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# Introducing the topic of self-harm in schools: developing an educational and preventative support intervention

Promoting the mental health of young people and the prevention of self-harm which emanates from psychological pain is undoubtedly the most challenging task faced by professionals working with young people today. Data from the Department of Health (Meltzer, 2000) regarding the mental health of 12,529 children and adolescents, indicated that 10% of children aged 5-15 years had a mental disorder and these children were also more likely to be boys living in a lower-income family with one parent. Of these children, half had been referred to a professional from the educational services and almost one-quarter had had access to specialist health care services whilst one-fifth had had contact with Social Services.

According to the DfES (2004), young people are unable to learn and remain included in the school context if they do not feel safe or if health or social problems create barriers to learning. Education is seen as the most effective route for young people out of both poverty and disaffection.

Many families today are exposed to high level of daily stress and the incidence of childhood depression is increasing. An estimated ten per cent of children in any school experience serious depression, such as going through extended periods of despair and even engaging in suicidal thoughts. Young people do not enjoy carefree childhoods but instead have to cope with the devastating effects of divorce, exposure to drugs and bullying amongst other significant stressors. Young people are most vulnerable to negative emotions and at risk of developing depression at the age of 11, when they move from primary to secondary education (Reivich and Shatte, 2002).

Professionals appear to be in agreement that any kind of intervention which purports to

protect and improve the mental health of young people would need to:

- be implemented at an early stage/age
- be targeted primarily at boys
- include and actively involve parents, carers, education, health and the judicial system
- be concerned with both skills and knowledge, e.g. self-esteem, self-confidence, emotional literacy and relationship building
- be focused on health, decision making and risk-taking behaviours.

### Shifting the emphasis

Consequently, in understanding health and therefore mental, emotional and social health, there needs to be a shift from the more usual focus of illness to also embracing the notion of positive wellbeing. Mental health should clearly be linked to, or described as, an increase in the general degree of happiness, vitality, sense of worth and achievement, alongside their concern/empathy for others. Within a school context this would suggest that the curriculum would need to actively prevent unhappiness - bullying, violence and conflict - while also encourage learners and those supporting them in schools to achieve their goals; to feel love; to feel joyful; to be energetic and to care about others. (Weare, 2000)

Consequently, when schools attempt to engage in mental health promotion, they would need to ensure the following:

- The development of a healthy schools policy which includes mental, social and emotional health, e.g. policies which actively prevent bullying violence and conflict.
- The development of personal skills, including

emotional literacy skills, amongst staff and students alike. These will consequently enable all stakeholders to deal effectively with bullying and conflict and will also ensure that there is an ethos of motivation, energy and a real sense of happiness within the school community.

- The creation of supportive environments, e.g. where all individuals actively and openly care for each other.
- The strengthening of community action, e.g. appropriate and significant contributions from a range of agencies, including Education, Health, Social Services and agencies within the wider community context.
- The encouragement of the whole school approach to mental health promotion which may involve the reorientation of some services (adapted from the Ottawa Charter, 1986).

### Understanding Suicide and Self-harm

Of all the areas of mental health promotion, suicide and self-harm are probably the most challenging for both the professionals and the target groups involved. If suicide rates are to be reduced and the damage that stems from self-harm is to be ameliorated, then it is essential that these issues are addressed in a coherent manner with both those supporting these vulnerable teenagers and the students themselves.

Suicide rates amongst young men in the United Kingdom rose significantly during the 1980s and early 1990s. This has led to a significant amount of public attention being drawn to this topic and rightly so, given the fact that the rates of suicide in England and Wales for young men between the ages of 15 - 24 years rose by approximately 60% within the 10 year period from 1981 to 1991. This led to the Government setting a goal in 1991 (Health of the Nation Strategy Document) to reduce the rate of youth suicide by 15% by the end of the century. The rate has been reduced by approximately 16 per 100,000 in 1990 to 12 per 100,000 in 2000.

In order to further support the Government's health strategy in this area, a specific 'National Suicide Prevention Strategy for England' was issued in 2002. This strategy has six identified objectives, including reducing risk in key high risk groups, e.g. men, and promoting mental

health wellbeing in the wider population, alongside reducing the availability and lethal nature of suicide methods. It seems still the case that young men are far more likely to commit suicide than young women. In England and Wales in the year 2000, the rate for young men was 12 per 100,000 while it was only 4 per 100,000 for young women, i.e. three times as many young men as young women commit suicide every year. The UK's rate is close to that of other comparable European countries but less than the rates in North America, Australia, New Zealand and Ireland. It is also concerning that the rate for young men in Scotland in the year 2000 was 36 per 100,000, i.e. three times the rate in England and Wales. Regional variations of this type are of great concern, having implications for service provision and public policy.

### Risk Factors

The risk factors associated with suicide can be divided between primary and secondary factors. Clearly no one young person will experience all of these factors but are likely to experience a significant combination. Such a combination will then lead to an increased risk of suicide.

Primary risk factors include the following:

- Alcohol and drug abuse
- A sense of real hopelessness concerning the future
- Serious depression
- A previous attempt at suicide
- Some form of psychiatric disorder

Secondary risk factors include:

- A severe dent to self-esteem which may lead to a sense of guilt or shame
- A recent loss or bereavement
- A family history of suicide
- Experiencing a significant other (e.g. a friend or significant adult) committing suicide.

Added to these factors, there are also groups of young people who are at much higher risk than would be expected within the mainstream group, including young people in custody, looked-after children, gay/lesbian or bisexual children and those who inhabit more isolated rural communities.

## Self-harm

### Definition

There has been a significant level of debate as to how to define self-harm. John Coleman (2004) suggests that we, 'take the view that it is most helpful to consider self-harm as a continuum, ranging from behaviour which has a strong suicidal intent (e.g. some kinds of overdose) to behaviour which is intended to help the person stay alive (e.g. cutting)' (p 6). Coleman adds that the problem with the term 'deliberate self-harm' is that it has an implication of wilfulness about it, which may be unhelpful to young people if they believe they have little control over their behaviour. Similarly, the problem with the term 'attempted suicide' is that some young people take an overdose with little suicidal intent. (p 7). Self-harm therefore appears to be the best term to use in order to describe this continuum of behaviours while also maintaining a focus on the degree of suicidal intent.

### Evidence

There is consistent and converging evidence (Whitlock et al., 2008) that the most commonly chosen form of self-harm is cutting the body with a knife or razor, typically on the arm or leg or stomach. Other common forms include scratching or scraping the skin until blood is drawn, burning the skin, or inserting objects (such as pins) under the skin. Less frequently reported forms include hitting or biting oneself, pulling out hair, or picking at wounds.

### Data

Data concerning hospital admissions (Hawton et al., 2003) suggest an increasing trend over these behaviours over the last two decades; while anecdotal reports from clinicians, other health professionals, and teachers also indicate a marked rise in these behaviours over the recent past. Rates of self-harm are far more difficult to identify than those for suicide. The reasons for this are clear and obvious. In a study carried out by Keith Hawton (2006) for the Samaritans, 10.6% of a 4,500 sample of secondary school pupils were found to have been involved in some form of self-harming behaviour. However, within this particular group many more had been involved in cutting (7.4%) than in self-poison (3.2%). The gender ratio here was approximately 3:1, i.e. more females than males were involved in this kind of behaviour.

### Assessment

When working with young people, the

professionals involved have to be able to assess the degree of suicidal intent in such behaviours.

The criteria most usefully utilised are as follows:

- The length of time that the attempt at suicide was actually being planned. If the planning period is extensive then the risk will be greater.
- The level and severity and intensity of depression that the young person is experiencing.
- The sense of hopelessness the young person is experiencing.
- If the young person was alone at the time of the self-harm incident, i.e. if the young person knows that they are not entirely alone then this would indicate a lower degree of risk.

## Why Self-harm?

### Self-poisoning

There are many reasons for self-harming and there are many meanings to each of the acts perpetrated by the individuals concerned. It may well be the case that when a young person attempts to self-poison, there is a serious attempt to die. However, this attempt could also simply be a wish to escape from a terrible situation or a perceived terrible situation. It may be the only way out that the young person considers to be possible at this point in time. He/she may also feel that they have no control over the situation and feel a total lack of self-efficacy whilst also experiencing a sense of life being simply too much to bear or cope with. Ultimately, many professionals would consider self-poisoning as a means of communication and according to Coleman (2004) 'Concentrating on the meaning of the communication may help to prevent a repetition of the act'. (p 8) Coleman also makes the significant point that, 'It is frequently the case that troubled relationships, either with the parent or a close friend, lie at the heart of an episode of self-poisoning. For this reason it is especially important that, following such an episode, the young person has the opportunity to talk with a caring adult, and to give expression to some of the painful emotions caused by her/his relationship difficulties'. (Coleman 2004 - p 8)

### Mutilation

In the same way that self-poisoning can be motivated by painful relationships and experiences, cutting and other forms of

mutilation are also similarly motivated. However, it is important to point out that self-harm is at the opposite end of the continuum in terms of suicidal intent. Cutting, itself, is frequently a way or means of being able to stay alive as opposed to achieving death. Generally, forms of self-mutilation are an attempt to gain release from severe emotional tension or distress. This form of self-abuse may also be a means of the young person redirecting the anger that they feel, i.e. they may hate their abuser but be unable to express that hatred towards that individual and this form of mutilation provides them with an outlet for these feelings.

### **Range of behaviours**

Overall, self-harm refers to a range of behaviours along a continuum ranging from low to high suicidal intent. In general, young people who tend to mutilate or cut themselves are likely to have a lower suicidal intent whilst those who take an overdose may have a higher suicidal intent. What is important is that the young person accesses appropriate assessment procedures within the context of a mental health organisation. Part of this assessment would include identifying risk factors which are similar to those identified with suicide. However, risk factors for self-harm also include physical, sexual or emotional abuse, low self-esteem and anxiety and difficulties in relationships.

### **The development of a school-based awareness raising intervention**

Keith Hawton (2015) has most recently identified the essential necessity to develop and deliver school-based interventions which educate and inform all young people about the causes and triggers to self-harm and suicide.

A key question to ask is: Whom do young people talk to first when they disclose their self-harming behaviours? We know that it is most likely that they will talk to their friends at school and not to parents in the home context or to teachers in school. Young people need to feel skilled up and confident in terms of talking about these issues, what to say to a friend who discloses to them, how to manage when they see images on line which are triggering, how to cope with pressure to engage in self-harm behaviours from peers and how to build effective thinking and resilience in order to manage the emotions and triggers to anxiety which may result in these behaviours.

It is this perspective that led to the development of this preventative programme for young people (Rae & Walshe, 2016). It was developed for high school students and aimed to raise awareness as to these risk factors for both suicide and self-harm behaviours amongst young people and those who care for them. Consequently, within the resource, attention is paid to identifying and further analysing such factors alongside also attempting to increase the mental health of the young people concerned or targeted by the programme. As stated previously, the authors were not simply concerned here with prevention of illness but also with the promotion of young people's vitality, validity, sense of self-worth and general degree of happiness. A key aim was to really ensure that young people have the opportunity within the school context to feel and be free from bullying, violence and conflict and to be able to engage in the learning process in an energetic, motivated and caring manner.

### **Trialling the resource – an on-going initiative**

To date, the resource has been trialled in 3 high schools and students and staff perceptions of the impact have been measured via scaling questionnaires and focus groups. The process is on-going and it is expected that data will be analysed via thematic analysis (Braun and Clarke, 2006) and the themes identified will support on-going development of the programme whilst also providing evidence of its efficacy in terms of changing perceptions and building resilience and coping skills in the students themselves.

At the outset, it was vital to enlist the support of the staff team and to ensure that the necessity for including the programme as part of their PSHE/Well-being curriculum. Overcoming the stigma and discussing concerns regarding any 'contagion effect' was an essential at the outset. An awareness raising and information session was delivered by the facilitators in order to ensure that staff in schools felt comfortable with both the approach and the content of the programme. They were also assured that delivery would be undertaken in partnership with the schools educational and child psychologist and that adequate debriefing for both staff and students would be made available to both staff



and individual students as and when needed. The programme was delivered on the understanding that school based staff would work together to formulate and agree a whole school policy regarding the management of self-harm in the school. Guidance was provided as to how to both inform and involve parents/carers.

### Using the resource

With these aims in mind the resource was consequently divided into two parts, aiming to ensure that knowledge and skills were developed at three different levels: the whole school level, the group level and at the individual level.

#### Part 1 – Working at the whole school level

- The first part of this resource is a training session designed to educate and raise awareness amongst professionals working with young people. A PowerPoint presentation is accompanied by a facilitator's script with detailed notes relating to each of the slides. The idea here is to provide much of the information provided in the introduction to the programme as published, alongside activities which provide the opportunity to gain a further insight into the nature of self-harm and suicide amongst young people.
- The appendices then highlight the ways in which school-based staff can develop a policy and raise awareness amongst the whole school as to best practice in this area. Key aspects of the policy are addressed and a sample policy is also provided within the appendices.
- The appendices also provide information leaflets for parents, staff and pupils as to the nature of self-harm amongst young people alongside resources and sources of support. The idea here is to dispel any myths and to ensure that accurate, up-to-date facts are provided so that many of the fears around these issues can, to a certain extent, be changed.

#### Part 2 – Working at the group level

This section is designed as an 8-session programme which can be delivered to groups of young people in a school or youth education

context. The 8 sessions are designed to cover the main issues surrounding self-harm and suicide in young people and to provide a safe framework in which students can develop preventative strategies and techniques alongside recognising the importance of peer support and appropriate access to therapeutic agencies.

The programme is divided into the sessions as follows:

Session 1	What is self-harm? – Myths and realities and tackling the stigma
Session 2	Understanding stress and anxiety
Session 3	Triggers and traumas – the impact of social media and the internet
Session 4	Stopping the cycle of self-harm – key tools and strategies
Session 5	Supporting friends who self-harm – key issues and sources of support
Session 6	Key tools from Cognitive Behaviour Therapy to practice and use
Session 7	Using tools from positive psychology to create a more positive mind-set
Session 8	Breaking the cycle and moving forwards

### An important point

It is very important to remember that young people participating in the group activities and staff involved in the training aspects of this programme may find themselves experiencing and dealing with some very strong feelings and emotions. Self-harm and suicide clearly involve very sensitive issues. Many of the people involved in this work may have been affected by self-harming behaviours or suicidal tendencies or behaviours within their own families. Some people may be engaged in or have engaged in these behaviours themselves. Consequently, it is recommended that prior to delivering the introductory INSET or work on policy and raising awareness or work at a group level in particular, that the facilitators ensure adequate time is spent in enabling group members to feel

relaxed and get to know each other and that appropriate risk assessments are undertaken to ensure the emotional and physical safety of all involved.

Session 1 of the group work in which the students formulate ground rules should also perhaps be undertaken prior to delivering the training with any group of professionals. Trust needs to be established amongst participants regardless of which part of the programme they are working on. It is also important for the facilitator to feel skilled, knowledgeable and secure in delivering these materials and dealing with many of the strong emotions that may erupt during the course of delivery. Being trained or having access to training in this area can result in some emotional and unpredictable responses. It is consequently recommended that facilitators are trained in group work and group dynamics and also that a minimum of two facilitators deliver the training and group work. It is also vital that facilitators have access to supervision and appropriate levels of support themselves if they are to be truly effective in both delivering the key aspects of this programme and maintaining their own wellbeing.

## Conclusion

It is hoped that the resource developed and trialled within the high schools will be disseminated further in a range of educational contexts. The drive to promote wellbeing and prevent the escalation of mental health difficulties and associated self-harming behaviours remains of vital importance to those of us who work with children and young people in the educational context and beyond. Interventions at a school level are essential in order to dispel myths, develop awareness and resilience skills and also to prevent the escalation of anxiety which leads to such behaviours in the first instance. A review of findings by Nock (2010) indicates that most individuals known to engage in self-harm report having access to psychological support or medication. However, there appear to be few (if any) current interventions (clinic- or community-based) that have a solid evidence base, although various forms of established treatment (behavioural therapy, cognitive therapy, and psychodynamic therapy) have been modified to target self-harm. We therefore hope that with additional trials we

can identify the evidence base for our intervention for working with young people at a preventative level.

Also, having focussed upon students at high school level and becoming aware of the fact that younger children are now engaging in these behaviours, the next step for the authors is to identify how to support and intervene at primary level. We know that self-harm has been witnessed in primary school aged children as young as six years (Palmer, B., and Martin, G. (2014), Nock, M. J., and Prinstein, M. J. (2004) and Barrocas et al., (2012). It is therefore essential for us to consider how to create preventative approaches and interventions which are both effective and age appropriate. This is clearly a much-needed work in progress.

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