. What happens if the research project stops earlier than expected?

Although unlikely, if for any reason the research project stops earlier than expected, you will be offered a full and clear explanation as to why.

9. What if something goes wrong?

If you feel something has gone wrong or would like to raise an issue/complaint, you are advised to contact the Research Supervisor Dr Victoria Lewis: v.lewis@sheffield.ac.uk. If you feel your complaint has not been handled to your satisfaction, you can also contact the Programme Director Dr Anthony Williams: Anthony.Williams@sheffield.ac.uk

If your complaint relates to how your personal data has been handled, information about how to raise a complaint can be found in the [University's Privacy Notice](#)

10. Will my taking part in this project be kept confidential?

All of the information that we collect through the questionnaire will be kept strictly confidential and will only be accessible to members of the research team. You will be given the option to add your name, this data will be stored separately to your questionnaire answers. You will be asked for your first name and initial if you would like to be invited to phase two of the research. You can change your mind and names will be deleted once they are used for this purpose.

11. What will happen to the results/findings?

The results will be analysed and summarised anonymously and will be used for the researcher's Thesis. It is also possible that the thesis may be published.

13. Who has ethically reviewed the project?

This project has been ethically approved via the School of Education's ethics review procedure. The University's Research Ethics Committee monitors the application and delivery of the University's Ethics Review Procedure across the University.

14. What is the legal basis for processing my personal data?

According to data protection legislation, we are required to inform you that the legal basis we are applying in order to process your personal data is that 'processing is necessary for the performance of a task carried out in the public interest' (Article 6(1) (e)). Further information can be found in the [University's Privacy Notice](#) The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.

14. What is the legal basis for processing my personal data?

According to data protection legislation, we are required to inform you that the legal basis we are applying in order to process your personal data is that 'processing is necessary for the performance of a task carried out in the public interest' (Article 6(1) (e)). Further information can be found in the [University's Privacy Notice](#) The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.

15. What if I have a safeguarding concern?

The University has developed a policy for safeguarding to aim to prevent harm in research and innovation and there is recognition that research activities can have an impact in the wider community and/or external individuals. The policy is designed not only to consider wider impacts of research but also to ensure that there are clear procedures in place for reporting and escalation, placing those who have been potentially affected in a key role in guiding how incidents or concerns are resolved. This policy is available at:

<https://www.sheffield.ac.uk/rs/ethicsandintegrity/safeguarding> Designated Safeguarding Contact is: Dr Victoria Lewis: Victoria.Lewis@sheffield.ac.uk

If the concern or incident relates to the Designated Safeguarding Contact, or if you feel a report you have made to this Contact has not been handled in a satisfactory way, please contact the Head of the School of Education: Professor Rebecca Lawthom, r.lawthom@sheffield.ac.uk and/or the University's Research Ethics & Integrity Manager (Lindsay Unwin; l.v.unwin@sheffield.ac.uk).

16. Contact for further information

If you have any questions about the study, please contact:

Email the researcher: [Lisa Forge](#)

Email the research supervisor: [Dr Victoria Lewis](#)

Thank you for taking the time to read about the project!

Next



Taking part in the project

I have read and understood the project information sheet, or the project has been fully explained to me. (if you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean)

- Yes
 No

I have been given the opportunity to ask questions about the project.

- Yes
 No

I agree to take part in the project by completing the questionnaire

- Yes
 No

I understand that my taking part is voluntary and that I can withdraw from the study by December 2021 if I include my name; I do not have to give any reasons for why I no longer want to take part and there are no adverse consequences if I choose to withdraw.

- Yes
 No

How my information will be used during and after the project

I understand that all my details will be anonymised. I understand that I will not be named in research outputs.

- Yes
 No

I understand that the resulting data or information from the study will be used for a thesis at the University of Sheffield, but I will not be identifiable from this data.

- Yes
 No

I give permission for the responses I provided on all tasks/activities to be stored securely on the University of Sheffield's Google Drive

- Yes
 No

So that the information you provide can be used legally by the researchers

I agree to assign the copyright I hold in any materials generated as part of this project to the University of Sheffield.

- Yes
 No

I consent to take part in this study

Next

Appendix 5: Self-harm questionnaire



The University Of Sheffield.

1. What is your job role? Please select the closest option

- Volunteer
- TA
- lunch/social time supervisor
- Trainee teacher
- Teacher
- Senior Leadership Team
- Site management
- Business support/administrative support
- Governor

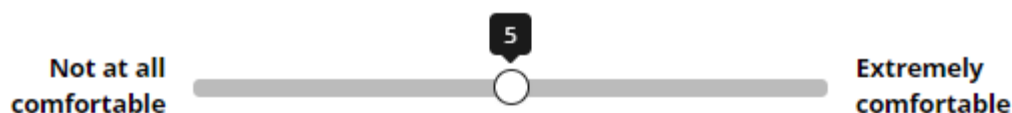
What is your job title if it differs from above? *Answering this question is optional as it may lead to identification*

2. How long have you been in this role in this particular school?

3. Which year group/s do you work with? Please select all that apply

- 6
- 7
- 8
- 9
- 10
- 11
- Other (please specify)

4. On a scale of 1-10, how comfortable are you talking about pupil self-harm?



5. How common is the identification of pupil self-harm in your school? (please select closest fit)

- daily
- weekly
- monthly
- bi-annually
- yearly

6. Is self-harm always a sign of a mental health problem?

- yes
- no
- Other (please specify)

7. Have you attended training on supporting students who have self-harmed in the last academic year?

- yes
- no

8. If a pupil told you they had self-harmed by cutting a part of their body, would you know what to do?

- yes
- no

9. Have you responded to pupil self-harm whilst being in your current role? If yes, how and to what effect? (please avoid identifying details)

- no
 yes

10. Who do you think is best placed to provide ongoing support to a student who has self-harmed?

- Adults in school
 Adults out of school

Who would this be?

Thank you for taking the time to complete the questionnaire. On the next page you will be invited to include your name if you are happy to be contacted to take part in a focus group. Please read the information on the following page.

Next



Thank you for completing the questionnaire.

Phase two of the research will be focus groups where participants will be invited to an online video call to discuss pupil self-harm.

Focus groups will last for 30-45 minutes and three members of staff will be invited to take part.

If you are happy to be contacted regarding focus groups, please leave your name below.

Please note that this information is stored separately to your questionnaire responses, so they will remain anonymous.

If you are randomly allocated a place on a focus group, your name will be given to David Mills and Lorraine Clewes, who will contact you with further information. At this point you will be given the opportunity to take part in the focus group and give consent. Noting your name below **does not** mean you have to take part in the focus groups. All data from the focus groups will also be anonymised.

Please add your name if you are happy to be contacted regarding focus groups

Next

Appendix 6: Prompts for round one

Thank you for coming along. It will be recorded, but voices only. They will then be transcribed anonymously and your names will not be attached to the research in anyway

Consider confidentiality, so do not name anyone, and consider confidentially with each other, for example if you refer to somebody who you know has self-harmed, avoid descriptive information

No right or wrong answers, it doesn't matter if this is an area you are confident in or not. Fairly informal, we can jump around etc.

I'm interested in how adults respond to student self-harm in secondary schools, and if there is anything that other services should be doing to support, so I plan to discuss the questionnaire in more detail.

If any of this is triggering for you, you can just leave, you don't even need to give a warning if you would prefer not to. If you do find yourself needing support, please access this through your GP or contact the Samaritans.

Any questions?

Okay before I begin recording I want to let you know the first question I will ask is job title and your name, give me a fake name, whatever you like. It helps transcription software and you do have a month to withdraw your data if you choose to so it will help to identify you

Begin recording

What are your job titles?

How comfortable are you talking about student self-harm?

Do you think self-harm is common in your school?

Do you think self-harm always means there is a mental health problem?

Have you attended training on self-harm? Do you think staff should? Which staff?

If you saw a pupil had self-harm marks on their body, would you know what to do?

Have you responded to pupil self-harm, can you tell me a bit about what happened?

Who do you think should provide students with support if they are self-harming?

Is there anything else you would like to share, any experiences or opinions etc?

End recording

Thank you

Any questions

Reminder about safeguarding

Would you be open to being contacted in future, you can later refuse

Appendix 7: Prompts for round two

Thank you for coming along. It will be recorded, but voices only. They will then be transcribed anonymously and your names will not be attached to the research in anyway

Consider confidentiality, so do not name anyone, and consider confidentially with each other, for example if you refer to somebody who you know has self-harmed, avoid descriptive information

No right or wrong answers, it doesn't matter if this is an area you are confident in or not. Fairly informal, we can jump around etc.

I'm interested in how adults respond to pupil self-harm in secondary schools, and if there is anything that other services should be doing to support, so I plan to discuss the questionnaire in more detail.

If any of this is triggering for you, you can just leave, you don't even need to give a warning if you would prefer not to. If you do find yourself needing support, please access this through your GP or contact the Samaritans.

Any questions?

Okay before I begin recording I want to let you know the first question I will ask is job title and your name, give me a fake name, whatever you like. It helps transcription software and you do have a month to withdraw your data if you choose to so it will help to identify you

Begin recording

What are your job titles?

I wanted to share my thesis title again as not everyone was here and wondered if you had any more thoughts?

So when we think of counting the sharpeners, do we think that's enough?

What is the biggest barrier to doing more?

End recording

Thank you

Any questions

Reminder about safeguarding

Would you be open to being contacted in future, you can later refuse

Counting the
sharpeners: How do
secondary school staff
experience student
self-harm?

Appendix 9: Example transcript

1 Transcript – Phase 2 – Transcript 6 Focus Group 4

2 Researcher = RED

3 Michael = black

4 Louise = green

5 William = blue

6

7 START

8

9 So we are now recording and just let me wait, let the screen change to recording before I commit to
10 believe in it. There we go. It's recording. Okay, we are now recording. Thank you very much for
11 coming back to the second focus group that you've been a part of, can we just go round and you can
12 give me your name and your job title, this is the hard bit because there's three of you. So one of you
13 just gonna have to start talking.

14 So my name's Louise, and I'm a teaching assistant.

15 Hi, I'm William, and I'm the

16 I'm Michael, I'm the Technician.

17 Thank you very much, everyone. Now this is when I'm going to share my screen. And it's all going to
18 go very well and neatly as technology does. So let's pop that up. And I'm just gonna read to you my
19 thesis question. It's a working title. So at the moment, can everybody see that? Yeah, so at the
20 moment, my working thesis title is counting, the sharpeners, a grounded theory study exploring
21 school staff experience of pupil self-harm. So I'll just give you a moment or two to reflect on that.
22 And then whoever wants to break the silence is very welcome to and if you could just let me know,
23 your reactions to my working title, I'm going to keep some notes. So carry on.

24 So I got myself, I think it's quite a grabbing thesis title, especially, I think the opening three, three
25 words, actually counting the sharpeners cause straightaway, in my head, I'm thinking loads of
26 different explanations behind what counting the sharpeners could be straightaway, my head
27 counting, the sharpeners came up with like a bit of a small bladed item, for example, like out of a
28 literal pencil sharpener, which are to, we see quite a profound, profound effect at our school of self-
29 harm. And again, as well as the staff experiences of the self-harm. I think it's like a two, two ended
30 question really, you've got sort of two questions where you've got the first part, which is a bit more
31 of a exploratory arm, and the second part where you're asking the actual staff members for their full
32 experiences, what I said that popped into my head straight away, the first three words
33 it made me think straightaway of like being in a classroom, especially one that have tools and things
34 like that, that could be used for self-harm. And that that, you know, at the end of a lesson, where
35 you've got to think, right, how many, how many do we have? How many, how many, you know,
36 we've got to get in and thinking back to all the risk assessments we've got in place, and you know,
37 what students we've got in that classroom, and it's always that thought of thinking, Yeah, you know,
38 sometimes that panic that you have, in a classroom thinking, making sure that no one could have
39 anything that they could harm themselves with.

40 Yeah. For me the first thing that sprung to my mind was counting scalpels from dissections in and
41 out.

42 So in chose the first part of the title it is a common practice that we sort of have. But yeah, it's sort
43 of come as sort of two sides of the coin. Really, it's sort of what we do and experience at the same
44 time. It's a good open title.

45 I think that was a very good point as well, where you mentioned about the actual volume of risk
46 assessments that we've got, try and actually remember, which, which student has the risk
47 assessment, but then also, what each individual has, for their specific needs. And like you said it
48 must be I've not experienced too much of the counting in and out, like yourselves have of different

49 equipment in lessons, like you and sometimes it might feel like quite high pressured environment,
50 because you've always maybe gotten in the back your mind. Well, what if we don't get the correct
51 number back? What? What's going to be the knock on effects from that? I think again, yeah, it's sort
52 of linked back into that thesis title about counting again, of how many different things you've got to
53 look at and yeah, make sure that we are counting in and out all the different items and count how
54 many students have got certain risk assessments, how many students do partake in shouting for help
55 through through through self-harm.

56 I think a further one as well, where it's speaking about the staff experience of the self-harm as well,
57 I'd like it'll be interesting to actually to ask and do a bit of a where, again, linking back to the
58 counting part of actually counting how many staff members feel confident in, openly speaking to
59 students and supporting them with with self-harm. Because I can imagine, some staff may feel a
60 little bit more apprehensive about potentially giving wrong advice or, or saying the wrong thing. So
61 just potentially due to not having, maybe not having the experience of speaking with students or
62 staff on ball. So again, depending on how severe the self-harm is, it sometimes can really, really hit
63 you, you sort of freeze. So actually yeah counting how many members of staff have that confidence
64 to approach a student actually speak about self-harm, will I I think will be a very interesting point to
65 take on as well.

66 Yeah, and it's also like, also things in, like, in a classroom, cause I move around the classroom a lot is
67 sometimes when you see a student with something that they then can potentially harm themselves
68 with. And like trying to, you know, do it in a sort of way of, you know, trying to get you take it off
69 them, like, you know of, yeah, thinking, you know, I don't, I don't want to be in a situation where
70 they, they've got I know, they've got something and then having to like, take it further than rather
71 than being able to just nip it in the bud. Right, right away, you know obviously letting the right
72 people know. And sometimes it's something that becomes, it's quite innocent, but other times you

73 think, well, I just want to make sure that it's not potentially something that they're making a habit
74 of, even if it's something like even a ruler, sometimes that they'll

75 I was just gonna say that as well. It's like. Sometimes it's are we, are we thinking that we're going a
76 bit too far. And over, over, over protecting and sort of not allowing for the children and young
77 people their own experience of what the classroom are like if we're getting to a point where we're
78 thinking like, gosh, you can't even have a ruler. It's, is that becoming like, creating quite a difficult
79 environment for learning to actually take place efficiently and productively for the students. And it is
80 like, are we wrapping students with too much in cotton wall at times where really we've seen I know
81 self-harm sometimes be superficial, which it can be quite quite a few on quite a few occasions
82 where sometimes it's trying to copy others. Again, I know self-harm can sometimes be a bit of a
83 shout for help. But I think sometimes it's sometimes can see jealousy, even sneaking within peer
84 groups, especially those of younger ages. And especially where I would feel with maybe year groups,
85 such as year nine as well, where it's sometimes a difficult year group where they sort of moving on
86 to being a young adult, but with the impact we've had of the pandemic with noticing how young
87 they actually are and I see that sometimes the self-harm can be out of jealousy really, where they
88 just want that extra extra love and attention really, and they do superficial. And then it's sometimes
89 exploded. Where really there's not. I know again, it sounds harsh, but there's not too much actually
90 there over than it's just a bit of jealousy when they're just wanting that extra bit of attention. But
91 then it's obviously a different difficult balancing act to judge whether or not they need this extra
92 attention and support and if it's not given will it then spiral out of control and then become a real,
93 real worry over self-harm?

94 Yeah, I would say we've had some discussions sort of with the department you know should we be
95 literally counting sharpeners in and out you know is that, you know, a step too far. it is that sort of
96 thing is to you know. What do you do you know Some things are very obvious to count in and out all
97 the things tht are on that cusp

98 Yeah. No I agree with that cause it's one of those, it's obviously a pencil sharpener, know I would feel
99 for us, it's just, it's a normal item, you wouldn't look at it as as anything out of the ordinary, it's got a
100 purpose. And that's just to sharpen a pencil. So you can obviously help help with your, with your
101 learning, you can write down what they need. Is it is it, I think it's very difficult to actually get a point
102 of, again, are we are we not allowing students to actually get on with their day to day because
103 obviously, when they leave school, they're out in the big wide world. And if that support that they've
104 got could then just completely disappear from all of the support from teaching assistants from from
105 teachers from support staff, and it just sort of disappears, where does that student or young person
106 then go to? So I think sometimes, if we're targeting too a bit too much, and over protecting them, it
107 could then actually lead to a bit more of a detrimental effect on them, where we potentially put
108 ideas in their head about oh, actually, they're not allowing me to have this pencil sharpener because
109 of the impact it could potentially have. On me, what can I use can harm. They're saying they're sort
110 of saying to me, I could use this to hurt myself. And that's given them sort of ideas going forward? So
111 I think, yeah, it's a very, very difficult balancing act, which again, links back into the thesis question,
112 which I perceived the question to be again, are we are we are we becoming to? Are we a step too far
113 over making sure we're counting everything in and out?

114 **Okay, we've been talking about 12 minutes, I don't know if there's anything else anybody would like**
115 **to add? About what comes up for them when they read the title?**

116 I think for me I think it just links back in again, where it says, exploring school staffs experience, yeah
117 I think it'd be very interesting to have like, a real good questionnaire potentially for all staff to say,
118 have you? Are you aware of self-harm that took place? Have you seen it? Have you dealt with it?
119 And then on a potential Ordinal Scale of feeling how confident you would be actually to sort of say,
120 Yes, I'm confident in knowing what to do or I'm confident in dealing with that I think that would be a
121 very interesting part again in thinking back to the counting aspects of how people would actually
122 perceive the experience and how they feel confident in tackling it head on really.

123 I say, I don't think we've had any specific training here on dealing with self-harm. So they they you
124 know they must be a real mix within the staff that's here as to who's going to be confident and you
125 know the people that just haven't you know. Myself, I'm I very rarely deal with students. But yeah, I
126 wouldn't, I wouldn't potentially know where to start.

127 Yeah, I can see. Yeah, I agree with that. Yeah. Cos I know, within my role it is more so just through
128 experience, where I know where we all have like bigger like on the inhsset days at the start of the
129 year, we sort of have the big presentations about where we need to, like log everything and speak to
130 and there's all there's always the obviously generic questions of like try to use open ended
131 questions. Try not to use leading leading questions because obviously that could lead to sort of
132 biases over students thinking that are potentially to asking me to say this students believe in that are
133 actually yeah they've sort of said ah you've got a bit of self-harm ah has has mums done that has dad
134 done that, then it could sort of lead to like a bit of a demand characteristic over the student or
135 young person. Sorta thinking oh they're wanting me to say that X parents done this X family
136 member. When actually that could then lead to quite quite a difficult and grey area over
137 approaching parents carers, and sort of saying, well, they've said that this has gone off when
138 actually, it's potentially a, again, a bit of a it's hard to say error on staff. But, obviously, we've not had
139 the full training to deal with it head on how to actually speak to students, and how to how to speak
140 to them about it. And again, not having any closed ended questions, any leading questions, and bits
141 like that, really?

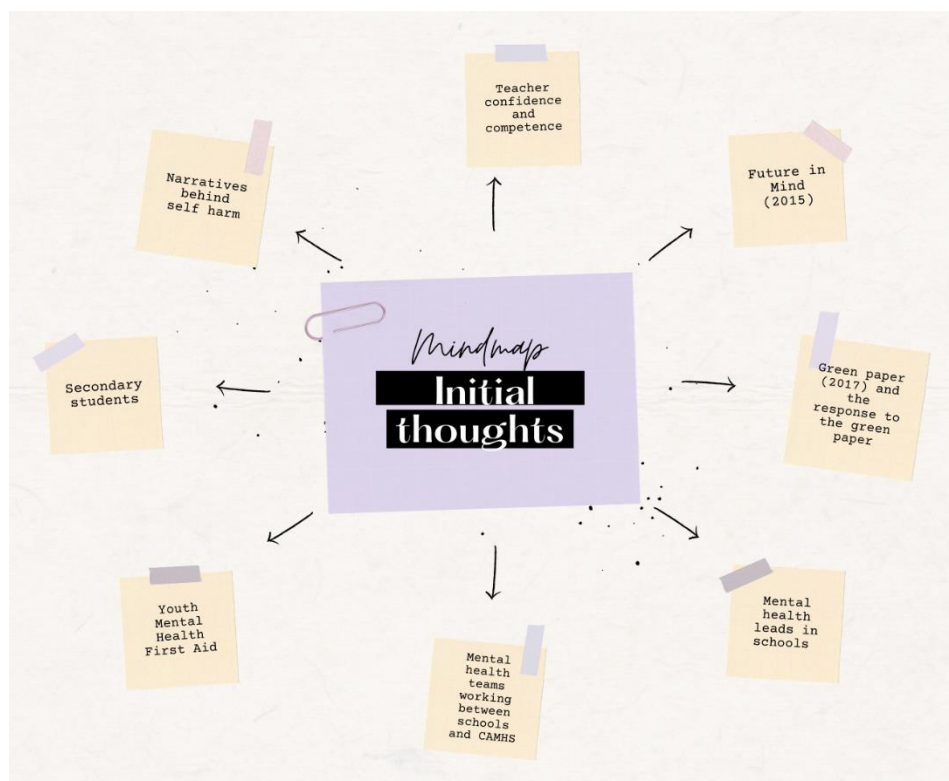
142 Yeah, I mean, my experiences, if I have seen anything that I thought could potentially be self-harm, is
143 that I've, I've logged it and like the safeguarding leads know, that's always been my, you know,
144 sometimes I might say, oh you know, oh what've you you know, if it looks like it could just be they've
145 tripped over and, you know, we'll have like, or if it's an injury somewhere, that's more obvious, I'd
146 say, you know, you know, what you done or something like that. And then I'd, if I thought that the
147 answer they gave me wasn't, I then might then think, Oh, I might, I'd log that. But erm, yeah,

123 I say, I don't think we've had any specific training here on dealing with self-harm. So they they you
124 know they must be a real mix within the staff that's here as to who's going to be confident and you
125 know the people that just haven't you know. Myself, I'm I very rarely deal with students. But yeah, I
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128 experience, where I know where we all have like bigger like on the inset days at the start of the
129 year, we sort of have the big presentations about where we need to, like log everything and speak to
130 and there's all there's always the obviously generic questions of like try to use open ended
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135 young person. Sorta thinking oh they're wanting me to say that X parents done this X family
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137 approaching parents carers, and sort of saying, well, they've said that this has gone off when
138 actually, it's potentially a, again, a bit of a it's hard to say error on staff. But, obviously, we've not had
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145 tripped over and, you know, we'll have like, or if it's an injury somewhere, that's more obvious, I'd
146 say, you know, you know, what you done or something like that. And then I'd, if I thought that the
147 answer they gave me wasn't, I then might then think, Oh, I might, I'd log that. But erm, yeah,

Appendix 10: Sample of memos

Memo: Considering ideas

What are the problems that exist relating to self-harm?

- *Schools are being told they have to take responsibility for mental health difficulties. Do they feel able?*
- *Is self-harm a mental health problem?*
- *How can we help schools to feel able?*
- *Is it fair to give them this responsibility?*

Memo: Narratives

Looking at the narratives behind self-harm, Cello Health and YoungMinds comment that self-harm is a child protection issue, but also that other behaviours including smoking and eating disorders are not. It also discusses different narratives around self-harm such as it is due to bad parenting. I had not come across that narrative before, perhaps as I do not have the perspective of a parent and wonder about the distance a teacher has as opposed to a parent?

Memo: Grounded Theory

Considering Grounded Theory, all is data, but is all data needed? And all is data but data is likely to be collected remotely only so will this act as a barrier to data quality?

Memo 9: Embargo

Consideration of an embargo – will the school be easily identified? I think steps can be taken to ensure that it is not, but it is something to be mindful of throughout the research in case details come to light that do make it identifiable. It will be my role, as researcher, to carefully consider which information to include about the school. Some information will be necessary or perhaps interesting for analysing data, such as socio-economic status but this does not need to be detailed information.

Memo: considerations from pilot

Considering pilot data collection and questions that could be helpful.

- *Job title*
- *How long have you been in the role*
- *How comfortable are you talking about self-harm?*
- *Is self-harm common in school? (very perspective led for most members of staff)*
- *Is self-harm a mental health problem?*
- *Have you attended self-harm training?*

Memo: Intention

I had a really interesting meeting with a Ph.D. student who is completing research on self-harm in primary schools. We spent a long time discussing the definition of self-harm. We talked about how in primary school children would talk about deliberately falling over so that an adult would tend to them or so that they could visit the school nurse etc. We talked about how this was self-harming behaviour but that the intent was perhaps different from how we would consider it to exist with older children and young people. Prior to the research, I felt sure that I understood the term 'self-harm'. But the more discussions I have, the less I feel sure of this.

Memo: Behaviour policies

When I mentioned to my colleagues that I was interested in self-harm in secondary schools, they all had the same story. They all spoke of a school that they knew that had 'students should not self-harm' written into their behaviour policy. This feels like a very extreme reaction and I wondered how the school would perceive this in terms of success. Is there less self-harm in the school where students are told they are not allowed to? What is the consequence of self-harm if it is written into the behavior policy? It brought up a lot of unanswered questions and perhaps the story is even just hearsay but it was interesting that this was a lot of people's first thought.

Memo: Ethics amendment

It was becoming quite difficult and frustrating trying to get everyone's diaries to match to meet for a focus group. Once they had worked it was often occurring that members of staff were unwell or had changed responsibilities. I knew all of these things were unavoidable but they were also delaying the research. After a discussion with my supervisor we felt it would be a good idea to just do interviews on these occasions, but to also make it clear that the participant would be meeting with the researcher alone and not in the format they were expecting. I also needed to amend my ethics form as although I had written that focus groups were the primary data collection method I had not mentioned interviews.

Memo: Possible questions to use

Prior to deciding which category to explore further, I created a list of questions that I could use for phase two for each category as I felt that this would help me decide which category to use. Ultimately, category two was the most populated and the question I had chosen (in red), I felt was the best direction to take the research. The other questions, however, were helpful for further understanding the data and I also felt they would be useful when later discuss future ideas for research

1.	<p>Do you think secrecy plays a role in self-harm? Who should be aware if a student self-harms?</p> <p>Grand tour: I'm supposed to be asking you about secrecy and how it links with self-harm in schools, but I don't have a specific question to ask, and wondered what you thought about this or what may be good questions to discuss?</p>
2.	<p>From speaking to staff in your school I'm really interested in the impact on you, as a staff member when supporting a pupil who has self-harmed - what is that experience like? Do you think there's a right and a wrong way to respond to self-harm? Do you think it's beyond your role to support pupil self-harm?</p> <p>Grand tour: From speaking to adults in your school, I'm considering my thesis title to be: (show on the screen?) Counting the sharpeners: A Grounded Theory study exploring school staff experience of pupil self-harm. What do you think of the title?</p> <ul style="list-style-type: none"> ● My understanding is that day to day, an adult in schools role is to keep a pupil safe, do you agree? How can you do this? ● What is your role, in school, to support pupils who self-harm? ● What actions do you take to support students who self-harm? ● What sorts of things would be on a risk assessment for a student who self-harms?
3.	<p>From speaking to adults in your school, I understand that you do a lot of work in school to support students who self-harm, do you know what this work looks like? Do you agree? From speaking to adults in your school, it seems that most feel self-harm needs to be supported by medical staff who are specialists, alongside school support, what do you think?</p>
4.	<p>Do you think self-harm is increasing, why? From speaking to adults in your school, most seem to think self-harm is increasing and there are lots of ideas around why - what do you think?</p>

	Do more or less students self-harm now? Do you have an idea why this has increased/decreased?
5.	Adults in your school think self-harm training would be a good thing - what difference do you think it would make? Grand tour: I'm supposed to be asking you about self-harm training in your schools but what I'm interested in talking about may not be what you are, so in terms of self-harm training, what do you think would be a good place to begin discussing?

Appendix 11: Order of action

	Order of Action	Timeframe	Adjusted
1	Submission of draft methodology to Supervisor	December 2020	-
2	Ethics, information forms and consent forms were submitted to the university	May 2021	-
3	Amendments made to ethics to state research may be published and approval was gained (appendix 1)	May 2021	-
4	Initial literature review was written based on researcher rationale	June 2021	-
5	Pilot questionnaire was sent out to secondary school staff	Jul 2021	-
6	School was recruited and a meeting arranged to discuss the research	June/July 2021	October 2021
7	Meeting attended on site with school link	July 2021	October 2021
8	Questionnaire distributed to all staff members via each staffing group	Sept 2021	Nov/Dec 2021
9	Questionnaire data is analysed	Oct 2021	Dec 2021
10	Participants are randomly chosen to take part in a focus group	Oct 2021	Jan 2022
11	Ethics is amended to include 1:1 interviews	-	Feb 2022
12	Round one of data collection	Nov 2021	Feb/Mar 2022
13	Round one is transcribed	Nov 2021	Mar 2022
14	Round one is analysed	Nov 2021	Mar 2022
15	Round two is planned based on round one analysis	Nov 2021	Mar/Apr 2022
16	Round two of data collection	Dec 2021	Apr 2022
17	Round two is transcribed	Dec 2021	Apr 2022
18	Round two is analysed	Dec 2021	Apr 2022
19	Round three is planned based on round one analysis	Dec 2021	May 2022
20	Round three of data collection	Jan 2022	May 2022
21	Round three is transcribed	Feb 2022	May 2022
22	Round three is analysed	Feb 2022	June 2022
23	All data is compared and analysed	Mar 2022	June 2022

24	Data analysis chapter is written	Mar 2022	May/June 2022
25	Main literature review is written	April 2022	June 2022
26	Discussion is written	April 2022	July 2022
27	Thesis is edited and reviewed prior to submission	May 2022	August 2022

Appendix 12: Qualitative data from questionnaire

The second question asked participants who said that they had responded to self-harm 'if yes, how and to what effect?

I noticed self-harm marks and asked the student if they needed to talk to someone. They confided in me and I explained they have done the right thing in telling someone, gave them emotional support and referred them to the pastoral team.
reported the incident and the pupil was observed by the safeguarding team
A Yr 8 female scratching herself on her back of hand/arm clearly distressed and she stopped when I asked her to and took her to the Pupil support centre
Reported it to the relevant members of staff.
I have spoken to the Safe Guarding Officer and logged it onto My Concern.
Passed concerns on to Safeguarding Team, talked to child and parent and advised TAs
a student told me that they were self-harming and I asked them to go to student support as they are more equipt than myself. if this has not been available then i have asked the student to wait in reception while i speak to my manager so that we can figure out the best way to help
Student explained about their self-harming and anxiety. Emailed information to contact in school.
Talking to pupil reporting the incident to the safegaurding lead
numerous occassions of people using pencil sharpener blades to harm their wrists etc. A need to identify, record, consider background information and who needs to have that relevent information in order to inform a planned next step as regards to safety and overall wellbeing.
Acted as first aid
Ensured the wound(s) appeared clean & not infected. Contacted parents / carers to inform them & advise all sharp objects such as knives be hidden at home. Advised teachers to ensure students have no access to scissors / pencil sharpeners etc.
Intial emotional support for the pupil. Unpicked the reasons why. Confiscation of object used to self-harm. Passed to DSL.
filled in my concern and given support to listen to the students needs before passing on the information
From superficial (e.g. rubbing or itching skin resulting in red marks) to sever self-harm in the form of using blades to cause profound/deep lacerations
Reported to the relevent staff and first aid applied to the student
One student said they had cut themselves and I immediately informed pupil support. They alerted me to the fact that they were aware of the issue.

Logged through 'My Concern'
Careful monitoring, e.g. making sure potentially dangerous resources are collected in, checking attendance carefully, not allowing them to use toilet without supervision,
Report to Designated Safeguarding Lead
One pupil displayed obvious signs of self-harm. I discussed with pastoral and child protection team, had conversation with the pupil and consistently enquire to their well being
Spoken to safeguarding at school
Not allowing certain pupils to have equipment which they may use to self-harm. Not allowing others to go to the bathroom unsupervised.
identification of issue, finding support
On one occasion, a student approached me to say a cut they had made on their leg was hurting them. Another time I noticed a student had self-harmed and got somebody to come and support the child immediately.
reported on My Concern
Speaking directly with pupils/referring to safeguarding team.

Appendix 13: Open and in vivo coding from focus group 1 transcript

Memo: Thoughts immediately after focus group 1

Michael seemed to notice quickly that he did not have as much knowledge as Lucy, and that this was almost a bad thing? He would often echo her answer or agree with what she had to say. I wonder if this means that he feels he should have the same level of knowledge?

A lot of Lucy's knowledge and experience comes from her personal life, she disclosed after the recording that she knows someone personally who has self-harmed – I wonder if her knowledge is more linked to this than her role as a member of staff in a secondary school?

It seems that self-harm instances are increasing, but only the lower levels

Self-harm does make people think of suicide

Memo: During first reading of transcript:

Phrases and ideas that arose at a surface level:

- Common
- Comfortable
- 'deal' with
- No experience
- Increase in instance
- Levels
- Coping
- Secrecy?
- Coping
- Talked about more
- Awareness
- Openness
- Not mental health
- Longevity

- Means of coping is unaware of better ways
- Personal connection – necessary when supporting
- Raise awareness
- Helpful to know more
- One pathway is limiting

The main things that were sticking out was that there seems to be two stages of self-harm, the initial reaction and then the support, and that the two are quite separate. There also seemed to be a level of secrecy around what happens and also an awareness that people should not what to do.

Transcript (from Focus Group 1 transcript, Michael and Lucy)	Initial coding
<p><i>Unsaid</i></p> <p>M: I am aware of certain students</p> <p>L: young children often go through self-harm as a coping mechanism</p> <p>L: It's very common in school</p> <p>L: you can be brought up in the most loving, caring, supportive family, and yet still feel that everything you do isn't good enough, and that you need to punish yourself for that. And as a result of that self-harm can come</p> <p>L: people that do self-harm aren't always the people that you'd expect.</p> <p>L: there's no set sequence of events that that leads to it.</p> <p>L: can't say that there's a set thing to look at, I think it's very much individual</p>	Who self-harms
<p>M: I am aware of certain students, but I think there's probably a few that I'm not aware of</p> <p>M: I've not got very much experience in school [of self-harm]</p> <p>L: I wouldn't say that staff are aware of all students who do, it's only those with the severest risk assessments</p>	Secrecy or levels of who should know

<p>L: Initial discovery</p> <p>L: Deal with the initial disclaimer</p> <p>L: Not approaching the student directly</p> <p>L: Going through the right sources</p> <p>L: There's slight tell-tale signs</p> <p>M: I've seen it but for someone who we're already aware of in school it's the individual I've got in mind, is somebody that I was made aware of</p> <p><i>It only needs to be responded to once</i></p> <p>L: There are more students exhibiting signs of self-harm</p> <p>L: we were measuring pulse rate. So in order to get measure that pulse rate, I was getting them feeling on their wrists and on the neck and trying to find a pulse. And I've got one young lady that was greatly struggling to find her pulse. And we went from one wrist to asking her to use the other. And she, she wouldn't, and it was the initial alarm bells. She went to put her hand up and her sleeve came back slightly and I saw a slight mark</p> <p>L: because I'd got a very good relationship with this young lady, because I've known her for a while that initial conversation actually came through me and the Child Protection Officer. And she disclosed fully, she felt comfortable to do that</p> <p>L: ended up getting her CAMHS support in the in the end. So she went down the route of needing CAMHS, and having full CAMHS support while she was at school</p>	Step 1: knowing
<p>L: I know the different pathways that I need to take and how to approach it</p> <p>M: They should be the right person for that individual student</p> <p>M: What support that student needs rather than pigeonholing people to say, person X because of this</p>	Step 2: helping

<p>M: I don't think I'd know that off the top of my head. But I've got a rough idea as to who I'd go and speak to to seek, you know, guidance from them</p> <p>L: So we have a range of people that they can go to, to work with them.</p> <p>L: it will be the person that is most appropriate for that student</p> <p>L: because I think it's very much down to why the student is health self-harming in the first place as to what support they need to put in place</p>	
<p>L: I've unfortunately come across many of these in the past</p> <p>M: Probably more common that I think it is</p> <p>L: More acceptable</p> <p>L: people are happier to discuss it</p> <p>L: More awareness... knowing about self-harm, knowing about mild methods of self-harm</p> <p>L: I would say that, that there is a higher proportion than there was only 10 years ago, of students who do self-harm or exhibit self-harm characteristics</p> <p>L: I think it's talked about a lot more than it ever was</p> <p>L: I've dealt with self-harm a lot</p> <p>L: It's very common in school</p> <p>L: I think it's more common now than it was only 10 years ago</p> <p>L: I would say that there's not an increase in the severe self-harm</p>	Common/increasing
<p>L: I know what signs to look for</p> <p>M: Everybody should attend [training on self-harm]</p> <p>M: Training would be useful</p>	Awareness/Training is helpful

<p>L: No I wouldn't say I've had any [training on self-harm]</p> <p><i>Training needs to be sought out personally</i></p> <p>L: The more people are aware of it the more we can support the young people</p> <p>L: [With training] the less likely we are to have the more aggressive forms of self-harm take place</p> <p>L: If you can spot these signs, and you can intervene at that early stage, then it's less likely to develop into the more severe forms of harm</p> <p>M: at the time it was helpful [previous training]</p> <p>M: It sort of got us more aware</p> <p>M: Not at this school ... I don't think I've had any training while I've been here on self-harm that I can think of</p> <p>L: I think it should be for all staff</p> <p>L: I think all staff need that knowledge and awareness</p>	
<p>L: 80% of the time it's a coping mechanism</p> <p>L: Doesn't mean that there's something wrong</p> <p>L: They don't know how to cope</p> <p>L: There are a lot of factors involved with it</p> <p>L: I don't think that self-harm automatically means that [there is a mental health problem]</p> <p>L: young children often go through self-harm as a coping mechanism</p> <p>L: They don't know how to deal with an emotion</p> <p>L: some of them starting to use it as a coping mechanism</p> <p>L: They know it exists as a coping mechanism</p>	Why self-harm?

<p>L: We're starting to talk more about mental health, we're starting to talk more about wellbeing and that awareness and openness conversation means that were finding out more than we used to</p> <p>L: Sometimes it's stress and it's learning to deal with different coping mechanisms of stress</p> <p>L: Mild self-harm, self-harm tendencies, that's become much more of a coping mechanism for students</p> <p>L: I think it's talked about a lot more than it ever was</p> <p>M: Could be there is something else going on in the background that needs to be dealt with</p> <p>L: I'd say there's triggers in terms of exams and stresses and pressures of growing up, hormones, all those sorts of things can be triggers, but they're not the only things that come into self-harm. And they're not necessarily the reason why somebody does</p>	
<p>L: I don't find it something that I become uncomfortable when I need to talk about</p> <p>M: I'm the opposite end of the spectrum, probably not as comfortable, erm just because my role is not student facing</p> <p><i>If you aren't confident, there should be a reason why</i></p>	Confidence/comfortable
<p>L: People go through for a short time</p>	Longevity = severity?
<p>L: Interest and also to support family members</p> <p>L: So there's there's several incidents, but there's there's one student that kind of sticks in mind</p>	Personal link
<p>M: I don't mean it's indicative... but I think it's something that you always it's something that you need to have in the back of your mind</p> <p>M: it's very difficult to say as to whether its mental health or not, without actually having open dialogue with the person</p> <p>L: I don't think that it necessarily is down to an issue in terms of mental health</p> <p>M: No I think there are cases where it's not indicative that there is a mental health problem</p>	Link to mental health

<p>L: we have students with individual risk assessment plans, who I would say are on a higher level of half harm than others</p> <p>L: And then it can go from one extreme to the other. And sometimes it can start mild and get more extreme</p>	Levels of self-harm
<p>L: The reason people are scared of it is because they can't relate to it</p> <p>L: sadly, she's no longer with us as a result of that self-harm that took place later on. But that was when she was 19 years old.</p> <p><i>The stories and incidents people remember are severe and sometimes linked to suicide</i></p>	Fear? Suicide

Appendix 14: Fully represented categories

1. Secret or levels of who know
2. Approaching the topic with the student, initial response to self harm, confidence and comfortability in responding to self harm, response related to 'severity' and impact on self when responding, including fear of getting it wrong.
3. Who should be helping longer term?
4. Self harm is becoming more common
5. Self harm training is needed
6. Why do students self harm?

Question ideas for each category

1.	<p>Do you think secrecy plays a role in self harm? Who should be aware if a student self harms?</p> <p>Grand tour: I'm supposed to be asking you about secrecy and how it links with self harm in schools, but I don't have a specific question to ask, and wondered what you thought about this or what may be good questions to discuss?</p>
2.	<p>From speaking to staff in your school I'm really interested in the impact on you, as a staff member when supporting a pupil who has self harmed - what is that experience like? Do you think there's a right and a wrong way to respond to self harm? Do you think it's beyond your role to support pupil self harm?</p> <p>From speaking to adults in your school, I'm considering my thesis title to be: (show on the screen?) Counting the sharpeners: A Grounded Theory study exploring school staff experience of pupil self harm. What do you think of the title?</p> <ul style="list-style-type: none"> ● My understanding is that day to day, an adult in schools role is to keep a pupil safe, do you agree? How can you do this? ● What is your role, in school, to support pupils who self harm? ● What actions do you take to support students who self harm? ● What sorts of things would be on a risk assessment for a student who self harms?
3.	<p>From speaking to adults in your school, I understand that you do a lot of work in school to support students who self-harm, do you know what this work looks like? Do you agree?</p>

	From speaking to adults in your school, it seems that most feel self harm needs to be supported by medical staff who are specialists, alongside school support, what do you think?
4.	Do you think self harm is increasing, why? From speaking to adults in your school, most seem to think self harm is increasing and there are lots of ideas around why - what do you think? Do more or less students self-harm now? Do you have an idea why this has increased/decreased?
5.	Adults in your school think self harm training would be a good thing - what difference do you think it would make? Grand tour: I'm supposed to be asking you about self harm training in your schools but what I'm interested in talking about may not be what you are, so in terms of self harm training, what do you think would be a good place to begin discussing?
6	I've spoken to different staff members in your school and we've briefly talked about why pupil's self harm. I wonder if we could discuss that in a bit more depth today.... What are some of the reasons why student's may self harm?

<ol style="list-style-type: none"> 1. M: I am aware of certain students, but I think there's probably a few that I'm not aware of 2. M: I've not got very much experience in school [of self harm] 3. L: I wouldn't say that staff are aware of all students who do, it's only those with the severest risk assessments 4. W: I think it's important letting staff know but giving a PG version sort of saying there has been significant, there's been a significant influence in their life 5. W: I don't want to say without letting staff know, because they need to know 6. W: it's just liaising in such a way that everybody is aware. But sometimes people don't need to know 7. W: There's individuals who need to know the full story. There's sometimes individuals who just need to know that they're struggling at the moment with their mental health there has been self harm 8. W: it's more so myself our DSLs knowing what's going 9. C: but then at that stage, you log your concern and then you for protection. You don't hear anything else 10. C: you don't get a follow up, which I understand but it can be quite difficult. 11. C: You don't hear anything else. So it all goes quiet because it's confidential 12. L: others are a lot more they want to keep it hidden 	Secrecy or levels of who should know
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<ol style="list-style-type: none"> 1. W: we have a bit of a chat with them 2. W: I saw a couple of marks on their thigh, and I thought Is it pen? So where I was quite confident in knowing that student, I just approached it 3. W: I said, obviously, you've mentioned this and this, and I'm just wondering, obviously, have you self harmed have you thought of self harming recently where you're in such a low mood, and obviously, that sort of led into something where they felt confidence to speak. 4. W: I saw a couple of marks on their thigh, and I thought Is it pen? So where I was quite confident in knowing that student, I just approached it 5. W: , it wasn't directly saying oh I can see you self harmed. It was trying to slowly slowly unpick it in a way where they feel confident in speaking to you 6. W: it's very, you need to be very clear in saying, Well, I'm now going to, I can't keep this to myself, because we need to, we need to help, we need to help here 7. W: And then from there it was, well, a supportive nature saying, well, obviously I want to help you with this. 8. C: I'd say about confidentiality, and you need to share things that you've seen 9. L: I would talk to them about it 10. L: the main thing I would do would be to pass that on into log it on my concern 11. E: talk to the student 12. E: I could be the first person that the student tells 13. E: get some first aid if they need it. 14. L: I spoke, I spoke to the student about it and, and why, you know, how she felt and why, you know, why she'd done it and things like that 15. L: I don't find it something that I become uncomfortable when I need to talk about 16. M: I'm the opposite end of the spectrum, probably not as comfortable, erm just because my role is not student facing 17. W: I'm a lot more comfortable. Now, I've dealt with it a lot more first hand. 18. W: But I feel now the more I've been exposed to it, the sorta. I don't want to say that it's sort of second nature, but the easier it easier it becomes to deal 19. W: , I wouldn't say I'm confident now but have gone a hell of a lot more confident than when I first started 20. W: I think you've just got to deal with it 21. W: the more you deal with it, the more you get to know about it 22. C: it's not a nice thing to talk about 23. <i>If you aren't confident, there should be a reason why</i> 	<p>Approaching the topic with the student or responding</p> <p>& knowing about the self harm</p> <p>Comfortable</p> <p>& Graduated responding</p> <p>& Levels of self harm</p> <p>& Impact on staff</p> <p>& getting it wrong</p>
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24. L: I'm not as comfortable
25. L: I'm not exactly sure if it is what it could be
26. M: I don't mean it's indicative... but I think it's something that you always it's something that you need to have in the back of your mind
27. M: it's very difficult to say as to whether its mental health or not, without actually having open dialogue with the person
28. L: I don't think that it necessarily is down to an issue in terms of mental health
29. M: No I think there are cases where it's not indicative that there is a mental health problem
30. W: They've not potentially got real any mental health issues
31. W: (sometimes) real mental health struggles
32. W: But I would say 70% of the people we see self harm are due to having mental health.
33. W: , it's not always mental health to do with self harm
34. W: and it's not always mental health.
35. C: (is it always mental health) No, not at all.
36. C: Obviously, the more severe it can be, would be more linked to the mental health issue side of it
37. C: There's that there's the mental health, but then there's other things as well.
38. E: I think it is a sign of I think it is an indicator of how healthy their mental health is
39. E: I think it's an indicator where of how of how healthy they are, mentally
40. L: I still think it is probably linked to some kind of mental health issue in some way
41. L: we have students with individual risk assessment plans, who I would say are on a higher level of half harm than others
42. L: And then it can go from one extreme to the other. And sometimes it can start mild and get more extreme
43. W: But at the top end of the scale.... But then at one end...
44. W: surface scratches (and) severe self harm
45. C: Obviously, the more severe it can be, would be more linked to the mental health issue side of it
46. C: you can tell with kind of the superficial, like cuts compared to the deeper and sometimes more visual ones that you can see instantly.
47. C: Yeah, I think it'd be quite helpful just for maybe spotting it or knowing what to say
48. W: you took sort on how they were feeling as well
49. W: really sometimes you take it home with you as well.
50. W: it's you don't want to put more on staff when they've already got a lot there.
51. W: you don't want to be putting a lot of pressure on staff.

52. W: In lessons when they've also got 29 other people 30 People in class to try and help them provide an education.
53. W: , but a lot of stress on staff to try and put that support in place
54. W: I just sometimes feel we don't there's not enough hours to be able to do it within a day.
55. C: But everyone's busy. And it's very difficult to kind of find that extra time.
56. C: that's really difficult to deal with, especially when you're in a busy, practical classroom
57. C: You can't keep your eye on one when there's another 25 in the room
58. C: So it can be really difficult to manage. To the point where do you even do the practical for the sake of one student makes it really hard
59. E: I think they can be we're fully aware that it relates to young people but I think sometimes maybe thinking of the well being of staff as well and that it can sometimes relate to adults
60. W: you don't want to say something. Something potentially wrong, which would then obviously, inflict on that child even more and make them feel a bit self worth yeah self worth or made them feel selfish, or really, really they don't feel any support
61. W: I think we need to tread carefully, because obviously you don't, we're not we're in school and non-medical professionals
62. W: we don't want to say too much where we've got to put wrong things in student's heads,
63. W: where I think I didn't know whether to approach that and say you are in a safe environment or by approaching that that would then set off a bit of a chain reaction and then completely see a refusal to attend and go to lessons
64. W: something I personally feel sometimes the more you draw attention to it, the more self harm happens. I feel like it then becomes in their head.
65. W: it's a very, very sensitive topic where the more you talk about it at times, the more students just then turn to self
66. W: have we got anything on their person at this time, which could cause I like to go down the route not only harm to them, but if somebody if you accidentally drop a bit of a, what we see a lot is razors from pencil sharpeners.
67. W: making sure we remove any harm to them immediately
68. W: then it's letting parents know, sometimes students can be very, very cautious about letting us let parents know
69. W: if parents don't know about this, they can't help out at home
70. W: want to let parents know if they can remove any sharp items, for example, within the bathroom razorblades.

71. W: create a bit of safe space at home
72. W: Could you please obviously make sure we're ringing the Support Centre, if said student needed to go to the toilet, again, just trying to create a bit of a more of a safe environment
73. W: Can we just be mindful of when handing scissors out? Can we please count them back in? Can we not give pencil sharpeners out? Can we just give them a new pencil
74. W: Sometimes there are risk assessment that's popped in place
75. C: You have to be very careful about leaving equipment out because she'll swipe it and take it with her
76. L: Initial discovery
77. L: Deal with the initial disclaimer
78. L: Not approaching the student directly
79. L: Going through the right sources
80. L: There's slight tell tale signs
81. M: I've seen it but for someone who we're already aware of in school it's the individual I've got in mind, is somebody that I was made aware of
82. L: we were measuring pulse rate. So in order to get measure that pulse rate, I was getting them feeling on their wrists and on the neck and trying to find a pulse. And I've got one young lady that was greatly struggling to find her pulse. And we went from one wrist to asking her to use the other. And she, she wouldn't, and it was the initial alarm bells. She went to put her hand up and her sleeve came back slightly and I saw a slight mark
83. L: because I'd got a very good relationship with this young lady, because I've known her for a while that initial conversation actually came through me and the Child Protection Officer. And she disclosed fully, she felt comfortable to do that
84. C: because I'm not a teacher, I feel students have a different relationship with me. So I potentially would be someone that they would confide in for that
85. C: Ask them if they're okay
86. C: She claimed it was an accident, but it was clearly not an accident. And she did it intentionally
87. C: it was a burn on her arm, and she claimed that she dropped her hair straightener on it
88. C: I just took her aside and said, Listen, this isn't it doesn't look like it was what you're telling me. I need to report it for your safety. And she's like, she actually thanked me
89. C: it's very visible as soon as you see her
90. C: I will go to somebody else when I identify it
91. L: they might bring it up that they've been doing something like that

<p>92. E: So I'm working one to one and I'm, young people are coming to me for one to one sessions. So it's much more likely I think, in that sort of environment or that sort of setup that they will talk to me about the things that they're doing to manage to manage their emotions.</p> <p>93. L: some young people who I've worked with, it's that they're more likely to want to show it to people as to say, this is what I've done.</p> <p>94. C: So it'd be straightaway, my concern</p> <p>95. C: if it was an urgent referral, obviously press the button on my concern, but also make that phone call or head over to support centre</p> <p>96. L: the student immediately showed me and told me about it</p> <p>97. C: But it's always logged</p> <p>98. C: we read the risk assessments. But do we actually know what they mean</p> <p>99. C: You know, that's a it's a piece of paper some people might read in September and never read again. Till next September.</p>	
<p>L: I know the different pathways that I need to take and how to approach it</p> <p>M: They should be the right person for that individual student</p> <p>M: What support that student needs rather than pigeonholing people to say, person X because of this</p> <p>M: I don't think I'd know that off the top of my head. But I've got a rough idea as to who I'd go and speak to to seek, you know, guidance from them</p> <p>L: So we have a range of people that they can go to, to work with them.</p> <p>L: it will be the person that is most appropriate for that student</p> <p>L: because I think it's very much down to why the student is health self harming in the first place as to what support they need to put in place</p> <p>L: ended up getting her CAMHS support in the in the end. So she went down the route of needing CAMHS, and having full CAMHS support while she was at school</p> <p>W: then the advice that you can provide to students, it's just advice like you've either heard given to students from CAMHS, or from the NHS, or from even our school nurses at times</p> <p>W: it gets passed more to our safeguarding early help. And obviously myself now as well</p> <p>W: So then it's sometimes it can be a very simple fix of changing the seating plans in general.</p> <p>W: I do feel again, it's it's a medical expert that you'll need</p> <p>W: the waiting list for CAMHS is ridiculous</p> <p>W: if you've got the mental health lead within school I still feel that they're got to be more signposting students, to different agencies</p> <p>W: we're trying to get more funding to help get art therapists in</p>	<p>Step 2: helping and who should help after self-harm has been responded to</p>

W: , I feel like schools can definitely, definitely do more

W: we need more funding to help provide either train or in house more people who can be a counsellor

W: Art therapies

W: that even the basics like that of just speaking, and it doesn't even have to be speaking about what they're going through

W: play a potential board game, and it just helps them to know that school is a safe space.

W: medical expertise is more needed

W: I feel EPS need to have not deal with this

W: it would be amazing if we could get art therapists in school or train in house

C: particular students will either relate better to a certain teacher or to a support staff.

C: d forward it through MyConcern on our school system, so that it can be logged and we know that things are happening that need a conversation.

C: it can be anyone at my school, it tends to be the Support Centre because they're the ones that do all the pastoral care

C: students will always warm and get along better with a certain member of staff. So if that can be accessed in any way I think it should b

C: we've got a quite a big support centre. So we've got people that come in every week anyway, so there's always going to be support around for them.

L: normally it would be passed on elsewhere.

E: obviously refer on to safeguarding

E: it's about checking in on them again afterwards

L: I had to make sure that a parent or guardian knew

L: see the safeguarding lead and making sure it were all logged down

c: I know he presents to me because he wants to talk to me

C: it is it's just having that person who they feel comfortable with to have that conversation with

E: school and home ideally

C: , the supports available in school

E: outside agencies as well.

E: know there's a lot of students waiting for CAMHS or who really need it

E: if they are being supported by outside agents? Well, that's, that's better. In my opinion

L: it's got to be someone who the young person trusts and feels comfortable to speak to about it

L: it's got to be partly that the young person feels that it's someone they want to talk to,

L: there's got to be that relationship and at at home as well that they feel comfortable

<p>C: , I think is that partnership, isn't it between parents home, outside providers in an ideal world that that is what we need.</p> <p>C: We don't need to be working in isolation as a school</p>	
<p>L: I've unfortunately come across many of these in the past</p> <p>M: Probably more common than I think it is</p> <p>L: More acceptable</p> <p>L: people are happier to discuss it</p> <p>L: More awareness... knowing about self harm, knowing about mild methods of self harm</p> <p>L: I would say that, that there is a higher proportion than there was only 10 years ago, of students who do self harm or exhibit self harm characteristics</p> <p>L: I think it's talked about a lot more than it ever was</p> <p>L: I've dealt with self harm a lot</p> <p>L: It's very common in school</p> <p>L: I think it's more common now than it was only 10 years ago</p> <p>L: I would say that there's not an increase in the severe self harm</p> <p>L: There are more students exhibiting signs of self harm</p> <p>W: we're seeing more and more risk assessments now being put in place quite a lot for mental health and self harm now</p> <p>W: becoming a lot more mainstream</p> <p>W: But you hear more and more about it</p> <p>W: I don't know if that's just because I've seen the progression where I have all incredibly a lot more access to sensitive information</p> <p>W: I feel it's becoming a lot more, a lot more mainstream now</p> <p>W: a lot more people talk about it</p> <p>W: you see it a lot more</p> <p>W: Maybe it's just me but I just feel it's getting a lot more. A lot more mainstream now</p> <p>C: I've seen less of it recently.</p> <p>C: it's still alarmingly high compared to when I first started in education. (8 years)</p> <p>E: It's part of my normal day</p> <p>C: I'm probably not as comfortable</p> <p>E: It's something that I deal with, not on a daily basis, but regularly throughout the week.</p> <p>E: It's not an uncommon thing for me.</p> <p>C: that's becoming more common</p>	<p>Common/increasing</p>

<p>C: , we've not even reached a peak yet I don't think E: it's something that's increasing for me. L: it seems more common L: , I definitely noticed an increase.</p>	
<p>L: I know what signs to look for M: Everybody should attend [training on self harm] M: Training would be useful L: No I wouldn't say I've had any [training on self harm] L: The more people are aware of it the more we can support the young people L: [With training] the less likely we are to have the more aggressive forms of self harm take place L: If you can spot these signs, and you can intervene at that early stage, then it's less likely to develop into the more severe forms of harm M: at the time it was helpful [previous training] M: It sort of got us more aware M: Not at this school ... I don't think I've had any training while I've been here on self-harm that I can think of L: I think it should be for all staff L: I think all staff need that knowledge and awareness W: I've not, which is something that I would really like to get more involved in W: I'm sort of working towards trying to be one of the Mental Health Leads here W: The setting is really kindly helped me to go forward with a psychology degree as well. So I've sort of covered in there as well W: It is something that I think I'd really like to actually have an official training on specifically W: it's definitely something where I would like personally to have a lot more, a lot more training on as well as to help parents and carers. W: (who for) Definitely pastoral workers W: I really feel it's I think all staff could do with a basic on it W: the teaching staff are sorta they see people more all in class, so I think they could be given some advice on how to potentially see the to see the first point of how it starts. W: And then I think, enhanced training for those such as the DSLs, within school, who will then have the bigger picture W: So more training could be given W: I don't feel you can have like, a set in stone instruction manual for this W: I think you'd have to just have experience of dealing with it</p>	<p>Awareness/Training is helpful</p>

<p>W: feel that we could definitely do with more training within schools</p> <p>W: it needs to be filtered down to us where we get more training to be able to actually give sound advice, instead of just winging it</p> <p>W: the government's wanting more onus placed on schools, we need to have that training to be able to do it,</p> <p>C: I think everybody because anyone can see it at any time</p> <p>C: it's important that everyone's aware of it, and everyone can see and help.</p> <p>C: I think everyone</p> <p>C: everybody interfaces with the students.</p> <p>E: all of us, ideally.</p> <p>C: careful on how it's delivered and who delivered</p> <p>C: delivered all as one, or whether it was smaller groups, you know, like this</p> <p>C: I think people are more likely to get involved and think, yeah, it applies to me rather than Oh, I'm one of 50 of us in this room?</p> <p>E: . I think people engage better in smaller groups,</p> <p>L: it'd be good for the whole school to be trained on something like self harm</p> <p>C: we need to know how to deal with it.</p> <p>C: But we also need to be aware of it.</p>	
<p>L: 80% of the time it's a coping mechanism</p> <p>L: Doesn't mean that there's something wrong</p> <p>L: They don't know how to cope</p> <p>L: There are a lot of factors involved with it</p> <p>L: I don't think that self harm automatically means that [there is a mental health problem]</p> <p>L: young children often go through self harm as a coping mechanism</p> <p>L: They don't know how to deal with an emotion</p> <p>L: some of them starting to use It as a coping mechanism</p> <p>L: They know it exists as a coping mechanism</p> <p>L: We're starting to talk more about mental health, we're starting to talk more about wellbeing and that awareness and openness conversation means that were finding out more than we used to</p> <p>L: Sometimes it's stress and it's learning to deal with different coping mechanisms of stress</p> <p>L: Mild self harm, self harm tendencies, that's become much more of a coping mechanism for students</p> <p>L: I think it's talked about a lot more than it ever was</p>	<p>Why do students self harm?</p>

M: Could be there is something else going on in the background that needs to be dealt with

L: I'd say there's triggers in terms of exams and stresses and pressures of growing up, hormones, all those sorts of things can be triggers, but they're not the only things that come into self harm. And they're not necessarily the reason why somebody does

W: sometimes it's not done as a point of trying to get attention

W: like they're real really, really, really struggling and they just do not know where to turn to.

W: then at one end, we've also got students who are potentially doing this, because they've just seen others do it. But they're not really sure why they're doing it

W: Who would do it who would sometimes just done it because they've seen it on telly they've seen on YouTube seen on the internet

W: actually inflict real self harm on themselves because they don't know where to turn to.

W: some people have just just seen on the internet they don't know why they've done it

W: it's not always students are doing this because they really don't know where to turn to

W: Sometimes we've seen students who have self harmed, just out of pure frustration of something potentially something even sometimes not either going their way in a football game at school, at brunch and lunch.

W: we've seen it happen where students have been really, really upset within lessons because they've been given a detention for something they feel they don't, they don't warrant

W: due to impacts at home, family bereavements

W: think sometimes as well, it can sort of trickle down from if a parent has also got mental health issues

W: domestic violence in the household where if that student has then gone and self harmed out of which sometimes I feel is more frustration that they cannot actually help said parent rather than a mental health aspect

W: they've been assaulted within the community, and they just didn't know where to turn to

W: some of the stuff on TV I don't I agree with as well, some of the programmes that you see with celebrity endorsements saying they did this in the past

W: it's just not a healthy environment, on social media for students, and they see and pick up on it and I think something should be done more to stop your social media influencers, speaking about it, again, when they're not medically trained

C: I think a lot of it is kind of pushed through social media and trends

C: sometimes boredom has something to do

C: heavily on trends and someone's tried it, so they've tried it

C: trend is not the right word. But it's that ripple effect, isn't it? One does it? And it sort of ripples out into the year group

E: I'm seeing the effects, of lock of lockdown the pandemic,

E: anxiety about all sorts of things

C: cry for help

C: it's that cliche that cry that we just need help

C: it's one way to get them noticed

E: think there's different reasons why people, my young people use self harm as a as a way of coping