

School Response to Self-Injury: Concerns of Mental Health Staff and Parents

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Nonsuicidal self-injury (NSSI) among adolescents poses a significant problem for schools, adolescents, and their families. However, appropriate guidelines for addressing NSSI, including when to disclose the behavior to parents, are currently lacking. The present study aimed to understand how school mental health staff and parents of secondary school students view NSSI to determine how parent–school communication about NSSI, and responses to NSSI, can be improved. Nineteen school mental health staff participated in interviews and 10 parents of adolescents with a history of NSSI completed open-ended questionnaire items. Staff identified that sector-wide NSSI policy and education for teachers and principals would help them feel more supported and improve consistency in addressing NSSI between and within schools. In contrast, parents wanted more support directed at them rather than solely their adolescent. Implications for policy and parental support provided by the school are discussed.

Keywords: self-injury, parents, school mental health staff, communication

Schools deal with many high-risk student behaviors such as violence, truancy, substance use, and abuse. One of the most concerning behaviors is nonsuicidal self-injury (NSSI)—the deliberate destruction of body tissue without the intention to end life (Nock, 2009, 2010). NSSI involves behaviors such as self-cutting, burning, and punching objects (Nock, 2009, 2010) and is related to psychological distress (Martin, Thomas, Andrews, Hasking, & Scott, 2015), poor interpersonal relationships (including peers and family; Tatnell, Kelada, Hasking,

& Martin, 2014), poor academic performance (Kiekens et al., 2016), and suicidal behaviors (Hamza, Stewart, & Willoughby, 2012; Whitlock et al., 2013). On average, at least two students in every secondary school classroom engage in NSSI (~10–23% of adolescents; Jacobson & Gould, 2007; Martin, Swannell, Harrison, Hazell, & Taylor, 2010; Swannell, Martin, Page, Hasking, & St John, 2014). School mental health staff are staff members who engage with students about emotional, social, or behavioral problems and can include school psychologists, social workers, school counselors, nurses, teachers who act as well-being officers or welfare coordinators. The vast majority of school mental health staff have encountered at least one student who self-injures (Berger, Hasking, & Reupert, 2014a, 2014b; Duggan, Heath, Toste, & Ross, 2011). Despite this, more than three quarters of school mental health staff have not received any education or training about NSSI and request better education about the behavior (Berger et al., 2014a, 2014b). NSSI currently poses a significant problem for schools with two major issues identified: (a) the ability of school mental

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health staff to help self-injuring students and (b) communication between school staff and parents about NSSI.

Education and Training of School Mental Health Staff

“Gatekeepers” are members of the community who are in a position to detect mental health issues and provide or encourage assistance where needed (Cross, Matthieu, Cerel, & Knox, 2007). Given that high school students spend an average of 30 h per week at school, school staff are gatekeepers that may detect and assist adolescents who self-injure (Rickwood, Deane, & Wilson, 2007). Cases of NSSI detected by teachers or other staff members are typically referred to the school mental health staff member (Duggan et al., 2011). Previous research has focused on how teachers respond to NSSI (e.g., Berger, Reupert, & Hasking, 2015; Heath, Toste, Sornberger, & Wagner, 2011), but school mental health staff members are the primary source within schools to assist adolescents who self-injure; therefore, they will be the focus of the current study.

Unfortunately, school mental health staff feel unequipped to help self-injuring students (Berger et al., 2014a, 2014b; D’Onofrio, 2007; Roberts-Dobie & Donatelle, 2007) and often fail to appropriately intervene when NSSI is suspected or confirmed (Rissanen, Kylmä, & Laukkanen, 2009). Contributing to this problem is that most schools do not have a policy for responding to NSSI, or staff are unsure if such a policy exists (Berger, Hasking, & Reupert, 2015; Duggan et al., 2011). As a result, responses to NSSI are inconsistent between and within schools (Berger, Hasking, & Reupert, 2014c).

School mental health staff are calling for more information and training about NSSI prevention and intervention strategies (Berger et al., 2014c; Roberts-Dobie & Donatelle, 2007). In turn, education and training is related to more confidence in helping students who self-injure, greater likelihood of providing counseling, and greater likelihood to involve parents (Berger et al., 2014a, 2014b). Despite this, whether school mental health staff should involve parents after the discovery of adolescent NSSI behavior is a source of anger, frustration, and confusion for parents and schools.

Communication Between School Mental Health Staff and Parents

Given the gatekeeper role of school mental health staff, NSSI frequently comes to the attention of these staff members before parents (D’Onofrio, 2007; White Kress, Gibson, & Reynolds, 2004). Presently, many school mental health staff are at a loss as to how to respond to NSSI and are challenged by whether they should involve the parents or other professionals (Berger, Hasking, & Martin, 2013; D’Onofrio, 2007; Roberts-Dobie & Donatelle, 2007). School counselors want better consistency and guidelines for school responses to NSSI (Berger et al., 2014c). In some countries, legislation regarding suicidal behavior mandates parental disclosure, but disclosure for nonsuicidal behaviors is open to interpretation (Berger et al., 2015; Walsh, 2012). White Kress and colleagues (2004) advise that, in nonabuse cases, school counselors consult parents when they have decided to make a referral to an external mental health professional. However, Berger and colleagues (2014c) found in their sample of Australian school mental health staff that 80% chose to refer self-injuring students to external mental health professionals, but only 50% notified parents of the adolescent’s NSSI.

From one perspective, parents have been angered when school mental health staff have not disclosed the knowledge of their child’s self-injury (Lindgren, Aström, & Graneheim, 2010). Alternatively, adolescents may feel betrayed if school mental health staff choose to disclose to parents, which may damage the trust-based therapeutic relationship; recent work suggests only 5% of adolescents with a history of NSSI believe that school staff should involve parents when self-injury is discovered (Berger et al., 2013). Importantly, negative experiences of disclosure (both self and other referral) discourage future help-seeking, justifying the hesitance to inform parents (Hawton, Rodham, & Evans, 2006; Kerr, Muehlenkamp, & Turner, 2010; McAllister, Creedy, Moyle, & Farrugia, 2002). As such, there is an inherent tension between school mental health staff who may deem parental disclosure to be unnecessary and parents who may want to be fully informed about their child’s self-injury. The current study will further explore how school mental health staff attempt to bridge these conflicts of interest, if at all, and how parents perceive these strategies.

Engaging with parents after disclosure also poses a challenge for school mental health staff. Parents experience shock, stress, fear, and helplessness after discovering their child has self-injured and want more information, support, and follow-up from professionals (McDonald, O'Brien, & Jackson, 2007; Oldershaw, Richards, Simic, & Schmidt, 2008; Raphael, Clarke, & Kumar, 2006). Research from the parent's perspective regarding interactions with school staff is lacking, but such information could provide insight into what school counselors can do to better support families once self-injury has occurred. Therefore, the current study will investigate how parents perceive the support provided by school mental health staff.

The Current Study

As demonstrated, NSSI is a significant problem for schools, adolescents, and their families. However, appropriate guidelines for school responses to NSSI are currently lacking, which may leave school mental health staff and parents feeling unsupported. In the current study we used a triangulated design to explore how parent-school communication about NSSI can be improved to facilitate collaborative efforts for self-injury intervention. We also aimed to determine areas in which school mental health staff feel they need more support when responding to NSSI. To do this, we conducted semi-structured interviews with school mental health staff (i.e., school counselors). We supplemented these data with open-ended responses parents provided on a self-report questionnaire. School mental health staff discussed their experience with NSSI, support from the school, and interactions with parents of adolescents who have self-injured. Parents of high-school students detailed their experiences with school mental health staff following their child's NSSI and areas for improvement. The results of the current study can inform the development of NSSI policy as well as how schools can improve communication with parents and the support provided to parents.

Method

Participants

Participants were wellbeing or welfare coordinators ($n = 12$), school counselors ($n = 4$),

and school psychologists ($n = 3$) recruited from state and independent (i.e., private) schools in Victoria, Australia. Most participants were female ($n = 14$, 73.7%). Four participants were recruited from a larger study on NSSI among adolescents (the larger study recruited parents, mental health staff, and adolescents from schools and aimed to compare staff, adolescent, and parent reports of adolescent NSSI and family functioning). Four (21.1%) mental health staff members were employed within independent schools and 15 (78.9%) were employed within government schools. Eleven (57.9%) of the schools in which mental health staff were employed were situated in metropolitan areas, and eight (42.1%) were situated in regional/rural areas. Participants had worked as school mental health staff for 2–35 years ($M = 12.53$ years, $SD = 9.05$ years).

Parents were recruited as part of the larger study on NSSI among adolescents. Questionnaire booklets were distributed to 624 parents, of whom 204 (32.7%) returned the questionnaires completed. Ten of these parents (4.9%) reported that they had interacted with the school mental health staff regarding self-injurious behavior of their adolescent child and were included in the current study. All of the parents were female, and the average age was 45.20 years ($SD = 3.52$ years). Most of the mothers were married (60.0%), and three were divorced (30.0%); one mother did not answer this question. Most were born in Australia (70.0%; one each was born in Greece, Thailand, and The Netherlands) and none identified as Aboriginal or Torres Strait Islander. Parents reported that their adolescents with a history of NSSI were, on average, 15.10 years ($SD = 1.52$ years) of age and most were female ($n = 9$, 90%).

Procedure

The study was approved by the University Human Research Ethics Committee and the Victorian Department of Education and Training (DET). School mental health staff were invited to participate in an interview, and parents were invited to complete a questionnaire. School mental health staff employed at government and independent schools currently participating in another mental health project ($n = 5$) were emailed an invitation to the study, with four responding; snowballing was used to re-

cruit additional participants. In total, 19 school mental health staff members participated in semistructured interviews conducted by the first author; 4 interviews were conducted face-to-face and 15 interviews were conducted via telephone. Interviews concerned the staff member's experiences with self-injuring students and their families, their typical response to NSSI, their school's policy regarding NSSI and beliefs about sector-wide policy, and areas in which they felt additional support was needed. All interviews were audio recorded and then transcribed verbatim in accordance with standardized methods for transcription as reported by Silverman (2006). Interviews lasted, on average, 30 min.

Questionnaires were mailed to parents of adolescents in year levels 7–11 at the five participating schools. A definition of self-injury was presented, and two initial screening questions determined whether participant responses were included in the current study: (a) "To the best of your knowledge, has your child ever self-injured?" (b) "Have you had any contact with the school mental health staff member for your child's self-injury?". Only parents responding "yes" to both of these questions were included for analysis. Parents were asked the following open-ended questions: "What was your child's and/or your own experience with the school mental health staff member like? What were the positive and/or negative experiences with this staff member?"

Data Analysis

Thematic analysis was applied to the interview transcripts (school mental health staff) and the written responses to open-ended questions (parents). Interview transcripts were read and reread while listening to the audio recording to ensure accuracy and gain familiarity with the data (Braun & Clarke, 2006). Each transcript was analyzed individually using the qualitative data management program NVivo Version 10 (QSR International, 2012). First, annotations were made to highlight important sections, then these annotations were sorted into more concise and theoretically abstract themes (Braun & Clarke, 2006). Within individual transcripts from interviews with school mental health staff, themes were interpreted and assigned meaning. This process was repeated for emerging themes

across the 19 transcripts, with convergence and divergence noted (Braun & Clarke, 2006). Themes were then compared with the original transcripts to ensure they accurately reflected the data, and quotations were selected to represent the themes (Braun & Clarke, 2006). This procedure was replicated for the analysis of the parents' written responses to open-ended questions. An independent researcher coded 20% of the data and interrater reliability was "almost perfect" ($\kappa = .87$; Landis & Koch, 1977). Participants were assigned a de-identified label, which is presented alongside their quotations. The percentage of nodes identified for each theme are presented in Table 1 for school mental health staff and Table 2 for parents. The results section provides a detailed analysis of each of the themes, supported by quotations.

Results

School Mental Health Staff

Fifteen (78.9%) of the school mental health staff had undertaken at least one form of training in detecting and responding to NSSI, and these consisted of professional development that specifically addressed NSSI ($n = 6$), youth mental health first aid or another short course that addressed general mental health problems among adolescents including NSSI ($n = 10$), and aspects of their psychology degrees ($n = 3$). No staff reported ongoing training. Four (21.1%) mental health staff members had received no training in NSSI. All staff had encountered self-injuring students. The staff members reported that NSSI most often came to their attention by the adolescent themselves or by a friend of the adolescent. The prevalence of NSSI at each of the schools varied from two known cases of NSSI ("For us here, [NSSI]'s quite rare" staff member 5 [S5].) to dozens of known cases ("I would say [NSSI] is our most common issue right now" [S8].). Staff members with no NSSI training reported that the prevalence of self-injury in their school, to the best of their knowledge, was low. Alternatively, for those with training, NSSI prevalence was more variable across the schools.

Four important themes emerged from the interviews: (a) current school policies, (b) future sector-wide policy, (c) assistance for parents,

Table 1
Nodes and Themes for School Mental Health Staff Responses

Theme	Node	n	%
Current NSSI school policies	No formal policy—proceed case by case	10	52.6
	Parental disclosure of student NSSI may occur after risk assessment and discussion with the adolescent	10	52.6
	Written own school policy for NSSI	9	47.4
	Provide internal or external referrals	7	36.8
	Conduct a risk assessment	5	26.3
	Mandatory parental disclosure of adolescent NSSI	4	21.1
	Empowerment of student after NSSI	4	21.1
	Exclusion from school (suspension) for NSSI	4	21.1
	NSSI first aid	3	15.8
	Scars must be covered	2	10.5
Future sector-wide policy	Concern regarding inconsistencies across staff and schools	6	31.6
	Want policy/guidelines that are simple and easy to understand and use	5	26.3
	Want policy to cover parental disclosure	5	26.3
	Want policy	4	21.1
	Concerns about school's liability	4	21.1
	Concern for less experienced staff members	3	15.8
Assistance for parents	Guidelines to help all school staff	3	15.7
	Parents shocked/upset/distressed about NSSI	10	52.6
	Parents feel shame and blame themselves	7	52.6
	Parents not following up with external help	6	31.6
	Supporting parents is not the role of school mental health staff	5	26.3
	Provide support or educate parents about NSSI after disclosure	4	21.1
	Parents are supportive and want to help their child	4	21.1
	Parents ignorant about NSSI	4	21.1
Support for school mental health staff members	Parents minimize or ignore the problem	3	15.8
	Want supervision and to “debrief” with others	8	42.1
	Other staff members need NSSI training and education	8	42.1
	Support is when there is a “team environment” for dealing with student mental health issues	8	42.1
	Does not feel adequately supported in their role	6	31.6
	Feels adequately supported in the school	4	21.1

Note. N = 19; NSSI = Nonsuicidal self-injury.

and (d) support for school mental health staff members.

Current NSSI school policy. Of the sample, 10 (52.6%) mental health staff members revealed that, beyond other staff members reporting self-injury to them, their school had no

policy for NSSI (see Table 1). The other nine (47.4%) staff members reported their school had developed a formal NSSI policy. These policies differed from school to school. Most school mental health staff revealed that their policy would involve talking to the adolescent

Table 2
Nodes and Themes for Parent Responses

Theme	Node	n	%
Support and communication	Felt supported by school mental health staff	6	60.0
	Communication from the school was good	4	40.0
	Wanted more support as a parent from the school	3	30.0
	Their child liked and felt supported by the school mental health staff	2	20.0
	Lack of follow-up from the school	2	20.0
	Did not feel supported by the school mental health staff	1	10.0

Note. N = 10.

themselves, conducting a risk assessment, and then referring to external services for ongoing support if necessary.

Well first the student will need to be brought to me—so that might be a teacher who's seen it, or the student or one of their friends will come to me. Then I'll meet with the student and I'll do a risk assessment for the intent and severity of the NSSI—if they're low risk we'll then discuss alternatives to NSSI, other ways to cope and. . . . I'd make a plan to follow-up with them. If they're high risk, then we follow the suicide post-vention guidelines—so calling parents, meeting with parents and student, facilitate external support and follow-up with that [S10].

Three school mental health staff revealed that as part of their policy, the student has to receive a mental health plan from a general practitioner (GP) or external psychologist and is not permitted to attend school until this has been completed. "We developed a protocol that if it comes to our attention that someone is self-harming or self-injuring, we actually require them to then go see a GP, and they actually aren't allowed back at school until that has happened" [S7]. The school counselor went on to explain that the reason for this policy was to counteract parents who minimize NSSI; by enforcing a mental health plan, parents have to take action. "We felt that it sent a very strong indication to the parent that this is a significant issue and you really need to be getting help and support for that. And we have found that [to be] successful." Another reason cited for this policy was to protect other students from witnessing self-injury in the classroom.

Participants were concerned that witnessing a student self-injuring in class is traumatizing for the other students as well as the staff. In addition, school staff mentioned the potential contagion effects of witnessing self-injury. As such, school policies often addressed covering injuries while in school (e.g., "we also have policies around not having very visible injuries in the school so they need to be covered. We have, you know, a responsibility to manage those contagion effects of it [S8]").

Parental disclosure also differed between schools. Of the nine schools with an NSSI policy, four had a mandatory policy for parental disclosure. One wellbeing officer reported being confined by the school's policy regarding mandatory parental disclosure, guiding the student

away from disclosing NSSI if they do not want their parents to know.

In the school situation if I learn about self-harm I absolutely have to let my principal know and in this school I have to tell the parents. . . . I do make sure that every time I'm talking to a student they're aware of that. So there are students where I strongly suspect they are self-harming, but I'm not going to make them tell me because they know the situation. I try and get them to a place where they're going to tell me and acknowledge that to know that, I have to tell their parents if they tell me that. So I make that very clear—so that's why some cases my hands are tied [S3].

Staff at other schools reported that parental disclosure was only essential when the student was suicidal or that staff and students would reach a decision together.

If I was to suggest that it may be a good idea to ring or to speak to your parents about this, then we would have to agree. On the other hand, if I was so concerned, then I would just have to tell the young person "as a result of your disclosure I need to inform your parents because I'm required to make sure that you're safe". . . . Self-harm is not necessary linked to suicidal thoughts and so [parental disclosure] depends on the level of self-harm. Through the suicide assessment process that I do, then I determine whether or not a parent needs to be involved [S13].

As one wellbeing officer explained, balancing the needs of students, parents, and the schools is complex:

Significant self-harm would always be communicated to parents, but that's complex too, because the nature of some self-harm is that it's very secretive and students feel really exposed and sometimes they're betrayed if that information is communicated. So it's complex [S14].

Regardless of whether parental disclosure was mandatory or not, the school mental health staff all followed a similar procedure. First they would discuss parental disclosure with the student, with the emphasis on empowering the student. The school mental health staff members all worked to ensure that the student was aware why disclosure was necessary and when it would occur. In some cases, the student would disclose to the parents in the presence of the mental health staff member. One school counselor mentioned that he would "rehearse [parental disclosure] with the young person before bringing the parent in" [S13]. Other school counselors reported they would tell the parent without the student present to ensure that when the parent and adolescent unite, the parent's

reactions are not overwhelming for the adolescent.

I'll always do it in conjunction with the student. . . . I do try and empower the students a little bit to decide how I tell the parents. I let them know what I need to let them know and work with them on how the best way they think to tell them is. . . . So it would always be in discussion with the student, so if they were strongly opposed to it, I would try to find a way to work around it. Often, I have a conversation with the permission of the student with the parent separately, because when they come together with the student, I really want them to be a support for the student, rather than to be accusing or to be stressing out about their parenting, and you know that happens for a lot of parents, doesn't it? [S7].

Future sector-wide policy. School mental health workers lamented the lack of sector-wide policy for how to address self-injury in schools. Most of the participants felt confident in treating NSSI within their school and attributed this to their experience. However, they expressed concern for inexperienced mental health staff members, or staff members working in less supportive schools, and felt that sector-wide guidelines would assist them.

I think it is important to have guidelines 'cause you're not always getting situations where a wellbeing team is as cohesive or large or strong or experienced and so for people who are feeling very much on their own or less experienced I think it's really important to have guidance [S14].

I'm fortunate in that I'm quite experienced in this role and have sought further education, but . . . there are student welfare officers who come in with minimal qualifications and those poor workers are dealing with self-harmers . . . there's a lot of people out there who are working with people who are self-harming in schools who are not given the skills or the "how-to's" and . . . is just overwhelmed by it. So I think we need to resource our school staff better, or welfare or counseling school staff better [S7].

With a lack of sector-wide policy, decision-making is up to the discretion of the individual staff member or the school, which the staff believed placed them in a legally tenuous position. The legal issues that staff referred to regarded their duty of care.

I think it's really unfair to leave me in a potentially legally awkward situation—not just me, me and the school, but I take a lot of that stress on. . . . I had to work through a policy for the school and do my own research on it, when it's just becoming such a huge issue. Give me a checklist that we have to do. It's ridiculous . . . do not tell me what to say to a kid, but tell me what . . . to do in this situation, and what's

going to keep—I know it sounds cold—but what's going to keep the school legally safe . . . it's been like we're floundering and do not have that much support with exactly what to do about the problem [S3].

School mental health staff particularly wanted policy to address parental disclosure and again noted that such explicit policy would help with the legal confusion they experience.

I'd like there to be some clear written guideline about do we notify a parent immediately. Just a clear procedure, a step-by-step procedure, you know, whether it be notify parents or not, whether it be follow-up and make sure they're referred out, do you know what I mean? I'd really like to see some clear procedure written down in that policy. . . . It would certainly take a lot of the legal pressure off us [S6].

School mental health staff frequently mentioned the need for guidelines to be clear, simple, and easy to use. Where school mental health staff expressed reluctance about NSSI policies, it was due to the "bureaucratic" language often used in such policies. "I'm ambivalent about [sector-wide policy] because it's just so cumbersome, and almost alienating in its language. If they'd just write some policy in damn simple plain English, I'd feel a lot more welcoming" [S10]. Another wanted NSSI policy to be more specific.

Policies are usually not what I find—are not really specific, you know, they're fairly broad and general . . . you need some specifics in there sometimes. . . . They're fairly broad and, kind of, you have to go "well that's a bit obscure, I do not really—you know, that could be taken either way, really" [S11].

Despite these concerns about sector-wide policies, the school mental health staff also expressed concern about their approach to NSSI. The school mental health workers discussed the lack of consistency with regards to school-based responses to adolescent NSSI behavior. In the extract below, the school counselor has devised their own policy within the school but acknowledged that their policy may vary from other schools.

We developed a protocol over a couple of years . . . there doesn't seem to be a lot of information out there . . . in terms of strategies, there doesn't seem to be anything concrete. It depends on your therapeutic approach and so on. . . . I suppose all counselors or whatever work different or maybe we all work somehow similarly, and may be that's an issue in itself—that we may be all approaching it all a little differently [S7].

This lack of consistency has left the school mental health staff unsure about whether the policies at their school are the best way to help self-injuring adolescents (e.g., “there’s always that concern with whether or not I’m dealing with [NSSI] the right way” [S3]). The staff members revealed that sector-wide policy would improve consistency in the approaches to NSSI, and ease the doubt they experience. “I’m not sure [our policy is] the right or the wrong policy . . . it is easier to deal with when there is a [sector]-wide policy . . . in . . . schools this is what needs to happen” [S18].

Assisting parents. After the initial disclosure to parents, school mental health staff would discuss mental health plans with parents and avenues for external help. However, the school mental health staff members recounted difficulties with this process because often the parents need assistance and guidance. Specifically, parents would often experience significant shock and upset at the disclosure of their adolescent’s NSSI. The school mental health staff members reported that many parents assume that NSSI means their child is suicidal, which contributes to their distress.

I do not think the parents know much about [NSSI] and they think their child’s suicidal, which it doesn’t necessarily mean, so that’s probably harder than talking to the student because the parents—especially if they do not know—are very upset about it. . . . So I just reassure them that it doesn’t mean their child wants to commit suicide because often they just jump to that straight away [S4].

Their initial reaction is often one of shock and concern but also a lack of understanding of self-harm and therefore part of my role in that conversation is to give them an understanding of self-harm and my assessment of self-harm and whether or not it requires further intervention or a referral or whether it doesn’t [S13].

Here the mental health staff members report that they take the opportunity to educate the parents about NSSI to help assist them through their shock and fear. In addition, the school mental health staff members reported that parents would often experience shame and blame themselves for their adolescent’s NSSI.

There would be parents who have shame and all that and concern that they’re being judged. . . . Cause I suppose what does it mean for the parent? . . . This “oh my goodness I’m awful, I haven’t done the right job” . . . but you do not want it to be about the parent, it has to be about the student [S7].

This sentiment was echoed by other mental health staff members who reported their priority was helping the students, not the parents. “I’m not specifically here to support parents so therefore I kind of give them more avenues to link in with outside services, rather than get that through me as much” [S11]. In addition, one school psychologist reported they did not provide support to the parents because the parents did not appear to need it: “The parents’ anxiety always seems to be quite contained . . . so they’re not seeming like they need support themselves” [S17]. One wellbeing officer, employed at a large school where NSSI is very prevalent, reported that the school provided ongoing support to parents.

We would offer the parents short-term counseling from us at the school if they want it. We would certainly resource them—part of the conversation of telling, you know, informing them of self-harm would be resourcing them with factsheets, crisis numbers and then just sort of coaching from us around (a) how to keep the student safe and (b) how to help them slowly but surely move away from the self-harm and into more healthy coping mechanisms [S8].

Some school mental health staff members noted that upon the initial discussion of their child’s NSSI, parents promise to seek external help for their adolescent. However, after following up with the parents or the students, the staff member realizes that this external help has not been sought.

I have felt, sort of down the track when I’ve sort of followed up to ensure that they have aided their child in getting additional help, that you know, parents have sort of been a bit vague or sort of giving excuses about being busy or haven’t quite got round to it, and that’s sort of, of concern [S1].

Sometimes parents promise the world then do not do anything—well they do not know what to do—they hope it will go away if they just ignore it . . . often parents will revert to their way of handling stress within their family [S7].

Support for school mental health staff. The level of support that the school mental health staff felt from their school varied. The participants who reported working in a “team environment” felt more supported. “I’m part of a very strong team, and obviously very experienced in this particular school so I do feel well supported and—but that’s largely through the strength of our school community in terms of our wellbeing team” [S14]. The school mental

health staff suggested that other staff members in the school could receive training in NSSI, which would help bolster the team environment, and help the participants feel more supported. In particular, the school mental health staff wanted teachers and principals to be educated about NSSI.

The thing that I think will probably help me the most is if I was able to increase the understanding of self-injury among teachers but certainly among the principal[s] . . . so that's, that's one thing that's important and I guess having guidelines also gives teachers that want more information, somewhere so I can refer them to, and that helps them and their anxiety. If they haven't dealt with much before, teachers can become quite unsettled [S12].

I think it would be really good for principals to be educated because the principal, like, they carry the can for whatever happens in the school and they often—I feel they often do not understand about self-harm, that they think “oh my goodness it's self-harm they're gonna kill themselves tonight.” So to have education for principals as an inoculation—not if it happens, but for all principals, that when it does happen—this is what you're response needs to be and understand that it's not necessary going to end in a—it's unlikely to end in a suicide attempt [S2].

Another area the mental health staff members identified as contributing to the lack of support was the lack of supervision. Although the school counselors and school psychologists had regular contact with supervisors, the school welfare coordinators did not have supervision and this left them feeling unsupported. “I have no one to kind of bounce ideas off, or—we don't get supervision, we don't get secondary consult, we don't get reflective practice, nothing, so I kind of make my own decisions” [S11].

I do not have an external—like a supervisor or a lineman that I report to so, so self-harm in this school all get referred through to me and then they sort of leave it with me. So I guess I do not—you know the structure of the school doesn't allow for lots of support for someone in my role [S12].

One wellbeing officer stated that supervision was necessary in all schools to help mental health staff, and subsequently, the students.

All wellbeing staff in all schools . . . need clinical supervision . . . there doesn't seem to be any obligation . . . to provide it. I think that needs to change. For the safety of the students as well as the safety of the workers [S8].

Parents

In general, the parent's experiences with the school mental health staff were positive, with all parents identifying helpful aspects of their interactions. Support and communication was the major theme identified among the parents' responses (see Table 2). Whether parents felt personally supported played an important role in how helpful they considered the interactions with school mental health staff to be.

The school counselor made me feel really supported. Extremely positive, encouraging—I do not know how each of us would have got through without school involvement. I couldn't have done this alone. I was completely illiterate to what to do to help (Parent number 5 [P5]).

Support came by way of sustained communication with the mental health staff member who kept them informed regarding their adolescent's progress. “Regular contact with the school counselor has been great—he keeps me informed and lets me know what they are working on” [P2].

This is a small school and the school counselor is very smart and has a lot of understanding toward my daughter . . . treats my daughter very gentle and with love . . . has done a good job finding information and communicating with parents and mental health team involved [P4].

Alternatively, where communication was not sustained, parents felt unsupported. As one parent reported, the school counselor was supportive at first, but the lack of ongoing communication left them feeling abandoned in the long term.

The school counselor was supportive when it first happened. We sat down and talked with my daughter, but there was no follow-up. I didn't know how to proceed from there. My daughter refused to go to school and I wanted to insist she go, but then again I was worried that if I push her she would start [the self-injury] up again [P6].

Similarly, although parents were able to identify some support offered from the school mental health staff, they wanted more support for themselves. As one mother mentioned, she felt she needed more support directed to her as a parent, and she was still unsure how to get this.

School support and conversations with school welfare officer (my daughter and I) were great. We did this straight after disclosure and continued for a few weeks. Pointed out to her how her actions affected other

people; gave her strategies; made her realize she is loved. But I felt I needed more support for ME not my daughter. I didn't know where and how to access and still do not know if there is anything for parents . . . still have not reconciled in my mind how, why and so forth this could happen to my child [P3].

One parent did not feel supported in her interactions with the school. The mother wanted more information about where to find help and support. "No one has offered any support. . . . I assume it's down to us to seek out support groups etc. ourselves" [P1].

Discussion

The current study aimed to assess the experiences of school mental health staff and parents regarding NSSI. The school mental health staff discussed issues surrounding current school policies and sector-wide school policies for NSSI, their ability to provide support to parents dealing with their child's self-injury, and the support they receive as professionals from the school. Parents also discussed their own support from school mental health staff and generally wanted more support directed at them as parents.

Half the mental health staff members worked in schools where there was no NSSI policy, as shown in Table 1. Where policies had been developed, they differed between schools. This inconsistent approach to NSSI across schools has been noted in previous research (Berger et al., 2014c). The staff in the current study were concerned that, without any sector-wide policy guiding their responses to NSSI, their school may not be responding to NSSI in the "right way." In addition, experienced mental health staff believed that sector-wide policy would help ease the pressure on inexperienced staff who were described as "overwhelmed" by NSSI. As such, the staff members called for a simple, easy-to-use policy to help them, and other school staff, better respond to NSSI. The participants also believed that sector-wide policy, as well as further education, would help improve teachers' and principals' responses to NSSI—something that they believed was important to ease the pressure placed on mental health staff. Although the current participants were aware that NSSI is not a suicide attempt, they often used the term "self-harm," which is commonly used to refer to behaviors that may

or may not be suicidal (Kapur & Gask, 2009). Consistency of terminology is important for the development of clear policies, training, and education. Policy-makers would need to be mindful of the language used in any guidelines to ensure clarity and consistency.

Previous research has also advocated for the development of school-based NSSI training and policy (Berger et al., 2014c; Heath et al., 2011; Roberts-Dobie & Donatelle, 2007). Berger and colleagues (2015) developed such a policy for school response to NSSI, which included conducting a risk assessment and contacting parents if risk was moderate to high (four or more episodes of NSSI, the use of multiple methods to self-injure, light to severe tissue damage, and accompanying mental health problems). In the study, 48 teachers and school mental health staff evaluated the policy and were generally in favor of the policy and its use in schools (Berger et al., 2015). However, the staff were concerned that a lack of knowledge of NSSI may be a barrier to the implementation of the school policy (Berger et al., 2015). Indeed, accurate risk assessment, including the assessment of the future likelihood of NSSI and the severity of injuries, would require a high degree of knowledge of NSSI, suggesting the need for policy to be paired with training.

Development of sector-wide policy may also help school mental health staff feel more supported when responding to NSSI. Policy would allow school mental health staff to deal with each student on a case-by-case basis but provide structure as to the ideal responses. Table 1 shows that $n = 8$ (42.1%) of mental health staff members wanted supervision, particularly when dealing with NSSI, and $n = 6$ (31.6%) did not feel adequately supported in their current role. The interviews showed that mental health staff with supervision were able to discuss with their supervisors whether they were making correct decisions in regards to adolescents who self-injured, and this made them feel supported. In contrast, those without supervision had to make their own decisions regarding cases of NSSI in the school and were provided with little opportunity to debrief with supervisors. As such, many mental health staff members were uncertain about their approach to NSSI, and this appeared to add to the stress they experience. Although supervision for all mental health staff in schools would be ideal, feasible models of

providing supervision are negated given funding cuts to secondary schools (Organization for Economic Co-Operation and Development, 2013). In lieu of supervision for wellbeing of officers, sector-wide NSSI policy could reassure these staff members that their response to NSSI is supported by evidence-based research and is consistent with how other schools respond.

Staff in the current study particularly wanted NSSI policy to address when parental disclosure should occur (see Table 1). School staff discussed the “legal” uncertainties regarding treatment of NSSI in school, and this concern was largely associated with parental disclosure. Several mental health staff feared that if they did not report an adolescent’s self-injury to the parents, the school would be left open to legal consequences, but they were vague about what these consequences would entail when prompted for further details. Their responses suggest that many school mental health staff are unsure about their legal requirements regarding NSSI disclosure. However, no current legislation exists that specifies parental disclosure for NSSI in the Australian state of Victoria, where the current study was completed (Children, Youth and Families Act, 2005; Mental Health Act, 2014). As such, school mental health staff in Victoria are not legally bound to disclose NSSI to parents. The legal issues that the participants referred to may have been fears of civil litigation. As such, four schools had established a policy of mandatory parental disclosure after NSSI, but one staff member reported that this policy left her feeling as though her “hands are tied.” In addition, one staff member was concerned that adolescents would feel “betrayed” if their parents were told about the NSSI. These concerns demonstrate the need for guidelines to specify when parental disclosure of NSSI is necessary.

Ethical guidelines and school policy regarding NSSI are inconsistent within and between countries (Berger et al., 2014a, 2014b; Lieberman, Toste, & Heath, 2008; Roberts-Dobie & Donatelle, 2007; Schwartz et al., 2012). For example, some professional bodies (e.g., Australian Psychological Society, 2007) require student confidentiality unless a student is at “immediate and specified risk of harm” whereas government schools in the Australian state of Western Australia have been provided with guidelines that encourage parental disclosure in

all cases of student NSSI (e.g., Western Australian Department of Education, 2015). This leaves school psychologists in Western Australia in a precarious position; in any given case the state department expects disclosure while professional guidelines may deem disclosure unnecessary. Clear, consistent guidelines and policies enacted across agencies, which describe parental disclosure, would help schools and parents better understand their role and rights when responding to NSSI, ensuring the best care for the student (De Riggi, Moumne, Heath, & Lewis, 2016). Guidelines should also outline any local legal requirements regarding duty of care and NSSI.

The school mental health staff noted that parents needed support after disclosure, but they felt that the focus needed to be on the student, not the parent. One staff member reported that her school provided counseling for parents after disclosure of NSSI. However, this was not the usual response. Staff would typically provide psychoeducation to parents, informing them that NSSI does not necessarily mean their child is suicidal and in some cases would provide factsheets about NSSI. Beyond this, the help they could provide parents was limited. For parents, the key to feeling supported was ongoing communication and support; feedback from the staff about their adolescent’s progress was important to parents’ perceptions of the helpfulness of school mental health staff. However, parents addressed the need for more information and support directed specifically to them from schools. Parents, who at first perceived that school mental health staff were supportive after disclosure, began to feel abandoned and helpless once communication with the staff member had ceased. Table 2 shows how parents perceived the response of school mental health staff after their child’s NSSI; 30.0% of parents wanted better support and communication from school mental health staff. Parents engaged in clinical services for their adolescent’s NSSI also want more information and support directed at them as parents as well as better follow-up (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006). The present results show that parents want this support from schools also and that current school practice is insufficient to the long-term wellbeing of parents coping with a child who has self-injured.

Limitations

Because parent responses were gathered from questionnaires, we did not have the flexibility that interviews allow by asking follow-up questions to important themes. As such, the detail within the parent data is limited. For example, parents mentioned wanting more support from school mental health staff, and follow-up questions could have addressed the type of desired support. Future research may aim to interview parents about their experiences with the school after their adolescent's NSSI. Likewise, although follow-up questions were asked to the school mental health staff during the interviews, questions regarding how previous NSSI training (if they had received it) had changed their practice toward students and parents were not asked. When designing school policy and school-based interventions for NSSI, research should ensure the best way in which policy can translate to behavior for school mental health staff.

Although the sample sizes used were reasonable for a qualitative study, the generalizability of the current findings is limited because of the small sample of school mental health staff and parents. The parents were only recruited from five schools, meaning that their experiences with schools regarding NSSI were limited to a smaller pool of mental health staff members. In addition, all of the parents were mothers, and most discussed their daughter's self-injury. Therefore, the results from the parents in the current sample may not reflect the experiences of other parents of adolescents who self-injure. In the broader community, NSSI has typically been thought of as a "female behavior" (Favazza, 2011). Thus, school and parent responses to NSSI among male students may be different from responses among female students, and this warrants further investigation.

Implications

The current study shows the perceived need for sector-wide NSSI policy in secondary schools. In addition, the implementation of such policy would require school staff to have knowledge of NSSI; of the sample surveyed, 21% had received no NSSI training. Although this is a relatively low percentage of mental health staff who had not received training, given the purpose of the study and the self-selection

for participants, our sample may have been biased toward those with greater experience and training with NSSI. Therefore, inclusion of training and education should be a requirement for school mental health staff alongside the implementation of NSSI policy in schools. NSSI education is related to better knowledge and confidence among school personnel when responding to NSSI (Berger et al., 2015), and the mental health staff in the current study requested that other school staff, including principals and teachers, become more educated about NSSI. The current school staff reported that they had professional development courses on adolescent mental health, including suicide prevention, available to them. The present study suggests that including NSSI training within these modules would directly (through their own development) and indirectly (through the development of other school staff) help the school mental health staff. The inclusion of both NSSI training and policy in schools might lead to better detection of NSSI and compassion among staff members (Berger et al., 2015; Muehlenkamp et al., 2013), ensuring early intervention for adolescents.

In terms of school-parent communication, improvements could occur on both sides. Specifically, parents reported that they wanted more support from the school mental health staff whereas these staff members reported that their role was to assist the adolescent, not the parent. To better enhance these interactions, several changes may need to occur. First, although school mental health staff may not have the time and resources to directly assist the parents, they can ensure that parents know where to find help. The mental health staff frequently reported that they took the time to explain to parents the difference between NSSI and suicide attempts. Staff could supplement these conversations with information about parent-specific support such as online forums, local support services, and resources. Second, an issue raised by the school mental health staff was that parents may indicate they will seek help for their adolescent, but upon follow-up it is revealed that no such help has been sought. This highlights how important it is for school mental health staff to follow-up with adolescents and/or parents after NSSI disclosure. It also indicates that school mental health staff may require training about how to address the parent's reticence to seek

external support for their child's NSSI (Heath, Toste, & Beettam, 2006). Third, parent education about NSSI may be beneficial. Such education may be particularly useful to prepare parents in how best to respond should their adolescent self-injure. This would ensure that if their child engages in NSSI, they are more knowledgeable of NSSI, better equipped to help their adolescent, and know where to go to seek help. Better education for parents about NSSI could also help ease some of the burden on schools mental health staff because parents may not need as much assistance from the staff after disclosure. Parent education about NSSI could occur in school-based seminars, such as the type that have been successfully implemented for positive parenting (Sanders, Prior, & Ralph, 2009).

Summary

The current study found that school mental health staff want more support when dealing with NSSI among students in the form of sector-wide policy and education for themselves as well as other school staff. In contrast, parents of adolescents who self-injured frequently reported that school mental health staff adequately helped their adolescent, but that they wanted more support directed at them as parents. Sector-wide NSSI policy combined with staff education could help improve quality and consistency of NSSI treatment across and within schools. In addition, after parental disclosure, school mental health staff can educate parents about NSSI, ask parents if they need more support, and provide resources and follow-up to ensure that external help has been sought. Parent education on NSSI before their adolescent engages in the behavior may also help parents with their response to self-injury and ease some of the pressure on school mental health staff.

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