Non-Suicidal Self-Injury in New Zealand Secondary Schools.

An Investigation of School Staff Attitudes, Beliefs and Knowledge of Non-Suicidal Self-Injury.

A thesis presented in partial fulfilment of the requirements for the degree of MSc Psychology.

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ABSTRACT

Non-Suicidal Self-Injury (NSSI) is a self-destructive, maladaptive behaviour with high prevalence rates among adolescents. In New Zealand, prevalence of NSSI has been identified at high rates among our adolescent populations, which is cause for concern. Increasingly, calls for advocacy and action in supporting adolescents have turned towards schools, as adolescents spend much of their time in education settings and school staff are primed in an optimal position to support students. But how equipped are school staff for this additional job, and how do they feel about students engaging in NSSI?

This research aimed to investigate staff's current attitudes, beliefs and knowledge of NSSI throughout New Zealand Secondary Schools. An online survey-based design was used, which included a mixture of multi-choice, Likert scale and open-ended questions. Participants were 458 Secondary School staff from throughout New Zealand. School staff roles included senior and middle management, guidance teams and school nurses, teaching staff and support staff. Findings provide evidence of a mixtures of attitudes and beliefs towards students engaging in NSSI and reasonable levels of staff knowledge of NSSI as behaviour and how to identify signs of NSSI among students.

In total, 77% of participating Secondary School staff had encountered at least one student engaging in NSSI, with results identifying relative levels of self-disclosures to staff and teaching staff as being in a valuable position to notice physical and behavioural signs of NSSI behaviour amongst students.

Training was identified to be associated with increases in positive attitudes and beliefs and increases in knowledge across varying professional school staff roles. It was associated with increased competence and confidence in engaging in conversations regarding NSSI with students, and more positive attitudes towards supporting students engaging in NSSI. Results identified low levels of NSSI staff training in New Zealand, and a consequential call for action from staff for training in this area. Just 10.9% of participants had received training in the area of NSSI, with upwards of 85% of staff in most staff categories identifying they would benefit from further training in NSSI.

Keywords: Non-Suicidal Self-Injury Adolescents Secondary School Staff New Zealand

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Introduction and rationale

Non-suicidal self-injury (NSSI) is a behaviour which is gaining increasing amounts of attention and discussion. Current research alludes to a worldwide increase in the behaviour, particularly among adolescent and early adult populations. As a behaviour, NSSI is often perplexing and misunderstood by onlookers, and frequently met with preconceived ideas about the nature of the behaviour and the individual engaging in it.

Non-suicidal self-injury (NSSI) is the intentional, culturally unaccepted, self-inflicted, immediate and direct destruction of body tissue, absent of lethality and suicidal intent (Nock & Favazza, 2009). It does not include socially normative practices, such as body piercings or tattoos or long-term damaging behaviour such as disordered eating (Favazza, 1998; Walsh, 2006). The most common forms of NSSI include cutting or slashing the skin, self-hitting, and burning (Laye-Gindhu & Schonert-Reichl, 2005; Ross & Heath, 2002; Swannell, Martin, Page, Hasking, & St John, 2014). Self-inflicted cutting has been the most documented mode of non-suicidal self-injury, with 80.1% of reported cases involving cutting (Muehlenkamp, Xhunga and Brausch, 2018). Self-battery, scratching, biting, wound interference and head-banging are the other methods often identified by individuals (Swannell et al. 2014; Muehlenkamp et al. 2018).

Prevalence

In recent years NSSI has drawn widespread attention, with current literature calling the behaviour a major public health problem among adolescents (Swannell et al. 2014). This is undoubtedly due to the adolescent age bracket identified as the developmental stage where non-suicidal self-injury commonly begins and most frequently occurs (Kumar, Pepe, & Steer, 2004) and the serious physical harm which can come from NSSI.

NSSI occurs most frequently among adolescent populations. Saunders and Smith (2017) identified in their study that 65% of all documented NSSI occurs within the teenage years. The age range of NSSI onset is documented as between 10-22 years; however, the average age of onset is reported between 13-14 years (Muehlenkamp & Gutierrez, 2007; Muehlenkamp et al. 2018).

Research across different cultural contexts indicate incidence rates range between 17-20% within adolescent populations (Muehlenkamp, Claes, Havertape, & Plener, 2012; Swannell et al. 2014). Moreover, (Swannell et al. 2014) in a meta-analysis of community samples, reported 17.2% of adolescents engaging in NSSI and 13.4% of young adults reported previously engagement in the NSSI behaviour. International prevalence rates of NSSI in school-based populations average around 18% for at least one incidence of NSSI (Muehlenkamp et al. 2012) and 4% for repetitive NSSI (Bruner et al. 2007; Plener, Kapusta, Brunner, & Kaess, 2014).

New Zealand, lifetime prevalence rates indicate higher rates of incidence; approximately 50% of adolescents (Garish & Wilson, 2016) and 38% of university students (Fitzgerald & Curtis, 2017) reporting to have undertaken non-suicidal forms of self-injury. The New Zealand Ministry of Health Report of Deaths and Intentional self-harm Hospitalisations in 2013, also provides an indication of the prevalence of self-harm in New Zealand. This report indicates: there were 7267 intentional self-harm hospitalisations, female rates of hospitalisation were twice the male rate, the age group with most admissions was for females 15-19years and males 20-24 years (Ministry of Health, 2016). It is important to note, however, that that categorisation of self-harm in this report is inclusive of suicidal intent and therefore does not accurately represent the NSSI incidents throughout New Zealand.

NSSI and suicide

NSSI is a behaviour some think to be on a continuum between harm to oneself and suicidality. Although identified in current literature as distinct behaviours, they are not mutually exclusive. NSSI is distinguished from suicidal behaviour and suicide by definitional exclusion of self-harming with the intent to cause fatal injury. For some individuals, NSSI engagement is a way to decrease and avoid suicidal urges (Klonsky, 2007; Klonsky & Muehlenkamp, 2007).

Well-being and mental-health differences between these behaviours are documented in current literature. NSSI is associated with, higher levels of self-esteem, and lower levels of anhedonia and negative self-evaluations than self-harm with suicidal intent (Brausch & Gutierrez, 2010).

Despite NSSI pertaining to behaviours occurring without suicidal intent, it is associated with subsequent risk of suicidal acts (Hamza, Stewart & Willoughby, 2012) repeated incidents of NSSI and early age of onset have been identified as increasing the likelihood of an individual eventually making plans to commit suicide (Ammerman, Jacobucci, Kleinman, Uyeji, & McCloskey, 2018) and of future suicide (Hasking, Whitlock, Voon, & Rose, 2016; Saunders & Smith, 2017). NSSI onset between 10-14years appears to have an added vulnerability for individuals, increasing the risk of a later suicide attempt (Muehlenkamp et al. 2018).

Although many people who self-injure with non-suicidal intent may never attempt suicide, it is still a relevant risk factor for suicidal behaviour. The rate of completed suicides from individuals engaging in NSSI remains relatively unknown. Although one related study found that approximately one-half of people who died from suicide had a history of some form of self-harm (Foster, Gillespie & McClelland, 1997). Additionally, the majority of those who self-injure will report at least one suicide attempt in their lifetime (Sher & Stanley, 2009).

Factors associated with a heightened risk of future suicide include; increasing frequency of NSSI and for prolonged periods, use of multiple methods or feeling no pain during NSSI (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006; Nock 2009). The progression of NSSI is common among adolescents engaging in the behaviour, particularly from an early onset. More than three-quarters of youth in a study by Andover, Pepper and Gibb (2007) reporting on NSSI behaviour, identified repeated incidents. Almost half reported 2-10 lifetime incidents and 20-25% reporting more than ten life-time incidents.

Earlier age of onset also appears to be a factor which influences the ability an individual has to move past self-harm towards recovery. Individuals with early onset of NSSI behaviour are less likely to report perceived recovery than individuals who had an older age of onset (Muehlenkamp et al. 2018). Greater social, peer and family support and higher self-esteem have also been associated with adolescents engaging in self-harm without suicidal intent, when compared to suicidal behaviour (Brausch & Gutierrez, 2010).

Gender differences

Gender differences have been identified in incidence rates, location and mode of self-inflicted injury. Historically NSSI has often been documented as a maladaptive behaviour most common for females. However, recent research identifies key differences in location and mode of self-injury among males which may have previously been overlooked or classified as behaviourally different from NSSI (Sornberger, Heath, Toste, & McLouth, 2012). Females are more likely than males to report cutting and scratching, whereas males are more likely to report burning themselves, punching, hitting or self-injury with an object such as a wall (Whitlock, Eckenrode. &, Silverman,2006; Sornberger et al. 2012).

Gender has been identified as a factor which may influence the location of where an individual inflicts non-suicidal forms of self-harm onto the body. Research by Sornberger et al. 2012 identified a variation between genders; females were identified as more likely to inflict NSSI to the arms and legs, while males were more likely to target the chest, genitals and face. Findings such as these emphasise the importance of understanding additional signs of NSSI rather than solely looking for physical destruction of the skin as this may fail to identify a percentage of individuals, particularly males, at risk of or engaging in NSSI behaviour.

Andover, Pepper and Gibb, (2007) and Whitlock et al. (2011) recorded, females as more likely to engage in severe forms of NSSI and for more extended periods than males. Whereas, NSSI behaviour among males is more likely than females to be associated with alcohol use and intoxication (Whitlock et al. 2011).

Both males and females report social aspects of NSSI, with males discussing self-injuring themselves in the company of others (Whitlock et al. 2011). Whereas investigation of social influences by Prinstein et al. (2010) identified female engagement in NSSI behaviour to be associated with friends engaging in NSSI individually and in groups. NSSI behaviour amongst females has also been documented as interacting with mental disorders such as depression, eating disorders, bipolar disorder and anxiety and conduct disorder at greater rates than their male peers (Hintikka et al. 2009). This relationship has also been observed within New Zealand populations of individuals who self-harm. Robinson et al. (2017) findings

identified females engaging in NSSI are reporting depression and anxiety at higher levels and frequency than males.

Rationale for engaging in NSSI

Several factors have been identified as predisposing individuals to engaging in and maintaining NSSI behaviour. Early adverse life events have been implicated as possible key contributors to NSSI engagement including childhood sexual abuse (Jacobson & Gould, 2007), child maltreatment, parental drug and alcohol use, domestic violence, poverty (Horner, 2016), parental emotional neglect (Gratz, 2003), bullying (Claes et al. 2015), or being exposed to NSSI behaviour through a peer (Deliberto & Nock, 2008). Additionally, self-criticism and hopelessness can increase the likelihood of individuals engaging in NSSI as a form of behavioural self-punishment (Nock, 2009; Gong et al. 2019).

In both clinical and non-clinical studies, NSSI has been linked to various mental health difficulties. Psychological distress, increased symptoms of depression, panic and anxiety and difficulties in emotional regulation have all been identified as being associated with NSSI behaviour (Zielinski, Hill & Veilleux, 2018) However, in similar research adolescents engaging in NSSI have been identified who do not exhibit signs or symptoms of mental health difficulties and otherwise appear psychologically 'normal'(Stanford & Jones, 2009). This study also identified psychologically pathological, and impulsive subgroups of adolescents who engage in NSSI.

Research from Buelens, Luyckx, Gandhi, Kiekens, and Claes (2019) supports the theory of a bi-directional relationship between psychological distress and NSSI. This relationship suggest adolescents may be engaging in NSSI as a result of psychological distress and NSSI behaviour, which in turn, contributes to increased psychological distress over time.

Current literature indicates varying theories regarding the rationale for individuals engaging in NSSI behaviour. Theoretical models of NSSI identify the influence of both emotion and cognition in the initiation and maintenance of NSSI behaviour (Buelens et al. 2019; Hasking, Whitlock, Voon & Rose, 2017; Selby & Joiner 2009). Current literature identifies NSSI often as a sign of an individual's psychological distress, intense negative emotions, maladaptive coping strategies or behavioural responses to unhealthy environments (Buelens et al. 2019; Klonsky & Muehlenkamp, 2007; Nock & Prinstein, 2004; Stanford,

Jones & Hudson, 2017). NSSI may also serve to express self-directed anger or disgust, influence, or seek help from others and end periods of dissociation or depersonalization (Klonsky & Muehlenkamp, 2007). This behaviour has been associated with acts of self-punishment and as a behavioural strategy for avoiding suicide (Taylor et al. 2018).

The empirically recognised four-factor model of NSSI (Nock & Prinstein, 2004) identifies four functions involved in the initiation and maintenance of NSSI. This model proposes that NSSI behaviour is engaged in as a way of automatic positive reinforcement (e.g. NSSI motivated by the desire to feel something), automatic negative reinforcement (e.g. NSSI motivated by the desire to escape negative effects such as anger, anxiety or distress), social positive reinforcement (i.e. NSSI motivated by the desire to gain attention or access to resources), and/ or social negative reinforcement (i.e. NSSI motivated by the desire to avoid punishment from others).

Reinforcement of NSSI occurs either externally through the environment (social) or from internal release or relief (automatic/internal) (Messer & Fremouw, 2008). When NSSI is utilised as a means of affect regulation, the relief and reduction in emotional arousal negatively reinforce the behaviour over time (Hasking et al. 2016). When repetitive NSSI continues to provide a release from negative emotional thoughts and feelings, it maintains the cycle, therefore encouraging the behaviour to continue (Hasking et al. 2017). Comparatively, when used to create desirable states, NSSI behaviour is positively reinforced (Nock & Prinstein, 2004).

NSSI behaviour can sustain a longer-term maladaptive cycle between emotion, cognition and NSSI (Buelens et al. 2019). Individuals who self-injure may experience a positive feedback loop in which the tendency to ruminate on negative emotional thoughts and feelings increases the level of negative emotion (Selby & Joiner 2009; Buelens et al. 2019). An individual's high levels of rumination, repetitive thinking patterns, particularly when associated with self-criticism can add additional risk for NSSI behaviour as well as maintaining the behaviour (Gong et al. 2019).

Although not a traditional concept, Nock et al. (2006) discussed high levels of intrapersonal (within oneself) and interpersonal (between people) distress as associated with NSSI behaviour. This theoretical explanation for NSSI has similar undertones to the four-factor model in that it discusses both internal and

external influences which can provide a rationale for an individual's engagement in and the maintenance of NSSI.

Concerning intrapersonal distress, NSSI provides an emotional or physiological 'relief' for a short time (Klonsky, 2007; Nock & Prinstein, 2004). This regulation of distressing emotional states is the rationale most often endorsed by those engaging in NSSI behaviour within both clinical and non-clinical populations (Hasking et al. 2016; Klonsky, 2007; Nock & Prinstein, 2004; Taylor et al. 2018). For these individuals, the act of NSSI functions by reducing, managing or escaping intense and intolerable negative emotions (Klonsky, 2007). Individuals engaging in NSSI with intrapersonal rationale are more likely to attempt to avoid detection and do not wish to tell others (Gratz, 2003).

In comparison, individuals engaging in NSSI with an interpersonal rationale seek social motivations for the behaviour; such as communicating distress to others and attempting to deal with social problems (Nock & Prinstein, 2004). The interpersonal and social rationale for NSSI may reflect deeper difficulties with interpersonal problem solving (Klonsky, 2007; Nock & Prinstein, 2004).

NSSI is a behaviour just like any other, which can be learned and influenced by others. It has been identified as being a behaviour often copied by adolescents, particularly within social settings and groups (Whitlock & Rodham, 2013). In a recent study of the social aspects of NSSI Heath, Ross, Toste, Charlebois, & Nedecheva (2009) reported a total of 43% of adolescents engaging in NSSI claimed to have learned the behaviour from another, with 59% identifying that a friend had been the first to engage in NSSI

For some individuals, NSSI communicates status, group affiliation and the communication of distress or desire for connectedness (Whitlock, & Rodham, 2013). NSSI can, in a social way function to connect friends and peers with common interests and behaviour. Heath et al. (2009) identified that for some individuals, social motivators are common in both initiation and continuation of NSSI behaviour. For some individuals, there is an importance in seeking social connection or attention from others through NSSI behaviour. Social influences, including groups of friends using NSSI in competitive ways and for bonding purposes within social groups, have also been reported in recent studies (Curtis, 2007). Heath et al. (2009) found that among adolescents reporting NSSI behaviour, 17% self-injured in front of friends, while 65% had talked to friends about self-injury.

NSSI in the school environment

NSSI is inadvertently linked to key environments in an individual's life, which for adolescents, the main population of individuals engaging in NSSI, includes the school environment. Schools are among adolescents' microsystems, their most immediate developmental contexts and consequently influence greatly on adolescents' development (Atkins, 2010; Bronfenbrenner, 1979). These microsystems are both affected by and influence an individual's behaviour.

There is strong evidence of the importance of the school climate in influencing adolescent's mental health and supporting health promotion (Aldridge & McChesney, 2018). Beyond the home environment, an adolescent's emotional well-being and ability to cope can be positively and negatively affected by how they perceive their school environment (Ozer & Weinstein, 2004). Indeed, the World Health Organisation (2013) called for a coordinated response from many sectors to improve adolescent's mental health and well-being; noting the education sector plays a critical role and is key in this response.

Related studies in the area of adolescent and student's psychological well-being have identified aspects of the school environment and interactions with others as influential in mental health. The larger social climate in schools is important for positive mental health, as well as personal relationship experiences with peers and adults (Oberle, Guhn, Gadermann, Thomson, & Schnert-Reichl, 2018; Thapa, Cohen, Guffey & Higgins-D'Alessandro, 2013).

The school climate reflects perceived values, practices and organisational structures and interpersonal relationships among students, teachers and staff (Thapa et al. 2013). The collective social interrelations among students, teachers and staff play a role in the school climate; reflecting the connectedness students experience at school and act as an important asset for positive development and resilience (Libbey, 2004). Belonging to peer groups becomes an important source of support and approval which is associated with positive mental health and well-being in adolescents (Steinberg & Morris, 2001). Moreover, higher levels of positive peer climate can decrease the likelihood of NSSI, while higher levels of negative peer climate in the school environment increase the risk of NSSI (Madjar et al. 2017).

Peer rejection and victimisation have also been associated with lower levels of well-being (Guhn, Schonert-Reichl, Gadermann, Hymel, Hertzman, 2013) increased mental health difficulties (Oberle et al.

2018) and higher levels of internalisation of problems (Gini & Pozzoli, 2009). Peer rejection acts in amplifying the risk factors for victims of bullying and creates an environment which makes them more vulnerable to initiation of NSSI behaviour (Esposito, Bacchini, & Affuso, 2019). A meta-analysis identified peer victimisation is significantly related to NSSI behaviour during adolescence (Esposito et al. 2019).

Being bullied by peers in school environments has also been directly identified as a risk factor for engaging in NSSI in both adolescence and adulthood (Bruinstein Klomek et al. 2016; Lereya, Copeland, Costello & Wolke, 2015). In-fact just the engagement of being involved in bullying, as the bully or victim, has been recognised as a risk factor for engaging in NSSI behaviour at least once and repeatedly over time once initiated (Esposito et al. 2019).

Additionally, younger children that were victimised by peers reported significantly more NSSI than older children, indicating the age of victimisation as an additional factor (Van Geel, Goemans, & Vedder, 2015). Noble, Sornberger, Toste, Heath and McLouth (2011) identified that students in middle and high school who engaged in NSSI were more likely to report being the victim of bullying or threats at school. In comparison, the quality of peer relationships within a class can be both a protective factor and risk factor for adolescent NSSI behaviour. Positive relationship experiences in school are key contributors to positive mental health, over and above the absence of negative relationships and victimisation (Oberle et al. 2018).

In related New Zealand studies, Coogan, Bennett, Hooper, and Dickinson (2003) identified secondary school students who experienced bullying as more likely to suffer depression, lower self-esteem, stress and hopelessness. They were also found to be more likely to think about and attempt self-harm and suicide than students who have not been bullied. Of participants in this study, 27% reported experiences of bullying in secondary school, 22% of that population citing verbal teasing as the bullying mode, which was the most commonly identified form of bullying. Some 32% of this study indicated they had contemplated self-harming, while 19% had attempted it. Female students and those identifying as Māori, Pacific Islander or “other” ethnicities were found more likely to contemplate and attempt self-harm as a result of bullying.

School staff understanding NSSI risk factors such as bullying, peer victimisation and interrelation issues within school environments can help staff identify students at risk of engaging NSSI and students who are already displaying NSSI behaviour. Additionally, having a teacher who conveys support and acceptance can act as a protective factor for adolescents who experience mental health difficulties, and is associated with increased well-being and success in school (Pinata & Hamre, 2009).

Help-seeking behaviour

Positive relationships with school staff can offer an important source of support for early adolescents (Hall, 2010). Teachers are also at times trusted with disclosure of NSSI and are perhaps more relevantly, in the best position to identify possible NSSI in students (Heath, Toste, Sornberger & Wagner, 2011).

External support systems, such as peers, friends and groups outside of the family unit, are a differentiating factor between adolescents whom partake in NSSI and those whom self-harm with suicidality (Muehlenkamp & Gutierrez, 2007). In a New Zealand study of help-seeking behaviour among Secondary School students, clear factors were identified which promote individuals seeking support for mental health difficulties from professionals. Support networks outside of the family, such as having a non-family adult to talk to and being well known by a teacher were identified as associated with increased help-seeking behaviour (Mariu, Merry, Robinson & Watson, 2011).

Of those who seek help for NSSI, adolescents primarily turn to friends and family for support. The Internet may be more commonly used as a tool for self-disclosure rather than asking for help (Rowe et al. 2014). Self-disclosure of NSSI to friends is more common than to parents, teachers and health professionals (Berger, Hasking & Marin, 2017; Evans, Hawton, & Rodham, 2005; Fortune, Sinclair & Hawton, 2008b), adolescents who self-harm see their friends as an important source of support (Evans et al. 2005). Confiding in adults, however, may be an important protective factor against future self-injurious behaviour. Hasking, Rees, Martin and Quigley, (2015) identified adolescents who had disclosed NSSI behaviour to adults rather than peers reduced the severity of NSSI and increased adaptive coping skills.

Evans et al. (2005) study identified that although over 20% of adolescents indicated they could talk to their teachers about NSSI, friends and family were the preferred option for most. Previous studies investigating rates adolescent self-disclosure to teachers have identified between 2-6% of students with NSSI sought help and disclosed NSSI behaviour to teachers (Berger, Hasking, & Martin, 2013; Fortune, Sinclair, & Hawton, 2008a; Hasking, Rees, Martin, & Quigley, 2015; Hawton, Rodham, Evans, & Harriss, 2009).

Barriers to help-seeking behaviour

Barriers to help-seeking behaviour included fear of negative reactions from others including stigmatisation, fear of breaches in confidentiality and fear of being seen as 'attention-seeking' (Rowe et al. 2014). However, adolescents who experienced thoughts or behaviours of self-harm are less likely than their peers to ask for help (Evans et al. 2005) and school staff often express uncertainty about how to identify and discuss NSSI with students (Berger, Hasking & Reupert, 2014a).

Studies suggest, adolescents who self-harm are likely to feel the need for help but not actively seek it; feeling less able to talk to family and teachers and had fewer categories of people in their life they felt they were able to talk to (Evans et al. 2005). Additionally, when attempting to seek help, adolescents may not know where to turn for help or what to expect from the help they may receive (Klineberg, Kelly, Stansfeld & Kamaldeep, 2013).

Promoting help-seeking behaviour

Early help-seeking for emotional difficulties is central to developing resilience among adolescent and can act to reduce subsequent NSSI and suicide behaviour (Hasking et al 2015). The anticipation of support and non-judgemental attitudes have been identified as facilitating the disclosure of NSSI to adults (Berger et al. 2017). Adolescents have reported that some of the best ways to prevent the behaviour of self-harm, including NSSI, are to: have access to non-judgemental people to talk to at school, reduce concerns about confidentiality and stigma, and provide education to teachers about NSSI and how to respond

(Fortune et al. 2008a). In Fortune, Sinclair and Hawton (2008b) study, 28% of adolescents indicted talking and listening to students were ways of preventing self-harm in adolescents. In this research, talking and listening were identified by adolescents as ways of showing them someone is 'there for them' and supporting them (Fortune et al. 2008b).

Knowing others who self-injure, reduces stigma and facilitates disclosure of NSSI (Hasking et al. 2015). While, being treated respectfully, having a trustworthy person to seek help from and having the option of talking to someone similar in age and background were identified as encouraging individuals already engaging in NSSI to seek help (Klineberg et al. 2013).

Of pupils partaking in NSSI, 7% suggested it would be helpful to have someone to talk to at school who is not a teacher (Fortune et al. 2008b), with some responses indicating that it would be beneficial for staff such as school counsellors, tutors and mentors, to be proactive in making contact with all pupils rather than wait for someone to have difficulties and to approach them. A further 5% indicated improved access to teachers would be beneficial as well as teachers being aware of warning signs among students (Fortune et al. 2008b). Accordingly, positive measures such as being more open-minded, non-judgemental and talking to students about NSSI to reduce stigma were strategies outlined in (Berger et al. 2013) as ways for teachers to better support students with NSSI behaviour.

Additionally, school staff taking measure to reduce academic stress and bullying has been identified by researchers as an environmental strategy for reducing risk factors and factors influencing the maintenance of NSSI (Berger et al. 2013). Moreover, 6% of adolescent in Fortune et al. (2008b) study, also mentioned targeting bullying, particularly in school environments, as a strategy for minimising levels of self-harming behaviour.

However, between one third and one-half of adolescents who self-harm, with and without suicidal intent, do not seek help for this behaviour (Rowe et al. 2014). Curtis (2017) similarly found individuals who had normalised NSSI behaviour and thus did not want help in managing it. For these adolescents who are not seeking help, or do not know where to turn for support, there should be measures in place to both identify them and offer support where possible. The school environment is an environment in which adolescents spend the majority of their time, and therefore could be utilised for this cause.

Understanding and supporting NSSI in schools

As NSSI has greatest prevalence in adolescence, and only an estimated 10-20% of individuals eliciting NSSI seek medical help (Ystgaard et al. 2009), it is relevant for Heath, et al. (2011) to argue for appropriate attention be given within the school context to target this large population of those who self-injure who may not be receiving relevant support that meets their needs.

High rates of contact with students engaging in NSSI have been reported, providing validation of the large population of students engaging in the behaviour and the exposure to NSSI school staff have. Between 81% to 99% of school staff from Australia, Canada and the United States reported being in contact with a student presenting with NSSI and or suicidality at least once in their careers (Duggan, Heath, Toaste, & Ross, 2011; Robinson, Gook, Yuen, McGorry, & Yung, 2008).

However, only 43% of high school teachers from a Canadian study rated themselves as knowledgeable in the field of NSSI, 67% reported to feel confident in dealing with a student presenting with NSSI (Heath et al. 2011). Relating specifically to NSSI, Berger et al. (2014b), within an Australian sample of high school staff reported almost 70% of the teaching staff had encountered students with NSSI, yet 80% had not received education or training in NSSI, and just over 70% requested training in this area.

Heath et al. (2011) noted that although teachers expressed a willingness to be approached by students who self-injure, less than half of the teachers in the study felt they would know how to respond when approached and less than one-third felt knowledgeable about NSSI. There is often a lack of direction for staff as to the best response to NSSI behaviour and the absence of a key professional within the school to refer the student to for additional support. In a related Australian study, just 33% of school staff reported working at a school with a policy for NSSI, while 94.4% indicated their school needed such a policy (Berger et al. 2015).

From a staff members point of view, the top three barriers identified in providing mental health support for students were: insufficient number of school mental health professionals, lack of training for dealing with children's mental health needs, and lack of funding for school-based mental health (Reinke, Stormont, Herman, Puri & Goel, 2011).

Teachers reported that they felt it is the schools' responsibility to support children's mental health needs and that teachers should play a specific role in doing so. In particular, 89% of teachers agreed that schools should be involved in addressing the mental health needs of children (Reinke et al. 2011). However, only 34% of teacher reported that they felt they had the skills necessary to support these needs in children (Reinke et al. 2011).

Teachers have also been identified as being in an optimal position within the school, and close to students to be able to notice signs and behavioural changes which might indicate engagement in NSSI (Heath et al. 2011).They are often among the first people to notice signs of NSSI in students and are at times the first adults outside the family that students turn to for help (Fortune et al. 2008a). The ability of school personnel to recognise when an adolescent is engaging in NSSI is a critical element in providing an appropriate response and effective support. Staff training in schools has been demonstrated to increase confidence in responding to students who self-injure (Berger et al. 2014a).This demonstrates the importance of specific training in this crucial area, which could assist teachers in identifying children in need of support and providing it where possible.

School staff understanding of NSSI as a behaviour and the ability to identify those at risk of engaging in NSSI could increase the number of students receiving help and support for NSSI behaviour. Curtis (2017) voiced the concerns of individuals who previously engaged in NSSI that other people's lack of understanding of how Non-suicidal self-injury kept them in control of themselves ultimately helped to maintain maladaptive behavioural cycles. However, greater understanding of NSSI could increase the identification of at-risk adolescents and those undertaking non-suicidal self-injury. Although higher prevalence is often reported in females, research suggests this difference could be attributed to the forms of NSSI males and females are undertaking and whether a full screening is completed. Training in this area would encourage staff to look beyond cutting and scratching as determiners for NSSI and towards other behaviours which may be warning signs or indicators of NSSI behaviour.

Additionally, adolescents who identify as transgender have a higher prevalence rate of NSSI when compared to non-transgender populations (Marshall, Claes, Bouman, Witcomb & Arcelus, 2016). Claes et al. (2015) identifying 35% of transgender people in their sample identified a life-time history of NSSI. In

New Zealand Secondary School studies, transgender students report bullying at a 1 in 5 rate, 40% report significant depressive symptoms, had harmed themselves and had been unable to access health care when they needed it (Clark et al. 2013).

Beliefs and attitudes towards NSSI and individuals who exhibit this behaviour also impact on the care and response given when NSSI is disclosed. Madjar et al. (2017) reported that at a class level, teachers provide more support for the classes where NSSI was identified. However, individuals who engaged in NSSI reported a lack of support from teaching staff. This finding demonstrates a possible discrepancy in the form of support students engaging in NSSI require, and the support teaching staff in this study thought they needed/ provided. It also highlights the importance of individual perception of support and if the support is reaching the individual at the desired and required level.

Attitudes and beliefs

For professionals such as nurses, social workers and teachers, negative beliefs and opinions of self-harm have been found to decrease self-belief in the effectiveness and performance in care (Crawford, Geraghty, Street, & Simonoff, 2003). Heightened positivity, however, is related to increased confidence and empathy in caring for individuals who self-harm (McAllister, Creedy, Moyle, & Farrugia, 2002).

Attitudes and beliefs can be conscious, in which the individual is aware of them, or unconscious in which the individual is not. Situations that require an individual to make a behavioural response quickly can deny them the chance to engage in much reasoning and deliberation of the best course of action. Individuals are most likely to rely on their unconscious (implicit bias) when decision making in situations involving incomplete information, time constraints, and situations in which cognitive control may be compromised, such as through fatigue (Bertrand, Chugh & Mullainathan, 2005; Staats, 2015). Evidence demonstrates that implicit biases can be activated by any number of various identities we perceive in others, such as race, ethnicity, gender or age (Staats, 2015). In previous research on the connection between teacher's implicit bias and behaviour, biases have been associated with factors such as expectations on student achievement, decisions on discipline and in attitude differences towards specific racial groups (Staats, 2015).

To identify the needs of schools and staff in supporting students with NSSI, there is first a necessity to understand staff prior knowledge, beliefs and attitudes (Berger et al. 2014a; Berger et al. 2014b). There are a number of reasons for this, the first being that school staff will be the key people implementing any future resources in school environments. It has been identified in previous research that the underlying beliefs and attitudes of staff can either promote or hinder the implementation of initiatives. It is therefore imperative to understand the attitudes and beliefs of staff members towards NSSI, and how these may interact with the behaviours of staff in situations involving students engaging in NSSI.

In Steinback and Stoeger (2016) study, staff attitudes towards self-regulating learning hindered their efforts in planning, implementation and their willingness to attend professional development in this area. The more positive staff attitudes were towards the initiative, the more effort they assigned to implementation, planning and goal setting. Staff attitudes towards the programme also increased positively after undertaking professional training and implementation (Steinback & Stoeger, 2016).

Attitudes and beliefs influence human behaviour and decision making, particularly in situations which require a swift response. Characteristics of a behaviour, the attitudes of the person and the situation have all been implicated in influencing the extent to which attitudes predict behaviour (Fazio, & Roskos-Ewoldsen, 2005). When looking directly at NSSI behaviour and how this may affect decision making, the characteristics of NSSI, particularly when blood and extensive wounds are involved, could prove to be confronting to other individuals. Descriptions of NSSI behaviour often include terms such as '*attention-seeking'* and '*manipulative'*, which could prompt less than positive attitudes and beliefs about NSSI and the individuals engaging in the behaviour. Both of these factors could influence the response given to a student engaging in NSSI. It has been identified that poor responses to youth who self-injure may exacerbate student's feelings of isolation and their reluctance to reach out to others for support, especially because what we know of students who self-injure from Hasking et al. (2015) and Muehlenkamp et al. (2010.) Students who self-injure are likely to already feel disconnected from others and misunderstood. Additionally, school staff may hold misconceptions about NSSI, which may reinforce a student's belief that they are not understood if a poor response to NSSI is given (Heath et al. 2011).

Negative first reactions to NSSI can lead to a decreased likelihood of students seeking professional help (Fortune et al. 2008; McAllister et al. 2002), emphasising that the first contact is of utmost importance. Therefore, protocols, initiatives and guidelines for staff members when dealing with NSSI in schools need to build upon the current knowledge base staff have and take into considerations the attitudes and beliefs regarding NSSI which may act as a barrier for initiatives success.

Presently, New Zealand has policies and resource kits in schools for suicidality and suicide prevention but has yet to release initiatives regarding NSSI. The responsibility for supporting high rates of adolescents with NSSI, therefore, is left to the schools, and more specifically onto teachers who in this role have the most interaction with students.

Previous research of NSSI in New Zealand has been focused in identifying prevalence and behavioural patterns of students engaging in NSSI. Yet, there remains a gap in current research when discussing school staff involved in NSSI. This study aims at taking this first step in understanding NSSI beliefs, attitudes and knowledge of New Zealand Secondary School staff, as a starting point for future research towards providing support in schools for school staff and adolescence engaging in NSSI.

This research proposes to investigate New Zealand Secondary School staff attitudes, beliefs and knowledge of NSSI and how well equipped they feel in responding to students presenting with NSSI. The following questions guide the research process.

Research questions

1. What attitudes, beliefs about NSSI do New Zealand secondary school staff have?

2. What knowledge about NSSI do secondary school staff have?

3. How confident are staff in discussing and supporting students with NSSI?

4. How many New Zealand Secondary School staff have encountered students engaging in NSSI behaviour?
    - How recent was this, within the last 3/6/12 months?

- What were the general characteristics of these students?
- How did they respond to the student or the situation?
- How confident did they feel in that specific situation?

5. How many staff in New Zealand Secondary schools have received training in NSSI?
    - When did this occur, and how useful do they find it in their day-to-day interactions with students?
    - Do staff who have received training in NSSI report more positive attitudes and attitudes towards NSSI?
    - Is staff training associated with increased knowledge of NSSI?
    - Do staff who have received training in NSSI report higher confidence than staff who have not undergone training?

Methodology

Participant recruitment

Participants were recruited using four methods:

1. New Zealand secondary schools were identified utilising the online New Zealand school directory site: educationcounts.co.nz. They were categorised and separated into two groups, geographically as urban or rural. Fifty per cent of the schools within each of the rural and urban groups were selected at random using Microsoft Excel's randomisation tool. School principals from randomly selected schools were emailed an invitation of participation for themselves and schools (Appendix D). They were asked to distribute the information sheet and questionnaire to school staff upon acceptance of participation.
2. An advertisement was posted online detailing the outline of the research study and calling for participants across New Zealand education and teaching news sites, blogs and social media pages. Administrators of these outlets posted a small description, invitation to participate and survey link after the researcher sought permission. The major blogs were Education HQ and Education central. These sites were contacted to reach teaching staff, support staff and SENCO secondary school representatives (Appendix F).
3. Social media advertising consisted of a paid advertising campaign on the Facebook social media platform. The specific target audience included individuals working in secondary schools, teachers in secondary schools, school principals and support staff of Secondary Schools. The main criteria for the advertisement audience were that individuals were living in New Zealand. The terms secondary school and high school were both used in the criteria for audience targeting as these terms are used interchangeably in the New Zealand context (Appendix G).
4. Secondary school staff were contacted through school email accounts on an individual level, inviting participation. This process was based on a random selection of New Zealand secondary schools and publicly accessible information. Participants were approached from previously randomly selected New Zealand High schools (as noted above) with an individual email (Appendix E).

Participants

The *Staff Attitudes, Beliefs and Knowledge of Non-Suicidal Self-Injury Questionnaire* (Appendix A) was started by 483 secondary school staff members throughout New Zealand. It was completed to 55% or above by 458 participants, which created the final sample. Completion of the questionnaire to 55% or greater, was assessed as recording responses from items in each of the participants' beliefs, attitudes and knowledge of NSSI sections in the questionnaire, meeting the aim of questionnaire. Participants who completed less than 55%, therefore, did not meet the criteria, and their responses were excluded for research analysis.

Participants in this study consisted of 315 females, 139 males, and one participant who identified as 'other'. Ages of participants ranged 18 to 70 years (M= 30.23, SD= 12.53). Years of experience ranged from first-year teachers to 54 years in the education sector (M= 16.12, SD=11.58). The modal years of experience were twenty years (*n*= 37). Approximately three-quarters of participants (*n*=338, 73.8%) identified as ethnically New Zealand European/Pākeha, 5.9% identified as Māori. An additional 10.7% identified as European, 1.7% Asian, 0.4% Pacific and a further 7% as 'other'.

Participant roles within secondary schools

Multiple staff roles were reported, ranging from secondary school principals to administrative and classroom support workers. Roles were grouped into nine key categorisations for analysis (Table 3). Categories were based on similarities in job titles and roles within the secondary school, in particular, the degree and type of interactions with students (Table 1 and Appendix H). Participants who occupied more than a single role were coded as the most senior position unless mention of two positions was deemed necessary. For example, a participant who identified as a teacher and dean was classified for this study as a dean. The sample comprised mainly of teachers (*n*= 302), with a reasonable number of deans (*n*=50) and guidance staff (*n*=34) also participating (see Table 2).

Table 1

Categorisation of staff roles

Category	Roles included	Rationale
Principal/ Tumuaki	• School Principal • Principal • Tumuaki	
Deputy Principal	• Deputy Principal • Assistant Principal	
Dean	• Teacher/ Dean • Dean	A Deans role within a secondary school is often one which is split between classroom teaching and additional support for students through the role of Dean. Depending on the size and structure of the school; however, a Dean may not have teaching responsibilities. The majority (*n*=47) of deans in this study identified as both a teacher and dean; therefore, this categorisation recognises Deans as maintaining both roles.
Teaching Team	• Teacher- Head of Department (HOD) • Kaiako • Kaahui Ako • Assistant HOD • Teacher • Specific subject teacher (e.g. biology) • Part-time teacher	HOD was categorised within the teaching team as a HOD generally has a role which includes classroom teaching and curriculum-based leadership over staff and curriculum within a department (e.g. English HOD). Part-time hours and specific subjects were not deemed to change the overall role of a teacher.
Special Education Needs Co-ordinator (SENCO)	• SENCO • Teacher and SENCO	SENCO representatives are tasked with providing and finding additional support for students needing additional assistance, and at times presenting with emotional distress and behaviours such as NSSI.
Guidance Team	• Guidance Counsellor • Counsellor • Pastoral care • Kāhui Ako lead	Categorisation due to the shared roles of guidance and pastoral care staff. Kāhui Ako lead has been categorised within the Guidance Team category due to the role a Kāhui Ako takes in supporting students within their learning pathways and themselves to help them achieve their full potential. This role is deemed to be supportive of students directly.
School Nurse	• Nurse	Categorised solo due to the differentiated role and training of a school nurse and any other member of staff.
Support Staff	• Teaching assistant • Teacher support • Teacher aide • Career advisor	Teaching assistants, teacher support and teacher aides were coded in the overall category of support staff. This categorisation recognises roles which support staff and students within learning a setting such as a classroom and special education facilities. Careers advisors were categorised in the support staff role. This classification was made to recognise the role of careers advisors in supporting students directly, with contact and discussions a key part of this role.
Administrative Support Staff	• Executive manager • Office staff • Librarian	This categorisation recognises the role of supporting the school, staff members and students within the school through administrative activities. It is recognised that they may at times be tasked with finding support for students when they are referred to the student centre/office

Table 2

Participants roles within New Zealand Secondary Schools

Role	Total (*n*=458)	
	Frequency	%
Principal/ Tumuaki	8	1.7
Deputy Principal	21	4.6
Dean	50	10.9
Teaching Team	302	65.9
Guidance Team	34	7.4
School Nurse	4	0.9
Teaching team/ SENCO	8	1.7
Support Staff	21	4.6
Administrative Support Staff	10	2.2

Design

An online survey-based design was considered as the best fit for this research study, due to the intended geographical scope of the study to cover secondary school staff throughout all New Zealand. Additionally, the population of New Zealand Secondary School staff members generally have access to online facilities and regularly work on computers. Such a population was identified by Wright, (2005) as benefiting from online survey-based designs. Published studies of attitudes, beliefs and knowledge of self-harm, deliberate self-harm and self-injury, Berger et al. (2014b), Crawford et al. (2003), Heath et al. (2011), McAllister et al. (2002) and Timson, Priest and Clark-Carter (2012) were employed as exemplars to guide the survey-based design of this study. The questionnaire was developed to include open-ended questions to garner personal thoughts, descriptions of participants experience and to capture the voice of staff as they manage students with NSSI.

Measures

Questionnaire development

Development of the *Staff Attitudes, Beliefs and Knowledge of Non-Suicidal Self-Injury Questionnaire,* began with an extensive literature review which sought current measures of staff attitudes of, beliefs towards and knowledge of non-suicidal self-injury. This review included key terms; self-harm, self-injury, deliberate self-harm (DSH) and non-suicidal self-harm as these categorisations of harm to oneself are often used interchangeably. Questionnaires were searched for items related to staff attitudes, beliefs and knowledge about NSSI.

A current measure of staff or professionals' attitudes, beliefs and knowledge regarding NSSI was not identified. Therefore, the following documents were determined to be measures which fit the above criteria and could be adapted to align with the aims of this research. Permission was granted by Heath, McAllister and Crawford to utilise these measures for this research study.

- Teachers Knowledge and Beliefs about Self-Injury Questionnaire (Heath et al. 2006) and implemented in Heath et al. (2011) and Berger et al. (2014b).
- Attitudes towards deliberate Self-Harm Questionnaire (ADSHQ) (McAllister et al. 2002) and implemented in Berger et al. (2014b).
- Professional Attitudes to Self-Harm Questionnaire (Crawford et al. 2003) and implemented in (Timson et al. 2012)

Heath et al. (2006) and Heath et al. (2011) studies utilised a specifically designed *knowledge and beliefs of school staff questionnaire* relating to self-injury. These studies went on to direct training manuals and initiatives for training staff within the Canadian education system on how best to respond to students displaying signs of NSSI.

The population involved in both studies were Canadian high school/ secondary school, teachers. There is no research involving non-teaching staff members in the area of self-harm. Therefore, all secondary school staff members were incorporated in the current research to identify any differences between staff members in various roles concerning attitudes, belief and knowledge of NSSI.

One key finding directly related to the attitudes of staff towards self-harming behaviour was included in these studies. Heath et al. (2006) identified 48% of participants found the idea of a student cutting or burning their skin horrifying, while in Heath et al. (2011) this was identified as 60% of participants. This variation of agreement with this statement prompted the inclusion of this specific item in the *Staff Attitudes, Beliefs and Knowledge of Non-Suicidal Self-Injury Questionnaire* to identify if attitudes of school staff in New Zealand are similar concerning NSSI.

McAllister et al. (2002) focused their research on nursing staff, their attitudes towards patients whom deliberately self-harmed, and how these attitudes influenced the care and compassionate practice of

nursing staff when caring for patients. A major finding in this study was that staff positive perception of themselves in their abilities in discussing deliberate self-harm (DSH) and meeting the needs of their patients, was associated with decreased negative attitudes and increased feelings that's it was worthwhile working with patients presenting with DSH. This study raised questions of whether attitudes of staff in secondary schools would impact on the care and support students were receiving from staff in schools after disclosure of NSSI behaviour or staff became aware of the behaviour. Heath et al. (2006) and McAllister et al. (2002) included questions relating to staff training leading to the inclusion of a training sector in the current study; the aim being to investigate the relationship between staff training and confidence/competency levels when involved with students with NSSI behaviour as well as attitudes, beliefs and knowledge of NSSI.

Crawford et al. (2003) created the Staff Knowledge and Attitudes Questionnaire to investigate the training needs of professionals involved in the assessment and management of adolescents who self-harm. The population of professionals participating in that research included staff (psychiatric doctors, nurses, social workers, psychologists, psychotherapists, teachers) working at teaching hospitals and Child and Adolescent Mental Health Services (CAMHS) in three inner-city London boroughs. Findings included analysis indicating experience was not associated with knowledge, effectiveness, negativity or worry regarding self-harm. These findings influenced the inclusion in the current survey of a question about experience in the education section with students engaging in NSSI. An analysis is included to investigate whether this form of experience is associated with knowledge, competence, confidence and negative attitudes among secondary school staff.

Crawford et al. (2003), Heath et al. (2006) and McAllister et al. (2002) developed questionnaires focused on attitudes, beliefs and knowledge of self-harm, self-injury and DSH, therefore alterations were made to ensure cohesion with NSSI as defined by Nock and Favazza (2009) the definition widely recognised in research in the area of NSSI and by the International Society for the Study of Self-Injury (ISSS) (2018). Changes were required due to definitional differences between NSSI, self-harm, self-injury and DSH. NSSI can differ from these other forms of self-injury in lethality, motivations, patterns and treatment requirements (Swannell et al. 2014; Messer & Fremouw, 2008; Skegg, 2005). Importantly, NSSI pertains to the non-suicidal intentional injury to oneself, while self-harm, self-injury and DSH do not seek to

specify the suicidal intent of deliberate acts of harm and are therefore inclusive of both suicidal and non-suicidal harm to oneself. Adaptions of the ADSHQ implemented in Berger et al. (2014b) are equally relevant to the current research study. These include substituting hospital system for the education system and client/patient for student.

Questionnaire

The measure created, *Staff Attitudes, Beliefs and Knowledge of Non-Suicidal Self-Injury Questionnaire,* is a 42-item questionnaire, including demographic questions (Appendix A). The questionnaire employed multiple-choice questions, the implementation of a 5-point Likert scale and open-ended questions relating to personal experience (Appendix B).

The items in this questionnaire include:

Demographic

Socio-demographic information (gender, age, ethnicity) and questions relating to years of experience and current staff position within a New Zealand Secondary School.

Attitudes towards NSSI

Attitudes regarding rationale for NSSI, intent of NSSI, and attitude towards supporting students with NSSI within a professional job description.

Beliefs of NSSI

Beliefs of competence in identifying NSSI behaviour, and rationale for and intent of NSSI.

Knowledge of NSSI

Knowledge of prevalence rates, most commonly reported modes of NSSI and most likely age bracket for the first incidence of NSSI.

Experience with NSSI behaviour

Completed only by participants with prior experience of students engaging in NSSI. Personal reactions to any past disclosure or gained knowledge of NSSI behaviour from students.

Training in NSSI

Prior training in the area of NSSI and if future training would be recommended/desired.

Procedure

The *Staff Attitudes, Beliefs and Knowledge of Non-Suicidal Self-Injury Questionnaire* was implemented on the Qualtrics online survey platform. Participants were provided with an online link to access the questionnaire through email and social media platforms. Participants were asked to read the questionnaire information sheet provided, which briefly outlined what was required of participants and the importance of this research study. Participants were asked to indicate consent with the *yes,* or *no* options provided at this point, before commencing.

Participants were prompted to click through the survey answering the questions. Questions asked participants to choose from multichoice options, indicate their level of agreement with the provided statement on a 5-point Likert scale or provide open-ended answers regarding experience with students and NSSI. Questions were presented to participants as singular or multiple items on a web page. Answers were saved after each page, therefore were still included in the research study if the participant did not complete the questionnaire in its entirety.

At the commencement of the *Experience with NSSI* section, participants were asked to indicate if they had encountered student/s engaging in NSSI behaviour in the past or had they become aware of this behaviour. If no was indicated, participants were automatically taken to the training section of the questionnaire. If experience with NSSI was indicated, further questions were displayed for participants before moving onto the training section.

Participants were encouraged to reach out to colleagues and professionals (such as a general practitioner) for support if the content or participation in this survey was distressing. The scope of this

study extended throughout New Zealand; therefore, specific local support networks for participants could not be suggested.

Information sheet

Before the questionnaire, participants were provided with a brief overview of this study, comprising both the rationale for and an outline of the practical task of completing the questionnaire (Appendix C). The voluntary nature of this study was emphasised at this point.

The definition of NSSI provided by Nock and Favazza (2009) was specifically stated after item one. This step was in place to ensure participants were completing the questionnaire while retaining this definition in mind; promoting construct validity within the study. Additionally, predetermining the construct being measured (NSSI) identifies this behaviour outside of the framework of suicide and suicidal behaviour, aligning with current research in the area of NSSI and promotes future understanding and knowledge of NSSI outside this suicide framework (Taylor & Ibanez, 2015).

Ethics

This is a Massey University Research study. This research underwent ethical and cultural review in the development phase to ensure it met ethical guidelines and was created as a culturally inclusive research study. project was evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the Massey University Human Ethics Committees. The researcher was responsible for the overall ethical conduct of this research.

This process of providing informed consent was made explicit to potential participants before their inclusion in the research during the recruitment phase and beginning of the questionnaire with a yes/no item. Responses from participants who did not consent to continuing the research study were excluded from the final data.

Results

Results from the current study of secondary school staff attitudes, beliefs and knowledge of NSSI are presented below. Following the aims of the research, the results report the findings from the investigation into the beliefs, attitudes and knowledge of secondary school staff members across New Zealand. Specifically, sections are included identifying:

1. Attitudes, beliefs of participating Secondary School staff members.
2. Staff Knowledge of NSSI.
3. Confidence and competence levels of staff when responding to NSSI.
4. Percentages of staff reporting an encounter with students engaging in NSSI.
5. Staff responses to students and referral rates of students presenting with NSSI behaviour.
6. Rates of staff training in NSSI, forms of training, and how helpful individuals found this to be.

1. Attitudes and beliefs of NSSI behaviour

Suicidality and self-harm

This section sought to identify participants belief in the behavioural reality of self-harm without suicidality among secondary school students. Participants were asked to identify their level of agreement with the statement *I don't believe high school students self-injure with non-suicidal intent* on a 5-point Likert scale (Table 3).

Table 3

Level of New Zealand secondary school staff agreement with the statement: I don't believe high school students self-injure with non-suicidal intent.

Level of agreement	Frequency	Percent
Strongly agree	3	0.7
Agree	27	5.9
Neither agree nor disagree	84	18.3
Disagree	169	36.9
Strongly disagree	173	37.8

By disagreeing and strongly disagreeing with this statement, 75% of New Zealand high school staff members in this study identified that they believe students can harm themselves without suicidal intent. A further 25% of participants were unsure, agreed and strongly agreed with the statement indicating they were unsure of the intent of self-harm or they do not believe students self-injure without suicidality. This section is relevant to the overall research as the belief in NSSI as a behaviour influences an individual's reaction to a situation with a student engaging in self-harm. If a staff member does not believe in the behaviour of NSSI for example, self-harm may be assessed by them as always being suicidal, which undoubtedly influences their reaction to a situation involving a student engaging in self-harm.

Staff beliefs on their role in supporting students engaging in NSSI.

For this section, staff were asked to consider whether they believe it was within their staff role to support students with NSSI behaviour. This section was one item which asked participants to indicate with a yes/no response if they felt it was within their role to support students with NSSI behaviour. Responses were separated into staff roles to investigate a relationship between varying staff roles and feelings of support towards students engaging in NSSI (Table 4).

Table 4

Beliefs about supporting students with NSSI

Position/role within secondary school	Believe it is within their role to support students with NSSI	
	Frequency	Percent
Principal/Tumuaki	7	87.5
Deputy Principal	19	90.5
Dean	44	88.0
Teaching Team-SENCO	5	71.4
Teaching Team	249	82.7
Guidance Team	34	100.0
School Nurse	4	100.0
Support Staff/ administrative support staff	25	80.6

In staff groups, 87.5% of school principals, 90.5% of deputy principals and 88% of deans felt it was within their role to support students within the school engaging in NSSI. These were the categories with the highest agreeance that supporting students with NSSI was within their staff role. Surprisingly, lower

percentages were documented in the staff groups which arguably have the most contact with students; teaching staff, SENCO and support staff. It is relevant to discuss that just 71.4% of SENCO believe it is within their role, leaving 28.6% who feel supporting students with NSSI lays outside the parameters of their job. This percentage is the smallest percentage among the separated staff roles, which is not largely significant. Yet, when we consider school staff at times refer students to SENCO staff for support and referrals to outside agencies, this figure could indicate SENCO and other school staff have differentiated views of their roles within schools.

For this item, the term '*support'* was not specified and therefore, could be subjectively interpreted by participants. *Support* could be represented in both personal forms and organisational forms. Participants in teaching roles could interpret this term differently from that of a dean or principal for example, with a teacher looking at what this support might mean in the classroom environment. Yet it could be argued that all staff roles should be working at an organisational level to support students. Therefore, it is interesting that only 87.5% of school principals felt they needed to support students with NSSI. At an organisational level, it could be argued that 100% of secondary school principals and senior management should consider that their role is inclusive of supporting students physical and mental well-being.

NSSI as a behaviour

Staff attitudes and beliefs of NSSI as a behaviour were reported by on a five-point Likert scale, based on participants level of agreement with each statement from strongly agree to strongly disagree (Table 5). A response of agree or strongly agree in the items *I am knowledgeable about NSSI* and *I would feel comfortable if a student spoke to me about NSSI* indicate a more positive response. A response of disagree or strongly disagree for all other items indicates a more positive attitude or belief regarding NSSI behaviour and students who engage in NSSI behaviour.

Table 5

Staff attitudes of and beliefs about NSSI

Questionnaire statement	Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree	
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
I am knowledgeable about NSSI.	29	6.3	144	31.4	104	22.7	151	33	30	6.6
I would feel comfortable if a student spoke to me about NSSI.	120	26.3	232	50.9	63	13.8	37	8.1	4	0.9
Students who engage in NSSI are just trying to get attention.	3	0.7	47	10.4	137	30.2	197	43.4	70	15.4
Students who self-injure with non-suicidal intent are most always girls	1	0.2	53	11.6	146	31.9	191	41.7	61	13.3
Students who self-injure with non-suicidal intent are doing it to manipulate other people.	2	0.4	27	5.9	131	28.9	223	49.1	71	15.6
Students who self-injure with non-suicidal intent are often from middle to upper-income families.	1	0.2	54	11.9	184	40.5	168	37	47	10.4
Students who self-injure with non-suicidal intent often have poor communication skills.	2	0.4	50	11	135	29.7	210	46.3	57	12.6
Students who self-injure with non-suicidal intent often have low self-esteem.	25	5.5	275	60.8	95	21	48	10.6	9	2
Students who self-injure are often suicidal.	0	0	32	7.1	168	37.3	230	51	21	4.7
NSSI is an indicator of a mental disorder.	14	3.1	129	28.6	150	33.3	133	29.5	25	5.5
NSSI is an indicator of difficulties in regulating emotions.	61	13.5	275	60.8	84	18.6	27	6	5	11

An overwhelming 77.2% of participating Secondary School staff identified they would feel comfortable if a student spoke to them about NSSI. However, surprisingly just 37.7% indicated agreeance with self-perceived knowledge of NSSI; demonstrating that perceiving a deficit of knowledge on the topic of NSSI did not deter a significant number of participants from being willing to engage in this discussion with students about NSSI.

Throughout this section, participants most often expressed uncertainty through the endorsement of the neither agree nor disagree option, or positive attitudes and beliefs. Seven of the items in this section related directly to the attitudes and beliefs staff hold regarding students who engage in NSSI. Therefore, the overall positive endorsement in this section is significant in this regard and could have a valuable impact on responses to students in situations involving NSSI as well as staff participation in future training initiatives.

The two last items in this section, *NSSI is an indicator of a mental disorder,* and *NSSI is an indicator of difficulties in regulating emotions,* could theoretically be collective of attitudes, beliefs and knowledge of NSSI. For some individuals, NSSI behaviour can be a sign of both an underlying mental disorder and difficulty in regulating emotions. The critical aspect to note here is an assessment of NSSI behaviour should be conducted to determine underlying mechanisms, rather than assumptions such as these statements.

Importantly, the statements in this section could all be related to experience with one, or multiple students who engage in NSSI behaviour and generalisations may have been applied when selecting a level of agreement. Arguably though, it is such generalisations which can drive an individual's beliefs and attitudes towards others.

Beliefs regarding why students may engage in NSSI?

This section included one item which asked participants to respond to the open-ended question *Why do you think a student would engage in NSSI?* A total of 440 participants responded to this item. Participants identified three main themes as a rationale for students NSSI. These were: emotional difficulties, external

factors, and to control or manage feelings of pain. Emotional challenges identified by staff members included responses such as: *"lack of self-esteem; not being able to process emotions and feelings; a cry for attention; feeling unwanted/unloved; trying to mask other pain with physical pain"* and *"seek attention of an underlying problem they haven't or can't share".* One participant identified from personal experience they believed non-suicidal self-harm could *"provide physical release from mental stress and reduce feelings of numbness".*

External factors identified by participants included difficulties in home environments and friendships/relationships. One staff member suggested NSSI behaviour was *"maybe a cry for help, to punish themselves for some aspect in their lives, because of how they feel in their home, school or friend's environment".* Of 458 participants who responded to this questionnaire item, 51 staff identified the home environment and relationships within/with family as a rationale for students engaging in NSSI. Just 27 participants implicated the school environment as being a contributing factor to students engaging in NSSI.

The majority of responses which included the school environment either identified low academic performance or bullying/ issues within social groups. One participant identified the rationale as "*they (students) are overwhelmed by home, schoolwork. They are lonely and have problems with friends. They don't see worth in themselves. They are following a trend with a friend group,"* which identified both relational difficulties with friends and highlighted contagion of NSSI behaviour among peers. Whereas another response: "*Lack of self-esteem, failure to meet parental expectations, failure to meet staff expectations, lack of friends, loneliness,"* suggests difficulties within all of a student's environments as contributing.

Sixty-eight staff members used the word pain in identifying a rationale for NSSI behaviour, 42 responses referred to NSSI as a means of turning emotional/internal pain into physical pain. Staff members referring to pain identified students, both managing and controlling pain through NSSI behaviour. The concept of pain was discussed in both the internal and external forms. The participant identifying NSSI as a way *"to gain attention, to self-inflict pain because they think they deserve it, to punish themselves, they like the pain"* identifies the student as using external pain because of a student's inner turmoil. Another

participant suggested students engaging in NSSI *"…like the feeling of pain, being able to control the harm they do. Attention. Cry for help. To see what they can do, what they can tolerate".* This rationale could relate to controlling/managing both internal and external forms of 'pain'. Similarly, this example speculates NSSI behaviour is engaged in *"to externalise inner pain, as a measure of control, to externalise feelings of low self-esteem, to reach out".*

NSSI as Horrifying

Participants were asked to identify their level of agreement with the statement *"I find the idea of a student cutting or burning their skin horrifying".* Responses are recorded in frequency and percentages of level of agreement with the statement on a 5-point Likert scale ranging from strongly agree to strongly disagree (Table 6). The response rate was 99.33%, with just three participants choosing not to respond to this item.

Table 6

Participants agreement with 'horrifying' statement.

Level of agreement	All secondary school staff		Teaching staff	SENCO staff
	frequency	%	%	%
Strongly agree	80	17.5	21.85	42.9
Agree	131	28.6	32.12	14.3
Neither agree nor disagree	144	31.4	28.48	28.6
Disagree	75	16.4	12.58	14.3
Strongly Disagree	25	5.5	4.3	0
Total	455	99.3	99.33	100

Responses from this questionnaire item were separated into two further categories for analysis; teaching staff and SENCO staff. Responses from secondary school teaching staff were singled out in this section to enable the current research to consistently match with the secondary teaching staff studied in Heath et al. (2006) and Heath et al. (2011) to make direct comparisons.

SENCO staff members were identified as an additional group whose response to this questionnaire item was important to analyse. The SENCO staff category was inclusive of teaching staff, HOD staff, deans and deputy principals. A SENCO representative within a school is tasked with finding and providing extra support for students needing additional assistance for learning, behavioural and mental health difficulties

impacting their time at school. SENCO staff are at times sent referrals from staff members requesting additional assistance for students regarding behavioural difficulties such as NSSI. Participants in this study have also identified this process of referrals with SENCO staff as being part of some school protocols for dealing with students engaging in NSSI. The attitudes of SENCO staff towards NSSI and students engaging in NSSI has been identified as an area which could influence the progression of referrals to outside agencies and support networks available to students. This is particularly the case in smaller schools which do not have onsite guidance teams and where the SENCO staff is the key staff member for contact with outside agencies.

When considering all staff members agreement levels with this statement, 46.1% (*n*=211) of Secondary school staff within this study agreed or strongly agreed with this statement, indicating they find the idea of a student burning or cutting their skin horrifying. In this study, 53% of secondary school teaching staff members agreed or strongly agreed with the statement, while a further 57% of secondary schools staff members in the SENCO positions also agree or strongly agree with this statement. Interestingly, teaching and SENCO staff had overall similar levels of agreement with the statement. However, SENCO staff were more represented in the more extreme '*strongly agree'* category (*n*=42.9%).

2. School staff knowledge of NSSI

Three multiple choice and one 5- point Likert scale item, made up the knowledge section of the questionnaire. When asked to indicate the age bracket students are most likely to start NSSI behaviour, 88.6% (*n*=406) identified the age group 11-15yrs. A small 6.3% (*n*=29) identified the age bracket 16-20yrs and 4.1% (*n*=19) chose 5-10yrs. This Indicates the majority of school staff had knowledge of common onset.

Participants were provided with six forms of self-harm and asked to identify which three methods were the most commonly used for NSSI purposes. Non-suicidal Self-Injury through cutting was the most endorsed option, selected by 94.1% (*n*=431) of participants. Scratching was the second most endorsed option, 79.9% (*n*=365), followed by burning 48.5% (*n*=222), pinching 29% (*n*=133), self-hitting 22.9% (*n*=105) and biting 12.7% (*n*=58).

Participants were asked to identify what percentage of Secondary School students they believe self-injure with non-suicidal intent. Multiple choices were provided in ranges of percentages of the population of Secondary School students. The range 1-20% was the most endorsed choice by 266 participants (58.1%). This was followed by 21-40% chosen by 142 participants (31%), 41-60% chosen by 34 participants (7.6%) and 61-80% chosen by 4 participants (0.9%).

These questions were asked as general knowledge questions relating to NSSI behaviour amongst adolescents, and therefore participants were not asked to identify age brackets, most common methods or percentages of students engaging in NSSI directly concerning New Zealand populations. Current literature identifies the lifetime prevalence rates in New Zealand as approximately 50% of adolescents (Garish & Wilson, 2016) by the time they leave secondary school. However, it needs to be noted that this figure represents students engaging in some form of self-harm and is therefore inclusive of self-harm with and without suicidal intent.

Participants were asked to demonstrate their level of agreement with the statement *students who self-injure increase their risk of future suicide* on a five-point Likert scale ranging from strongly agree to strongly disagree (Table 7).

Table 7

Level of agreement with the statement students who self-injure increase their risk of future suicide

Level of agreement	Frequency	Percent
Strongly agree	11	2.4
Agree	142	31.0
Neither agree nor disagree	217	47.4
Disagree	72	15.7
Strongly disagree	9	2.0

The most frequently endorsed level of agreement with this item, neither agree nor disagree, demonstrates almost half of participants were unsure if future suicide is increased through self-harming behaviour. A further 33.4% identified agreement or strong agreement with this statement, which indicates a reasonable level of staff knowledge NSSI as a serious physical and mental health risk for students in the immediate and future tense.

3. Confidence and competence

Confidence and competence of secondary school staff in situations involving NSSI were measured across three items. Confidence was measured using the item *I believe I know how to identify NSSI behaviour.* This is a questionnaire item related to both knowledge of NSSI but also an individual's level of confidence in identifying NSSI as a behaviour. The following two items were intended to measure self-assessed competence of staff in managing situations involving students and NSSI: *I would know how to respond if a student in my class/ and/or school or under my care appeared to be performing acts of NSSI* and *I would be competent discussing NSSI with students.*

Participants were asked to indicate their level of agreement with each statement on a 5-point Likert scale ranging from strongly agree to strongly disagree. These items aimed to measure participants perceived confidence and competence in handling situations with students engaging in NSSI behaviour. This data is displayed in frequencies and percentages (Table 8).

Table 8

Staff confidence and competence in interactions with students engaging in NSSI.

Level of agreement with statements	I would know how to respond if a student in my class and/or school or under my care appeared to be performing acts of NSSI		I believe I know how to identify NSSI behaviours		I would be competent discussing NSSI with students	
	Frequency	%	Frequency	%	Frequency	%
Strongly agree	73	15.9	16	3.5	39	8.5
Agree	251	54.8	146	31.9	129	28.2
Neither agree nor disagree	48	10.5	144	31.4	108	23.6
Disagree	74	16.2	130	28.4	142	31.0
Strongly disagree	11	2.4	17	3.7	35	7.6

A total of 70.7% (*n*=324) agreed or strongly agreed with the statement, indicating they would know how to respond if they encountered a student engaging in NSSI, demonstrating a high level of perceived confidence in managing situations involving students and NSSI behaviour. However, this item relates to perceived confidence and does not demonstrate this percentage of staff are responding in a way which best supports student/s. Participants expressed less agreement with the other two items in this section.

Just 35.4% of participants believed they could identify NSSI and 36.7% felt competent in discussing NSSI with students.

Qualitative responses

Two of the items in this confidence and competence category also included an open-ended question asking participants to provide further details of how they would respond to a student engaging in NSSI and what signs of NSSI they would be looking to identify in students. The aim of this was to investigate whether staff confidence/competence was founded based on knowledge and positive practice in managing situations with students and NSSI. For example, whether percentages of participants identifying they would know how to respond to a student engaging in NSSI corresponded with the percentage of staff talking to students and seeking additional support for them. These questions asked for responses based on hypothetical situations and therefore, were directed at all participants regardless if they had experienced similar situations personally.

Identifying NSSI behaviours

Participants were asked to identify what signs of NSSI they would be looking for in students. Responses were identified to be in three main categories; behavioural changes to hide NSSI such as wearing unnecessary layers of clothing in summer and increased amounts of toilet breaks, changes in behaviour such as emotional withdrawal, decrease in academic performance and change in interactions with others and visible signs of NSSI such as cuts/ burns etc.

Of the 314 responses to this question, 171 participants indicated they would be looking for physical signs of NSSI behaviour such as cuts, abrasions, bruises and unexplained repeated injuries. A total of 87 staff identified they would be looking for fresh cuts/ cutting marks, while 25 stated they would look for scars. Arms and wrists were areas staff identified they were looking to for physical signs of NSSI. One hundred staff members indicated they were looking for behavioural changes in students. Seventy-three participants stated they were looking for excessive or inappropriate covering of limbs, while 17 participants identified they would be looking for social withdrawal in social groups and classrooms.

Two participants reported their personal experiences with NSSI gave them insight into what behavioural and physical signs they would look for in students. For example, *"I only know this because I have experienced it myself. It has never been taught or spoken about in a professional setting. I would look for scars, wearing long sleeves to hide injuries, strange explanations for injuries, consistently getting injuries, scratching or messing with scars."*

Another participant used this open-ended question as an opportunity to question whether looking for signs of NSSI falls within the scope of the teaching role:

> *"There are obvious ones, but I am sure there are some that I am not aware of. And it isn't something as a teacher that I actively look for. It's not really on my radar."*

Response to NSSI

Participants were asked to identify what response of action they would take if a student appeared to be engaging in NSSI behaviour. This was an open-ended item in the questionnaire, prompting variation and elaboration in responses. All participants were asked this question regardless of if they had encountered a student/s with NSSI. Therefore, these responses are in a hypothetical term for some participants, while others may be drawing on prior experience with students informing this response. A total of 363 participants answered this questionnaire item.

The majority of participants (*n*=245) identified they would "*refer the student to counsellors"* or "*follow school protocol"* already in place. One hundred and eighty-five participants identified they would refer to the guidance team, while 60 identified senior management (dean and deputy principals) as their point of contact. The responses which elaborated into detailing school protocol gave an insight into the steps school staff take when in situations with students presenting with NSSI behaviour. For example:

> *"In my role as Dean, the process is to inform the family and refer them to support services and counselling. We do this before referring the student to the counsellor as we can tell the parents where a counsellor may need to protect confidentiality. This way, the student gets help, and the parents are in the loop".*

This appears to be a way of creating support networks for the student before confidentiality issues become involved. This could be either positive or negative for the student and the family and should be done with caution as to the situation as a student could see this as a breach of trust, which could ostracise students from further support from both the school and family. Informing parents was mentioned in just six responses.

One participant also highlighted that identifying these two points of contact within the school may not be the best course of action for all students, and perhaps a case-by-case basis should be discussed. The participant highlighted that "*I agree that I understand the procedure, but I disagree that this is necessarily the best course of action to take. The students that I know dislike talking to our counsellor and don't have a positive relationship with senior management. Our health nurse is great but may be out of her league."*

Health and safety checks were identified as a key step in just 11 responses. One respondent indicated taking the student to the health centre '*if they were bleeding or wounds were exposed'* was part of school protocol that states *'students are not to expose their cuts to other students'*. Whereas, a member of a school guidance team noted they would perform a *"safety check…cover to try and reduce contagion factor…gentle questions about the intention of the behaviour…"* This finding could relate to checking health and safety as coming naturally for some and therefore was not mentioned. However, it is relevant that this was not reported as a first step or basic instinct reaction to NSSI behaviour.

Having a private discussion with the student was identified by 49 participants as being their first action. Interestingly it was mentioned that initiating a conversation with students was dependent on whether or not they had a prior relationship with the student or not. For example, one participant identified *"I would take these on a case by case basis, depending on my knowledge of, and relationship with the student. I have previously referred a student to a counsellor."* A further 45 participants indicated they would first talk to the student and then refer to either management or the guidance team.

Some responses indicated they would have a private *"I've noticed"* conversation with students, while others indicated they would be "*discrete about noticing/ looking at it".* One participant indicated they were unsure of whom to seek assistance from; *"I would like to know who I approach for assistance for this student."* Two participants mentioned personal experience, one noting if a student were engaging in NSSI

behaviour, they would *"relate to my own experience of NSSI as a teen and try to open up a dialogue around the reasons they may be doing it"*.

The role of teaching staff in handling situations with students and NSSI behaviour was raised in this response by multiple participants, highlighting that it is "*beyond the role of a secondary school teacher*". Some participants noted that they have not received training and do not feel they have 'expertise' in the area. While other responses indicated a negative response to NSSI behaviour, one participant indicating they would "*take them to the office! It's their parent's responsibility. I didn't sign up to be a social worker for pampered drama queens."*

These observations provide a call to action for training of teaching staff if they are expected to be supporting students who engaging in NSSI as well as important validation and the voice for those staff who feel it is not the role of the classroom teacher.

> *"Refer to the agency whose role it is to deal with this. Classroom teachers are not the people to deal with this"*
>
> *"As a classroom teacher, it's not really my place (or area of expertise) to do anything directly. As with any issue where we feel students are at risk, its best to follow school protocol. In my current school we are required to get in touch with the students dean and/or school counsellors."*
>
> *"I have no training in this area and have been given conflicting information about how to deal with it… the reality is as a secondary teacher; I have had one-year training for things like behaviour management and teaching theory. We were never taken through how to deal with anything to do with student mental health. It's a guessing game and guessing is dangerous. If a student presented self-harm to me, I would refer them to the school counsellor. That is what we are told to do in my school."*

4. Staff experience with students engaging in NSSI

Participating school staff were asked to identify if they had personally encountered a student/s presenting with NSSI behaviour. A total of 77.7% (*n*=356) of participants had encountered a student with NSSI behaviour. Just 20.5% (*n*= 94) had not encountered a student/s engaging in NSSI. When asked to indicate the recency of this experience, 28.2% (*n*=129) of participants whom had encountered a student engaging in NSSI indicated this was more than one year ago, 15.7% (*n*=72) in the last 12 months, 8.5% (*n*=39) last six months and 24.9% (*n*=114) in the last 3 months.

For analysis of this section, participants were categorised by their role within the school to analyse if specific roles were more likely than other roles to encounter students engaging in NSSI behaviour (Table 9).

Table 9

Relationship between staff positions and encounters with students engaging in NSSI behaviour.

Position/role within secondary school	Have encountered a student presenting with NSSI	
	Frequency	%
Principal/Tumuaki	6	75.0
Deputy Principal	21	100.0
Dean	42	84.0
Teaching Team	219	74.2
SENCO	7	100.0
Guidance Team	33	97.1
School Nurse	4	100.0
Support Staff/ administrative support staff	23	74.2

All secondary school staff participating in deputy principal, SENCO and nursing staff roles within schools had encountered students engaging in NSSI behaviour. Just 74.2% of teaching staff and support staff/administrative staff had encountered students with NSSI. This is surprising due to these staff positions, generally involving more time interacting with students in learning environments. It would have been expected that more of these teaching and support teams had experience in this area. However, this may evidence the referral protocols within schools. Members of the guidance team, deputy principals and school deans were identified as the point of contact for referrals of NSSI behaviour. It is not

surprising therefore that guidance team staff members indicated a 97.1% experience rate and deans indicated 84% had encountered NSSI among students within their experience.

Qualitative responses

Participants who indicated they had encountered a student/s with NSSI behaviour, were prompted to specify how they came to learn of the student/s NSSI behaviour and what initial action they took. Asking staff to indicate what their response was to a student/s NSSI behaviour, was similar to an earlier item in the questionnaire. This time, however, the question was aimed at only participants who had encountered students engaging in NSSI and sought recollection of actions participants had taken. The similarities in these questions may indicate whether participants actions during a direct situation with a student engaging in NSSI differed slightly from what they indicated they would do in a hypothetical situation.

Awareness of NSSI

Responses to the question *How did you become aware of the students NSSI behaviour?* were in the form of qualitative data. They were coded into the following five categories based on common themes identified in participant responses:

- Self-disclosure from a student.
- Disclosure from another student/friend/family member.
- Noticed physical signs of NSSI (e.g. marks, scratches, blood).
- Noticed behavioural changes and queried/referred student (such as repeatedly covering arms)
- Referral/reported by another staff member (such as a student being referred to the guidance team)

Qualitative responses were categorised based on the best fit as ascertained by the researcher. Where participants had disclosed more than one occurrence of learning of a student's NSSI behaviour, these were documented as such. Therefore, this data is presented in the frequency of incidence. The maximum responses per participant were four. Staff roles have been analysed to investigate if certain roles within a

secondary school are more likely to learn of students NSSI behaviour in one way more than another (Table 10).

Table 10

Methods of staff learning of student NSSI behaviour

Position/role within secondary school	Self-disclosure from student	Disclosure from another student/friend/family member	Notice physical signs of NSSI (marks, scratches, blood)	Noticed behavioural changes and queried/referred student	Referral/reported by another member of staff
Principal/ Tumuaki	0	2	1	1	3
Deputy Principal	2	4	9	3	4
Dean	7	17	19	1	10
Teaching Team	36	34	127	21	26
SENCO	0	0	5	1	2
Guidance team	15	9	4	4	15
School nurse	2	1	1	0	3
Support Team	8	2	7	5	1

Of teaching staff, 127 participants identified they had learnt of a student/s NSSI behaviour through noticing physical signs of NSSI; which was the most commonly reported method of discovering the behaviour. Teaching staff also identified high levels of noticing behavioural changes in NSSI (*n*=21) and of disclosures from friends and family close to students engaging in NSSI (*n*=34). Teaching staff identified the most self-disclosures of any staff category (*n*=36) with approximately 12% of teaching staff across the research sample indicating a student had personally disclosed NSSI behaviour to them. In total, approximately 14.5% of the participants in this study had been trusted with a self-disclosure. No school principals or SENCO staff had received self-disclosure of NSSI from students, SENCO staff had not identified disclosure from friends or family of students engaging in NSSI.

Self-disclosures from students were reported the most frequently from teaching staff (*n*=36) and the guidance team (*n*=15). Deans have identified self-disclosure from students (*n*=7), disclosure from other students/friends/family members (*n*=17) and noticing physical signs of NSSI (*n*=19) at relatively high rates. This could suggest that deans are in a position where they are both close enough to students to notice physical changes and are highly trusted by students both engaging in NSSI and those seeking help for others they are concerned for.

One member of the teaching staff appeared to highlight learning of a student's NSSI in a negative way, referring to attention-seeking and disruptive behaviour in the classroom; "*through their artwork and attention-seeking behaviour, talking about it loudly in the classroom."* In comparison, another teaching staff member described the learning of a student's NSSI in a more empathetic way, stating that they *"were aware she was having a hard time. She informed me she had done it in the past and I spoke with guidance then the next week she told me she had started again…"*

Some examples of staff learning of a student's NSSI behaviour stood out and are included below to highlight the situations in which secondary school staff find themselves in with students NSSI behaviour.

> *"As a dean approx. 25% of the students you will speak with self-harm. Students often report that their friends are cutting. Reports have come that the student bathroom have blood on the floors, so look for attendance data to see who is out of class. Deal with these concerns from serious cutting with blades needing A& E to students scratching their legs with compass points. Burning themselves with spray cans etc. Others hitting themselves".*
>
> *"I found her outside the gym crying. When I spoke to her, I could see all the blood on her hands, but her sleeves were down. We talked and it soon became clear what had happened. I managed to get her to a safe place for professional help from Guidance team."*
>
> *"I noticed they were reluctant to take their jacket off when asked (a rule by the school). I then saw the marks on their arm and then stopped asking them to remove their jacket. I referred to the Dean."*
>
> *"I was the mother. It was horrific, my world turned upside down. Nothing seemed as it was. My alertness heightened and my approach to everything in and her life changed. School nurse and mental health practitioners became involved".*

5. Staff responses to students NSSI behaviour.

Participants were asked to share how they reacted as a member of staff to the situation when they were informed or discovered a student was engaging in NSSI behaviour. This question, although similar to a previous item which was asked in hypothetical terms, identifies the actions/ responses participants had made in a situation with a student presenting with NSSI. There is more emphasis and analysis of this question for this reason, as it could be argued in a situation before intended actions may or may not be used.

This question was an open-ended item, prompting a range of replies. Participants responses were grouped into six key categories which stood out as common themes throughout responses (Table 11). These were based on the best fit as ascertained by the researcher. These categories were:

- referral to guidance,
- referral to school leadership,
- talk with student and referral,
- talk with the student,
- with kindness, care and empathy and
- nothing.

Table 11

Members of staff responses to discovering students NSSI behaviour.

Staff response	Frequency	Percent
Referral to guidance team/ social worker/ SENCO	135	29.5
Referral to school leadership	41	9.0
Talk with student and referral to guidance team/ social worker/ SENCO	49	10.7
Talk and listen to student	46	10.0
With Kindness, care and empathy.	23	5.0
Nothing	49	10.7

Of the 356 participants (77.7%) whom had encountered a student/s engaging in NSSI, 135 members of staff (29.5%) indicated they referred the student to another member of staff or an external organisation, without a talk with the student, or acknowledgement they had noticed the students NSSI behaviour and were enlisting more experienced staff. Of this group, 29.5% referred to a guidance team, social worker or SENCO. From this group, five participants identified the SENCO representative as their point of referral.

Only 9.0% referred directly to school leadership staff. Where it was indicated that a member of staff had checked, and the student already had contact with counselling staff, this was noted as a referral to the guidance team.

Notably, 10.7% (*n*=49) of the participants in this study indicated they did nothing when noticing or being informed a student in their class, care or school was self-harming with non-suicidal intent. Included in this category were responses such as the participant whom *"told her (student) to get on with her work. Not about to encourage her dramas",* where it was not indicated that a referral or any other action was taken.

The same number of participants (*n*=49) who talked to the student and sought additional mental health assistance for the student through the guidance team. Interestingly only 5% (*n*=23) of staff stated they responded with kindness, care and empathy. This category was inclusive of those participants who specifically stated their response was *'with care'* and those whose responses implied this level of care and compassion, such as *"I held her hand. She cried and told me. I kept her in class and discretely sent for the counsellor".* Two participants shared their rationale for responding to the student with care, elaborating by stating:

> *"I responded more as a human rather than a 'member of staff', relating to my own experience and discussing reasons behind their self-harm, gently easing into the bigger questions to gauge whether more drastic actions were likely, and making sure they know I care about how they are feeling".*
>
> *"I work with students who have multiple learning needs, e.g. Autism, Down Syndrome, Intellectual disability, Cerebral Palsy. We have a handful of students who self-harm because of their inability to self-regulate and understand their emotions. We have plans to support these students and look at preventative measures. We adapt the environments to help students to calm and help to teach them how to look after themselves. Our general learning environment is quite open, and most students feel comfortable talking to us".*

Most responses containing a referral indicated that teaching staff were those reporting NSSI incidents to guidance and management teams. However, it was positive to identify three respondents indicated they had received communication from school guidance teams indicating a student was engaging in NSSI behaviour. One participant stated that the *"student had been cutting. I was warned by the Counsellor that the student was engaging in this type of behaviour and was to be treated carefully."* This response demonstrates how communication within secondary staff teams can provide students with additional support as they manoeuvre the school environment.

Additionally, enlisting staff in contact with the student regularly to pay additional attention to any changes in the student's behaviour which may indicate an increase or change in NSSI behaviour. Some participants identified email communication as a way of sharing information and seeking referrals for students. One participant shared that they noted a student *"scratching in the classroom - received an email from the teacher who was concerned with her behaviour."* The staff can use this process of communication as a way of seeking support for students, but also as with all communication can be utilised for behavioural management where a staff member is seeking help or removal of a student due to this behaviour rather than out of concern for the student.

Some participants in responding to this item were able to highlight just how they created networks of support for students. For example, *"I was a dean at the time, the student and I attended a session with the counsellor, the student attended several more session".* This response demonstrates the care the dean had for the student's well-being and the ongoing support that was offered by this secondary school dean in attending sessions with the students rather than merely sending through a referral. One participant identified they responded to the student with *"care and concern. Contacted guidance team. Made a management plan. Worked with outside agencies."* While another staff member identified they *"reassured the friend (who disclosed NSSI) and referred her to the SENCO and school guidance counsellor".* This response demonstrates the process within some secondary schools of referring students and indicates SENCO representatives within secondary schools being utilised as key staff in the process of initiating support for students engaging in NSSI.

Discussion with parents/ family was not recorded as a category for this item as discussion with parents was always noted as being attached to a referral to guidance staff. Discussion with parents was recorded in just thirteen responses, from a total of 343 responses. Two very separate rationales for initiating this contact can be seen. One participant mentioned they *"called in the parent to remove from a potential situation",* another specifying the student involved was "*removed from school as it was too stressful for her peers."* These parents were involved as a way of managing the student's behaviour and the situation. The emphasis here has been placed on the impact the students NSSI behaviour has on others rather than the mental and physical well-being of the student engaging in the NSSI. This example is moving NSSI behaviour away from a physical and mental health risk towards a behavioural management concern for the school. Just three participants identified that they ensured the student engaging in NSSI was in a safe place physically and mentally. This was a significant decrease from the 11 participants who indicated in previous hypothetical question that part of their first response would be a safety check.

In another example, a participant noted that they *"had meeting with parent, went through an action plan as she was starting treatment, monitoring student from there".* We can see that in this situation, the parents were contacted as a way of increasing support and including all of those involved in the student's life in the treatment moving forward. As a way of moving forward, this option brings support around the student in a way which is focused on the health and well-being of the student during this journey through NSSI behaviour. This approach is evidenced in the follow response, where the response this participant had to a student's NSSI behaviour created a network of support which continued after the fact: *"Talked with student once noticed. Arranged DHB Councillor at student request. Several months later met with whanau, Councillor and student to plan next steps."*

Some teaching staff indicated they were making decisions about whether to refer students to guidance teams and school leadership. One participant noted that they *'didn't send them to the counsellors because it wasn't serious".* Another stated they *"had a discussion with the boy. It was relatively minor, so I asked him if I could look at it again over the next few weeks. If I notice an increase in the damage - I will refer him."* These examples demonstrate the decisions staff are making which could ultimately impact positively or negatively on a student's NSSI and support system. The following response demonstrates how a member of a teaching team assesses if the students NSSI behaviour is 'genuine' or not:

'I would consider it less likely to be a genuine threat if students were drawing attention to it, e.g. telling their friends about it, displaying it, than if it was repeated minor cutting, pulling eyelashes out- a habitual way of dealing with stress."

One participant referred to NSSI as a behaviour which was *"accepted as normal behaviour for this child"*, with another mentioning their strategy was to not respond to the student, instead *"treat the student normally".* Additionally, a participant indicated that they judged a student's NSSI behaviour as a reaction to being bored in class. Therefore, the action taken by this staff member was to *"…find tasks to keep him occupied"* In these examples of staff making decisions based on their knowledge of the students and NSSI as a behaviour. The acceptance of a student's NSSI behaviour when it directly visible is both surprising and worrying. In these instances, staff have made judgement calls as to the 'seriousness' a student's NSSI behaviour and whether additional support is required and referral to the guidance team. These staff also assessed the rationale for the student engaging in NSSI, without discussion or formal assessment.

Whether or not the staff had a discussion with students was identified in this section as being influenced by the presence of a prior relationship with the student. Some respondents indicated if they knew the student or had engaged in a previous interaction with them, they may engage in a discussion regarding the NSSI behaviour. One participant indicated that *"I did not have a relationship with this student, so I informed the school counsellor who did. The student received counselling and other support and was required to keep the cuts covered around other students."* Another participant indicated that they *"… offered to be someone they could speak to about it if they wished. I also expressed my concern for their health".*

An analysis was performed to investigate a relationship between attitudes and beliefs of staff and responses to students in this questionnaire item. A positive response to NSSI behaviour was assessed to be talking with the students and a referral, talking and listening and showing kindness, care and empathy. The most positive response was talk and refer, as the NSSI behaviour is validated through a discussion and referral ensures additional support has been sought.

There was deemed to be insufficient evidence in this research study to support a direct relationship between these two variables. This was based on current NSSI literature. More positive attitudes and

beliefs of staff members were not found to be associated at a significant level with more positive responses when encountering a student/s engaging in NSSI. Participants who indicated more positive attitudes and beliefs regarding NSSI, detailed various levels of responses when confronted with a situation with a student engaging in NSSI. More positive responses to student's engagement in NSSI was identified as just as likely to have come from an individual whom indicated more positive attitudes and beliefs than those indicating less positive.

The variables identified as being associated with a more positive response from staff were staff training in NSSI and the presence of a prior relationship with the student. Both variables were associated with greater frequency of staff engaging in conversations with students regarding engagement in NSSI, staff talking and referring students for additional support and staff responding with kindness, care and empathy.

Students engaging in NSSI behaviour.

This section relates to the characteristics of students engaging in NSSI as identified by Secondary School staff members. Participants were asked in this section to identify the characteristics of students they had been in contact with whom had displayed NSSI behaviour. This question was an open-ended item, asking participants to identify the characteristic of students such as age, gender etc. (Table 12). Information reported ranged from general identification of multiple children (for example all girls) to examples of specific student/s staff had contact with whom were engaging in or had engaged previously in NSSI.

Table 12

Characteristics of students identified as engaging in NSSI

	Female Māori	Female Pakeha	Female Other/ not identified	Male Māori	Male Pakeha	Male Other/ not identified	Transitioning/ transgender/ other
10-12yrs	1	3	34	1	1	10	0
13-15yrs	9	3	140	2	0	23	3
16-18yrs	1	0	40	0	1	23	4
External Factors	2	0	18	1	0	3	0
Internal Factors	1	0	29	0	0	3	2

*note: these characteristics are documented in frequency of identification. Some participants did not identify characteristics of students, while others identified multiple students' characteristics.

*note: no transgender and transitioning students were categorised by staff according to ethnicity.

Open-ended responses were categorised into major categories based on common themes identified in responses. These included age bracket, gender and internal and external rationale for engaging in NSSI. Externalised factors were those identified as occurring within a student/s home or school life such as in this example *"14 years old/ female/ Year 10 Māori/ has been a significantly disruptive student throughout year 9/ regularly truants/ father has been in and out of prison/ very difficult home life"* and *"14, female, lower socioeconomic background, broken family background".* Participants identified internal factors as occurring within the individual such as *"Senior, high levels of anxiety, low self-esteem"* and *"female, struggling to manage stress and emotions, feelings of being alone and unsupported".* Responses were grouped into these categories to identify possible patterns in attribution.

It needs to be noted that these characteristics of students and the rationale for engaging in NSSI are identified by members of staff, not the individual student. Therefore, responses in this section may more accurately represent the assessment staff members have made towards an individual student/s and factors influencing their engagement in NSSI rather than the personal feelings and behaviour the student/s has.

The rationale for student/s engagement in NSSI was an interesting characteristic for multiple school staff to identify without prompting. A total of 67 participants identified attributes of a student which they related directly to NSSI. There is no suggestion as to why staff attributed factors as a rationale for student/s engaging in NSSI. Attributing rationale may have been intended as a way of trying to understand the student/s behaviour or factors in the students/s life may have been identified as a form of justification for engagement in NSSI. It is also unknown if identifying factors are influenced by the perception of the student/s and if the identification of specific factors may change the type of help/assistance/support offered to the student. For example, when NSSI is attributed to a "*shy nature"* in comparison to being discussed in the context of the student *"having a tough life at home with dad in prison"*, does this change how students NSSI behaviour is categorised and how the student is then supported with this behaviour.

Of 331 participants who identified characteristics of students engaging in NSSI, 35 students were identified as engaging in NSSI due to internal factors, whereas 24 students were discussed as having

significant external factors influencing their behaviour. A total of 16 participants attributed a student's NSSI behaviour to circumstances in the student's home life, 15 participants referred to difficulties in the school environment as contributing. An example of a staff member implicating the school environment as a contributing factor to NSSI is seen in the response: "*Year 11, girl, bullied at primary, switched from catholic girls school to co-education due to bullying, isolated, no friends, easy going, sweet girl, very timid, lots of deep cuts all over limbs, not covered up".*

Females were identified most frequently across all age groups; with a total of 140 female students aged 13-15yrs being identified as engaging in NSSI behaviour. A total of seven transgender, transitioning or belonging to the LGBTQ community were identified by secondary school staff in this study. One participant in discussing characteristics highlighted the heterogeneous nature of individuals who engage in NSSI behaviour, noting it is *"Impossible to generalise, have seen boys, girls, rich, poor etc."*

Confidence of staff when responding to students engaging in NSSI.

Confidence of school staff in this section was measured using a 5-point Likert scale which asked participants to identify how confident they felt when in a situation with a student engaging in NSSI. This scale ranged from very unconfident to very confident (Table 13). This item was asked only of participants who had encountered students engaging in NSSI, therefore indicating staff levels of confidence in actual situations with students engaging in NSSI rather than hypothetical.

Table 13

Staff confidence when encountering a student engaging in NSSI behaviour.

	Frequency	Percent
Very confident	40	8.7
Confident	138	30.1
Neither confident nor unconfident	115	25.1
Unconfident	45	9.8
Very unconfident	6	1.3

Just over half (51.7%) of the participants who answered this question indicated that they felt confident or very confident in the situation. The remaining 48. 3% of participants indicated they were neither confident or unconfident, unconfident or very unconfident.

Confidence in this item could be interpreted in different ways by participants. However, participants likely indicated how confident they felt personally during this encounter with a student/s. It would have been interesting to ask participants at this point how confident they felt in the way they managed the situation, as this may have indicated how confident they felt in their abilities when faced with students engaging in NSSI behaviour.

6. School Staff Training in NSSI

In the training section of this questionnaire, participants were asked to indicate if they had training in the area of NSSI; 10.9% (*n*=50) responded yes while 86.2% (*n*=395) indicated they had no prior training in NSSI. The term *training* was not specified in this section, which provided the opportunity for participants to contribute their views as to what they regarded to be training in NSSI. When those who had received training were asked to stipulate what their training consisted of, participants listed a range of different training options. Responses, for example, range from *"teacher training"* and a *"staff meeting last year"* to an indication of staff undertaking relevant courses as part of training in counselling qualifications.

Some participants indicated they were involved in ongoing guidance from Child and Adolescent Mental Health Services (CAMHS) and pastoral/ guidance teams within their school, while one participant indicated they sought out training in NSSI *"when I became concerned that there was a lot of Self Harm occurring in the population that I deal with".*

Staff reported on the recency of their training through an open-ended question. Responses were coded into categories indicating recency; in the last three, six or 12 months or more than one year ago which can be seen in Figure 1. Data is displayed in valid percentages. Participants highlighted in some instances that they had undertaken training between 5- 10yrs ago; one participant indicating their training was 15-20yrs previous. This brings to question how relevant the training still is in the area of NSSI, given the significant time-lapse and advances in knowledge and understanding in the field of NSSI.

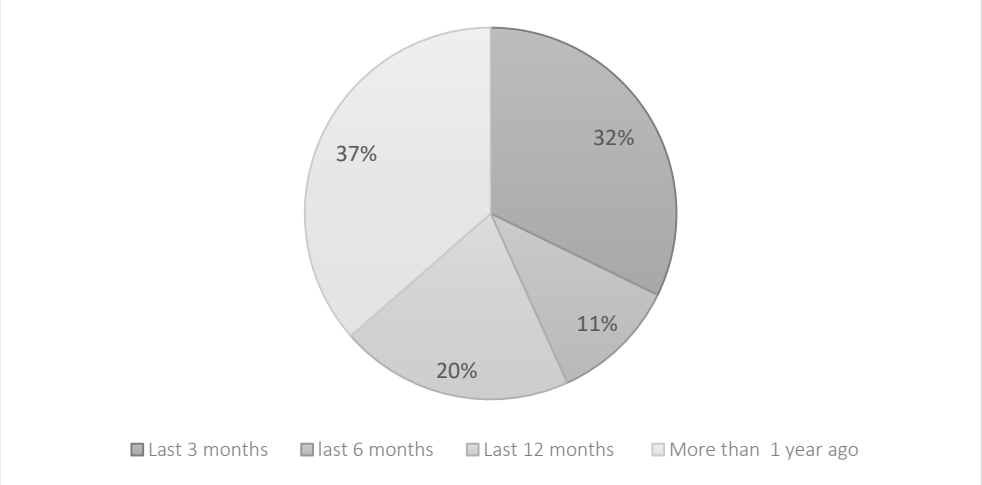

Figure 1. Percentages of recent staff training in NSSI.

Older training may not be representative of the current theories, and best practices of support as outlined in current NSSI literature. Most training (37%) occurred more than one year previous to this study, with a relevant 32% occurring within the last three months. This could indicate an increase in the need for training in NSSI, increases in the understanding that training is important or an increase in the training options available for secondary school staff members. This could also be an indication of newly trained teachers receiving some form of introduction to NSSI within their teaching training programme although there is no indication of inclusion of teaching in areas such as NSSI throughout current curriculum and teaching standards across the major New Zealand Universities.

Staff training was analysed against participants who had previous encounters with students engaging in NSSI to identify if experiences with NSSI increased staff's feelings of requiring training (Table 14).

Table 14

Staff who feel they would benefit from training

Training status	Feel they could benefit from training in NSSI.		Do not feel they would benefit from training in NSSI.	
	Frequency	%	Frequency	%
Have received training.	43	87.8	6	12.2
Have not received training.	345	87.6	49	12.4
Have encountered a student presenting with NSSI.	302	86.5	47	13.5
Have not encountered a student presenting with NSSI.	86	91.5	8	8.5

It is interesting to note that overall, 87.8% of staff who had previously received training in this area identified they would benefit from further training. Surprisingly, staff encounters with students engaging in NSSI was not associated with an increased indication that they would benefit from training. Of staff who had not encountered a student presenting with NSSI 91.5% indicated they would benefit from training, while from those members of staff whom had experience with students and NSSI 86.5% indicating training would be beneficial.

The eight main categories of staff roles (as outlined in Appendix H) were analysed against participants responses to identify if specific staff roles within secondary schools were more likely than others to receive training in the area of NSSI. The below table (Table 15) indicates the training status of staff throughout the key staff roles, also indicating if participants in these categories feel like training/ additional training in NSSI would be beneficial.

Table 15

Training in NSSI within secondary school roles.

Position/role within secondary school	Have undertaken training in NSSI		Have not undertaken training in NSSI		Feel they would benefit from training in NSSI		Do not feel they would benefit from training in NSSI	
	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Principal/Tumuaki	0	0	8	100.0	8	100	0	0
Deputy Principal	2	9.5	19	90.5	19	90.5	2	9.5
Dean	4	8.2	45	91.8	46	93.9	3	6.1
Teaching Team-SENCO	2	28.6	5	71.4	8	100	0	0
Teaching Team	11	3.7	283	96.3	251	85.7	42	14.3
Guidance Team	24	72.7	9	27.3	29	87.9	4	12.1
School Nurse	4	100.0	0	0	3	75.2	1	24.8
Support Staff/ administrative support staff	3	10.7	25	89.3	25	86.3	4	13.7

**note- these % represent the percentage of staff within the categorised position in each category.*

Expectedly, all school nurses had received training in NSSI; however, just one indicated they felt their training in this area was adequate, with a further three participants indicating they would benefit from additional training. Surprisingly, however, was the finding that just 72.2% of staff in school guidance teams had received training in NSSI. This amounts to a total of nine staff in guidance teams who may be counselling and supporting students with NSSI as part of their role without training in this area.

A very minimal 3.7% of the teaching staff had received training, with 85.7% reporting they would benefit from additional training. Just two SENCO representatives indicated they had prior training, which is concerning as it has been identified SENCO representatives are at times receiving referrals to support students with NSSI. None of the school principals and just two deputy principals indicated they had received training. This is unsurprising due to the management duties these staff roles usually involve, which usually limits time interacting with students and in classroom settings. However, all staff in principal and deputy principal roles who had not received training indicated that it would be beneficial. This could suggest a desire to gain more understanding of NSSI behaviour and available tools to support students or develop more beneficial protocols and strategies from a management perspective. Regardless of the motive, a greater understanding of NSSI from staff in senior positions should ultimately enhance support for staff and students in day-to-day situations involving NSSI.

Overall, upwards of 85% in most staff categories indicated they felt they would benefit from additional training in the area of NSSI. This suggests a huge call for training in NSSI from secondary school staff across all positions. All of the school principals and SENCO representatives indicated they would benefit from training in NSSI, which is surprising as staff in these two roles previously indicated that they feel it is not within their role to support students with NSSI.

Effectiveness of training

All but one participant who responded to this item identified that their training in NSSI was useful in day-to-day interactions; indicating training was useful, very helpful, awesome, very useful and invaluable. One guidance team staff member indicated that training was;

> "*Really useful- it takes the shock, and fear away and facilitated understanding. I view self-harm as a solution to deeper issue, a way of trying to manage their pain, or lack of pain…This allows me to be curious, and ask questions I need to ask, but in a respectful way".*

One more pragmatic response indicated that training in NSSI specifically for teachers was:

"Not very (useful). I think it is important to consider where a teacher's role should stop and start as a mental health professional I was trained, and this was my main job. As a teacher, I realistically am there to teach and am not professionally trained specifically as a person for this. I believe it puts teachers at a risk and adds to an already overloaded plate. All schools should have social workers".

Training and Attitudes and belief of all staff

When training was analysed against staffs' beliefs about supporting students engaging in NSSI behaviour, a positive relationship was identified. All of those participating staff members who had received some form of training indicated that they felt it was within their role to support students with NSSI. This is a positive result from training, particularly when considering the variation of staff roles who had trained in this area included all Secondary Staff roles apart from principal/Tumuaki. In comparison, 82.8% of staff who had not received training agreed that supporting students engaging in NSSI was within their role, while 17% disagreed.

As detailed in Appendix J, training in NSSI was associated with more positive attitudes and beliefs in some questionnaire items, when compared to responses from participants who had not received training, Notably, staff who had received training more frequently endorsed the strongly agree option when asked if they would feel comfortable if a student spoke to them about NSSI. However, this could be due to the number of staff on school guidance teams and in school nurse positions who had received training as this would naturally fall within their role within the school.

Staff who had received training identified significantly higher levels of self-perceived knowledge regarding NSSI when compared to participants who had not received training. Another notable finding was greater endorsement towards disagree and strongly disagree with the statement regarding students engaging in NSSI are doing it to manipulate others. This demonstrates a more positive attitude towards this behaviour as manipulating was associated with training.

When looking towards the item regarding cutting and burning the skin as horrifying, more positive attitudes were identified as associated with staff training (Table 16). However, this relationship could again be influenced more by the staffing roles in this study who most frequently identified they had received training. Whereby, nurses and members of the guidance team may have had more experience and exposure to NSSI behaviour and therefore the behaviour may have lost its *horrifying* or shocking effect on them.

Table 16

Level of agreement with the 'horrifying' statement.

Level of agreement	Training		No training	
	Frequency	%	Frequency	%
Strongly agree	3	6.0	76	19.2
Agree	5	10.0	122	30.9
Neither agree nor disagree	17	34.0	120	30.9
Disagree	17	34.0	57	14.4
Strongly disagree	8	16.0	17	4.3

Staff training and knowledge

As well as self-perceived knowledge of NSSI, staff training was also associated with higher levels of factual knowledge of NSSI when compared with staff who had not received training. Staff who indicated they had received some form of training in NSSI, indicated higher endorsement for research backed correct responses in most common method of NSSI and most common age of onset (Table 17 and Table 18). Training was associated with a slight increase in knowledge of the percentage of students engaging in NSSI (Table 19).

Table 17

Staff knowledge of most common methods of NSSI.

Multi-choice options	Training		No training	
	Frequency	%	Frequency	%
Cutting	49	98.0	371	93.9
Scratching	43	86.0	312	79.0
Biting	7	14.0	51	12.9
Burning	19	38.0	202	51.1
Pinching	11	22.0	113	28.6

Table 18

Staff knowledge of the most common age of onset for NSSI.

Multi-choice options	Training		No training	
	Frequency	%	Frequency	%
5-10yrs	0	0.0	16	4.1
11-15yrs	49	98.0	348	88.1
16-20yrs	1	2.0	28	7.1

Table 19

Staff knowledge of the percentage of students engaging in NSSI.

Multi-choice options	Training		No training	
	Frequency	%	Frequency	%
1-20%	22	44.0	239	60.5
21-40%	22	44.0	118	29.9
41-60%	4	8.0	30	7.6
61-80%	1	2.0	3	0.8

Knowledge of NSSI as a risk factor for future suicide was not significantly related to staff training (Table 20). Curiously, 6% of staff who had received training in NSSI strongly disagreed with this statement, which is comparable to the 1.5% who had not received training and strongly disagreed. This finding could relate to the importance of recent training in the area of NSSI, with current literature making this connection between increased NSSI behaviour and future suicides, whereas past literature may not have highlighted this relationship.

Table 20

Level of agreement with statement: students who self-injure increase their risk of future suicide.

Level of agreement	Training		No training	
	Frequency	%	Frequency	%
Strongly agree	0	0.0	11	2.8
Agree	15	30.0	125	31.6
Neither agree nor disagree	21	42.0	191	48.4
Disagree	11	22.0	60	15.2
Strongly disagree	3	6.0	6	1.5

Staff training and confidence and competence

Confidence and competence of staff were analysed against staff training to investigate a possible relationship between training and increased levels of confidence and competence in situations where students are engaging in NSSI (Figure 2,3 and 4).

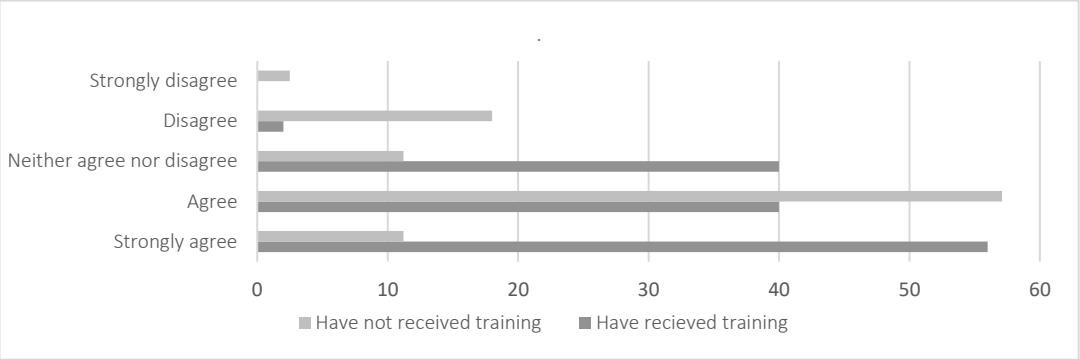

Figure 2. Relationship between staff training and confidence in responding to NSSI

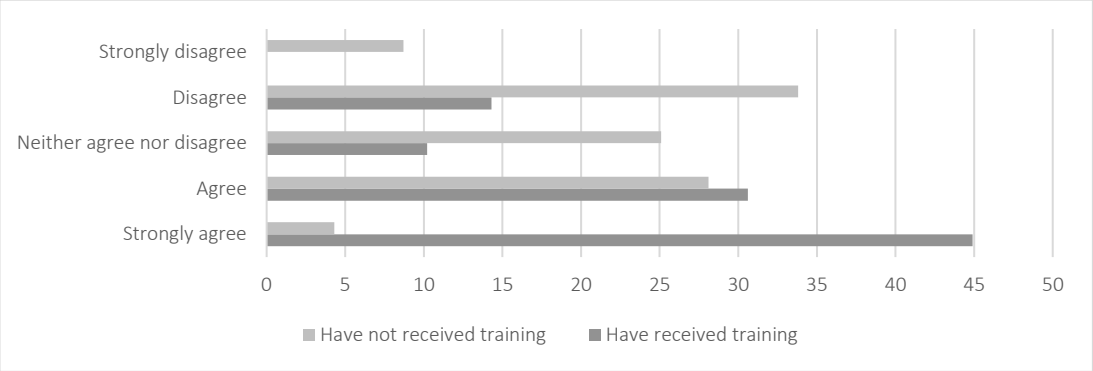

Figure 3. Relationship between staff training and competence in discussing NSSI with students

Figure 4. Relationship between staff training and confidence in identifying NSSI behaviour.

Notably, staff training in NSSI was not identified as a significant influence on the confidence levels of staff in responding to students displaying NSSI. However, higher levels of endorsement in the agree and strongly agree options in images three and 4 demonstrate a relationship between these questionnaire items and training. Therefore, staff training was identified as being related to increased confidence in responding to students engaging in NSSI and self-assessed competence in discussing NSSI with students and in identifying signs of NSSI, when compared with staff who had not received training.

Support for staff in the workplace

Participants were asked to identify if they had someone at work, they could talk to about NSSI should they become concerned about a student. This was scored as a yes/no item with all but 14 participants providing an answer. From participants who responded, 93.4% (*n*=428) indicated there was someone at work to discuss concerns regarding students engaging in NSSI. Just 3.5% (*n*=16) indicated this support was not available in their current secondary school.

DISCUSSION

This research aimed to investigate current New Zealand Secondary School staff's attitudes, beliefs and knowledge of NSSI. The objective was to identify NSSI in schools, how the behaviour and students engaging in it are being responded to and whether students and staff were supported adequately in situations which include NSSI behaviour.

The identification of in-depth staff recounts of discovering a students NSSI behaviour and the response in this situation provided an unexpected amount of testimony detailing situations directly involving staff and student's engagement of NSSI within the school environment. Although not a direct aim of this research, this data provided the opportunity to investigate the relationship between attitudes, belief and knowledge and training of staff and responses to situations involving students NSSI engagement.

The discussion section is organised around the key research questions investigated throughout this study. Staff experiences with students engaging in NSSI are first summarised as the starting point for this discussion, progressing on to discuss the following sections and how they relate back to staff experiences. Confidence, attitudes, beliefs and knowledge of staff were identified as key sections of the current study which impact and influence how staff respond to student's engagement in NSSI.

1. Staff experiences with students engaging in NSSI.
2. Confidence and competence of staff in discussing and support students engaging in NSSI
3. Staff attitudes and beliefs of NSSI.
4. Staff knowledge of NSSI.
5. Staff training in NSSI.

1. Staff experiences with students engaging in NSSI.

This study identified staff experiences with students engaging in NSSI at lower rates than previously identified in studies relating to self-harm among Secondary School students. Previously reported rates of student self-harm engagement from Australian, Canadian and American populations indicated 81%-99%

of school staff experienced a student engaging in self-harm during their career (Heath et al. 2011; Robinson, Gook, Yuen, McGorry, & Yung, 2008). However, some caution needs to be taken with this comparison as these reports indicate self-harm in both non-suicidal and suicidal intent and figures may be closer to that from this study if NSSI was reported independently. Additionally, Secondary School staff from varying roles throughout a school were included in the current study, whereas related studies from other countries focused on teaching staff.

One of the areas missing from other research was descriptions from staff regarding how NSSI behaviour was discovered and responses given to students. This current study has given an extremely valuable insight into the situations which staff are facing as well as they are handling situations. As we have seen from levels of training, the majority of these staff whom ha encountered students engaging in NSSI did not have prior training in this area. Therefore, were, and most likely still are responding to NSSI behaviour without training. Given the graphic nature of some situations detailed, this can not be best practice for students as well as staff being exposed to these experiences.

It needs to be mentioned that some of the experiences staff detailed involving students engaging in NSSI would have been confronting to say the least. Staff identified they found students bleeding profusely, in the act of cutting themselves, leaving blood throughout communal bathrooms and taking apart stationary to use as weapons against themselves. With no prior training or experience to draw expertise from, a staff member may well be reacting in the best way they see fit in the situation.

The highest number of reported self-disclosures from students came from teaching staff, demonstrating that some staff within this role have formed relationships with students which promotes the large amounts of trust which comes with disclosure. Previous research which discusses this rate of NSSI self-disclosure to teaching staff, identified 2-6% of students informing a teacher (Berger et al. 2013; Hawton et al. 2009; Fortune et al. 2008a; Hasking et al. 2015). This identifies that some teaching staff are in a position to be approached by students and have developed relationships with students which encourages help-seeking behaviour, such as disclosures of NSSI.

2. Confidence and competence

Confidence in identifying NSSI among students was the most evidenced sub-category in this section, with detailed qualitative responses identifying the use of underlying knowledge of physical and behavioural NSSI signs informing confidence in identifying NSSI.

However, a greater number of participants agreed or strongly agreed with knowing how to respond to student's engagement in NSSI, which was not evidenced in a as much of a positive way through qualitative responses. Responses more readily indicated staff as able to refer to a more qualified professional, than to respond to the immediate needs of a student on a caring and compassionate level.

Staff levels of competence and confidence were identified as increasing with training in two of the three items related to this section. These were identified as self-perceived competence in discussing NSSI with students and confidence in identifying signs of student engagement in NSSI.

3. Staff attitudes and beliefs of NSSI

Staff attitudes towards students who engage in NSSI as well as NSSI behaviour were evidenced in the current study as being relatively positive. The major finding was the 77% of staff identifying they would be comfortable if a student spoke to them about NSSI. This demonstrates staff are willing to be approached by students to discuss NSSI, however this does not speak to the approachability of staff members which is another aspect of this finding to consider.

Moreover, the identification of staff attitudes and beliefs towards student's engagement in NSSI can arguably be best detailed in the personal responses to experiencing students engaging in NSSI. Some incredibly negative responses were detailed in the results section, as were some positive responses with underlying positive attitudes and beliefs. These demonstrate the variation in attitudes and beliefs of staff of staff, through the actions taken and response given. Relating directly back to conscious and conscious attitudes, these findings may demonstrate staff's unconscious level of attitudes and beliefs which influence decisions when dealing with real time situations.

The current study did not identify an association between staff attitudes and belief in the multi-choice and Likert scale questionnaire items and staff responses to student's engagement in NSSI behaviour.

However, increases in positive attitudes and beliefs were associated with staff training in NSSI, which was associated with more positive responses to student's engagement in NSSI.

NSSI as horrifying

Level of agreement with the statement *I find the idea of a student cutting or burning their skin horrifying,* was subjective as individuals find different factors horrifying. However, the term *horrifying* refers to something which causes horror, great distress, a shock of dismay and is a powerful word, particularly when discussing a behaviour. When used in this context, the word '*horrifying*' undoubtedly demonstrates strong attitudes towards NSSI behaviour.

In the current study, levels of teaching staff either agreeing or strongly agreeing with the statement, was identified as between the 48% documented in Heath et al. (2006) and the 60% agreement rate documented in Heath et al. (2011). Therefore, in relation to this questionnaire item, more positive attitudes and beliefs regarding student's engagement in NSSI was demonstrated by participating teaching staff.

However, when looked at separately, staff members in a SENCO position demonstrated higher levels of agreement than documented in Heath et al. (2006, 2011) that a student cutting or burning their skin was horrifying. Consequently, this uncovered fewer positive attitudes of SENCO staff towards the act of NSSI.

These findings could demonstrate the presence of less negative attitudes towards NSSI amongst New Zealand teaching staff. However, this finding could also relate to the variation of staff demographics between the studies and in other variables which have been noted as influencing this questionnaire item. Of these variables, training in NSSI was associated with more disagreement with this horrifying statement, and therefore a more positive attitude towards the behaviour.

Additionally, this questionnaire item was not found to be associated with the staff responses to situations involving students engaging in NSSI. Staff who strongly agreed that an individual cutting and burning the skin was horrifying were observed to have responded in positive ways; shown care and concern, talk and listen to students and talk and refer. These items were assessed as being positive responses when

compared to a referral without talking to the student and staff taking no action or responding when learning of students NSSI engagement. The variance in responses to students engaging in NSSI was consistent across all levels of agreement with this horrifying statement.

This finding was not consistent with McAllister et al. (2002) research that identified an increase in positive attitudes as being associated with increased care and compassion when caring for patients engaging in DSH. Care and compassion were demonstrated by participants who detailed positive and less positive attitudes and beliefs towards NSSI, including this questionnaire item.

4. Staff knowledge of NSSI

Knowledge is discussed here in three key sections; overall knowledge of NSSI, knowledge of identifying signs of NSSI among others and knowledge in responding to NSSI. These were identified as key themes throughout the results of this study.

Participating Secondary School staff, identified high levels of knowledge of common methods of NSSI, and age of onset. The majority of participating Secondary School staff hold knowledge of the most common methods of NSSI currently identified in NSSI literature (Laye-Gindhu & Schonert-Reichl 2005; Swannell et al. 2014).

However, prevalence was significantly underestimated across the population of students. Findings in the knowledge section, align with discoveries in similar research studies which identified that many school staff can identify correct typical age of onset and the most common methods of NSSI (cutting) (Best, 2006, Heath et al. 2006 Heath et al. 2011) yet still commonly underestimate how prevalent NSSI is in schools (Lewis et al. 2019).

Knowledge in identifying NSSI

In Lewis et al. (2019) a general increase in school staff knowledge in NSSI was identified, yet issues in staff translating this knowledge into practice was noted. In the current study however, participating staff identified key signs of NSSI they were looking for: visible signs of NSSI such as cuts, abrasions, bruises and unexplained repeated injuries, behavioural changes to hide NSSI, changes in behaviour such as emotional

withdrawal, decrease in academic performance and change in interactions with others. Conceivably, participants working knowledge of NSSI influenced the identification of students engaging in NSSI

A high percentage of staff identified they were either looking for physical signs (blood/cutes) or behavioural changes which involved excessive use of clothing to cover wounds. Teaching staff, the role within Secondary Schools with the most contact with students, reported the highest frequency of NSSI experience with students in which they discovered this behaviour through noticing physical signs of NSSI. Additionally, some teaching staff identified NSSI through noticing behavioural changes, with the majority of these being attempts to cover the physical signs of self-harm. This finding supports the claims made in Heath et al. (2011) which identified teaching staff as being in the optimal position to identify student's engagement in NSSI through behavioural and physical symptoms. Details of these discoveries of students NSSI behaviour also reinforce staff utilising working knowledge of NSSI signs in identification of NSSI. Early intervention, early detection and accurate intervention are essential in the treatment of forms of self-injury (Shapiro, 2008).

The school environment

A very limited number of staff members implicated the school environment and relational issues within the school environment as influencing students NSSI behaviour. Participants more often identified the home environment and difficulties outside of school than within the school context. In failing to see the school environment as a contributing factor staff may be overlooking students experiencing difficulties within this environment which could predispose students to NSSI and maintain engagement in NSSI. Attending to the psychosocial school climate is a manageable way in which schools can promote student's mental health while drawing on the existing knowledge and skills of teachers (Aldridge & McChesney, 2018).

Knowledge and understanding of the influence of the school environment in mental-health and well-being is directed related to supporting students in the area of NSSI, both in those engaging in NSSI and in reducing risk factors. This link in with knowledge of supporting students in their mental-health and physical well-being in the classroom. Student engagement in NSSI is related to this, with evidence of

positive interactions and relationships within classroom and school environments and promotion of belonging associated with protective factors for decreasing student engagement in NSSI and decreasing risk. Furthermore, if staff members had additional knowledge of NSSI which included the understanding of the association between the school environment and NSSI, perhaps this would prompt an increase in staff feeling it is within their role to support students engaging in NSSI.

Additionally, without this understanding of factors within the school environment influencing NSSI behaviour, staff may not be implementing strategies in the school environment which promote support and help-seeking behaviour for students engaging in NSSI. Current literature on best practice of engaging with students displaying NSSI in schools is to assist in reducing stigma by assuring that responses to NSSI among staff are calm and compassionate, that students are not shamed or blamed, and that the students' physical and emotional needs are met with caring and direct attention (Lewis et al. 2019). This is in direct contrast to some responses from staff detailed in this study, demonstrating there is room for improvement

Knowledge in responding to students engaging in NSSI behaviour

As a behaviour, NSSI is often described as *'a cry for help',* '*manipulating*' or '*attention-seeking'.* As can be seen evidenced in this research, some people will look the other way when noticing NSSI, failing to act when recognising behavioural signs. Others will instinctively care and support, offering help in the best way they know. This study also highlighted the impact student's engagement in NSSI can have on those around them. Participants detailed how NSSI can compel people to relive their own experience to support others, can cause students to be singled out and dismissed from classes and how it can turn worlds upside down.

Investigating the responses of staff when learning of student engagement in NSSI was important to understand current procedures being utilised in school environment when responding to and supporting students. It was also important to ascertain how attitudes, beliefs and knowledge of NSSI interacted to create the responses of staff when confronted with students engaging in NSSI. Responses of current Secondary School staff members were documented along a continuum from demonstrating care and

concern to ignoring the behaviour. Staff were evidenced as accompanying students to counselling sessions to increase support, while others were documented as removing the student engaging in NSSI from the classroom and school, so other students were not affected. Training in NSSI and prior relationships with students were the factors identified in the current study as being associated with staff initiating a conversation with students and then either referring to listening and supporting.

If NSSI and students who self-injure are viewed negatively, NSSI may be dismissed, or conversations with students about NSSI may transpire in a way that invalidates the experience of students, implicitly or explicitly communicate judgement or disgust, and can hinder help-seeking (Lewis et al. 2019). Because NSSI is often associate with low self-esteem and fear of rejection (Braush & Gutirrez, 2010), it is vital to avoid inadvertently reinforcing these negative associations, particularly because responses to first disclosures that are perceived to be harsh or judgemental can reduce the likelihood of future disclosures resulting in a further delay in providing support and/or treatment (Walsh 2006)

Some participants identified that they were able to refer to school protocols, experience with students and even training as a means of guiding their response to student engagement in NSSI. However, only a very few documented that their first response would include care, compassion and understanding. This is relatable to Heath et al. (2011) study which noted that although teachers expressed a willingness to be approached by students who self-injure, few felt they would know how to respond when approached. Lack of knowledge and associated lack of confidence in addressing NSSI can lead to inappropriate responses to disclosures and inadequate referral, follow-up and intervention (Heath et al. 2011).

When interacting with students engaging in NSSI, staff need to be assessing the situation to ascertain the best way to proceed in supporting the student. Ideally, the perspective of the student should be considered as well as knowledge of NSSI and understanding of best-practice and school policy. At the very least we need to consider the student. A staff member noticing a student's NSSI may be the first time someone has notice the behaviour. It may also be help-seeking behaviour and the student indicating to others they need support. Ideally, all communication with adolescents about the NSSI behaviour (verbal and non-verbal) should be conveying respect, a willingness to understand, and attentiveness to the students' needs and well-being (Lewis et al. 2019).

5. Staff Training

Training in the area of NSSI was identified as a variable with a relationship to increased knowledge, more positive attitudes and beliefs of NSSI as a behaviour and more positive responses from staff when in a situation with students engaging in NSSI Although this could be attributed to the high rates of staff training in roles such as the school guidance teams and school nurses, staff training was still identified as being associated with increased knowledge and more positive beliefs and attitudes of staff in other school roles. These findings are consistent with those from Karmen, Kool, Gamel and Van Meijel (2015) which documented training directed towards attitudes of self-harm, attitudes shifted from judgement to understanding.

Increases in confidence and competence were also found to be associated with training, connecting the relationship between increases in knowledge and attitudes and beliefs. This relationship is consistent with increases in NSSI knowledge being associated with increases in confidence in responding to situations involving NSSI which were reported in (Berger et al. 2015; Groschwitz, Munz, Plener, Straub, & Bohnacker, 2017).

In the current study, 86% of participating Secondary School staff indicated they had not received training in the area of NSSI. This is comparable to the rates of training levels identified in Berger et al. (2014b) and Heath et al. (2006) where 80% of staff indicated they had not been involved in NSSI training.

It is noted that 82.7% of school staff within the teaching team believed it was within their role to support students with NSSI, yet 96.3% identified they feel they would benefit from training in order to support students. This large number of staff members calling for training in NSSI provides an indication that they are prepared to use knowledge and skills gained to support students who are engaging in NSSI.

Additionally, staff experience with students engaging in NSSI was not found to be associated with staff, indicating they would benefit from NSSI training. On the contrary, staff who had not experienced student NSSI engagement indicated they would benefit from it at higher rates than those who did have this experience.

Effectiveness of training

A notable finding to emerge from this research, was the identification of all staff whom had received some form of training in NSSI indicated they feel supporting students engaging in NSSI is within their role. This was regardless of their roles within the school and included all participating school roles excluding school principals. Training was not all the same either, it included a discussion in a staff meeting to research at counselling level. This demonstrates that gaining even a small increase in knowledge of NSSI can influence the understanding of the staff role in supporting students.

A study of a 2-day workshop was assessed as improving confidence, perceived knowledge, and knowledge of NSSI and suicidality (Groschwitz et al. 2017). This demonstrates that intensive and time-consuming training is not necessary for staff, but rather a brief workshop could promote positive increases in confidence and positive practice in situations involving students engaging in NSSI.

The current study highlighted the need for on-going training in NSSI alongside initial training. Close to 90% of staff in this study who had received some form of training in NSSI, still indicated they felt they would benefit from additional NSSI education. On-going professional development in the area has been identified by Lewis et al. (2019) as one of the ways to ensure staff have up to date knowledge in the current understandings and research in the area.

Lewis et al. (2019) proposed at least two key points which should be shared in efforts to upskill staff; 1) the prevalence of NSSI, with discussion including that it can be a behaviour frequently hidden, and 2) emphasis on NSSI being a serious mental health concern that although is distinct from suicide still has numerous harmful outcomes. These efforts coincide with findings from the current study, which indicate prevalence is highly underestimated and that more staff could benefit from understanding NSSI as a serious physical and mental health risk for adolescents in the present and future tense.

Some staff in this research detailed making decisions about referring a student or evaluating NSSI behaviour as ‘normal’ for the student and therefore do nothing. Training was a factor which was identified as influencing the response of staff when interacting with students engaging in NSSI. If a general knowledge base of best practices was shared through staff training, making decisions in difficult situation, in full classrooms and when faced with a potentially confronting situation, then staff would

have a knowledge base to fall back on. The implementation of clear school protocols on what to do when facing these situations could also improve the response of staff during such encounters. When developing school protocols however, factors need to be considered such as best practice based on current literature, the development of a knowledge base and training for staff and alternatives to school based professionals (management and guidance teams) to contact on a case by case basis.

Limitations of the present study

There are several limitations to the present study.

The question regarding training may not have been specific enough and was open to interpretation. It did not specify if the question meant 'formal training' or also referred to discussions or learning experiences from organisations attached to or outside the school. One participant commented that formalised training was never undertaken, yet outside organisations had engaged in discussions with members of staff regarding students and NSSI in schools. This feedback may indicate other individuals had experienced more informal discussions and guidance from knowledgeable organisations and had not included this; alternatively, individuals may have included this in methods of training they had received.

Additionally, participants were not asked to indicate in training in NSSI had been initiated as part of their current role/position within the school, or if this was before being employed in a secondary school, for example, guidance counsellors who had previous experience and training in NSSI in past careers.

Furthermore, coding of open-ended questions may not have been as accurate as predetermined options could have been, and misinterpretation of roles and errors in coding may have occurred.

Future research directions

Future research should involve a comprehensive investigation of the New Zealand population of students engaging in NSSI, to investigate the ways staff can best support them through their journey with NSSI behaviour. It has been identified in research by Madjar et al. (2017) that often there is a discrepancy between the form of support students' needs and support that is being provided by school staff. Therefore, identifying one side of this support network may not be identifying what students require from staff. Investigating this relationship could endeavour to align future staff training initiatives towards the best ways' students can feel supported with engagement in NSSI behaviour.

Future research should aim to investigate practical tools and training initiatives which could be easily and readily made available to staff throughout New Zealand. If training in NSSI was to be implemented in schools, evidence from this research supports the notion that forms of training in NSSI could increase staff positive attitudes and beliefs towards NSSI, increase knowledge of how to identify NSSI behaviour, respond in best practice ways to students and best support students engaging in NSSI.

REFERENCES

Aldridge, J. M., & McChesney, K. (2018). The relationship between school climate and adolescent mental health and well-being: A systematic literature review. *International Journal of Educational Research, 88,* 121-145.

Andover, M. S., Pepper, C. M., & Gibb, B. E. (2007). Self-mutilation and coping strategies in a college sample. *Suicide and Life-Threatening Behaviour, 37*, 238-243.

Ammerman, B, A., Jacobucci, R., Kleinman, E, M., Uyeji, L, L., & McCloskey, M. S. (2018). The relationship between nonsuicidal self-injury age of onset and severity of self-harm. *Suicide and Life-Threatening Behaviour, 48,* 31-37.doi: 10/1111/sltb.12330.

Atkins, M. S. (2010). Towards the integration of education and mental health in schools. *Administration and Policy in Mental Health and Mental Health Services Research, 37*(1), 40-47.

Berger, E., Hasking, P., & Martin, G. (2013) 'Listen to them': Adolescents' views on helping young people who self-injure. *Journal of Adolescence 36*, 935–945.

Berger, E., Hasking, P., & Martin, G. (2017). Adolescents' perspectives of youth non-suicidal self-injury prevention. *Youth and Society, 49*(1), 3-22.

Berger, E., Hasking, P., & Reupert, A. (2014a). Response and training needs of school staff towards student self-injury. *Teaching and Teacher Education 44,* 25-34.

Berger, E., Hasking, P., & Reupert, A. (2014b). "We're working in the dark here": Education needs of teachers and school staff regarding student self-injury. *School Mental Health 6,* 201-212.

Bertrand, M., Chugh, D., & Mullainathan, S. (2005). "Implicit discrimination". *American Economic Review, 95*(2), 94-98.

Brausch, A. M., & Gutierrez, P. M. (2010). Differences in Non-Suicidal Self-Injury and Suicide attempts in adolescents. *Journal of Youth and Adolescence*, *39,* 233-242.

Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design.* London, England: Harvard University Press.

Bruinstein Klomek, A., Snir, A., Apter, A., Carli, V., Wasserman, C., & Hadlaccky, G, et al. (2016). Association between victimization by bullying and direct self-injurious behaviour among adolescents in Europe: A ten country study. *European Child and Adolescent Psychiatry.*

Brunner R, Parzer P, Haffner J., Steen, R., Roos, J., Klett, M., Resch, F. (2007). Prevalence and psychological correlates of occasional and repetitive deliberate self-harm in adolescents. *Archives of Pediatric and Adolescent Medicine, 161*(7), 641–649. doi: https://doi.org/10.1001/archpedi.161.7.641

Buelens, T., Luyckx, K., Gandhi, A., Kiekens, G., & Claes, L. (2019). Non-Suicidal Self-Injury in Adolescence: Longitudinal associations with psychological distress and rumination. *Journal of Abnormal Child Psychology.* doi: 10.1007/s10802-019-00531-8.

Claes, L., Bouman, W. P., Witcomb, G., Thurston, M., Fernandez-Aranda, F., & Arcelus, J. (2015). Non-suicidal self-injury in trans people: Associations with psychological symptoms, victimization, interpersonal functioning, and perceived social support. *Journal of Sexual Medicine, 12,* 168-179.

Clark, T. C., Lucassen, M. F. G., Bullen, P., Denny, S. J., Fleming, T. M., Robinson, E. M., Rossen, F. V. (2013). The health and well-being of transgender high school students: Results from the New Zealand Adolescent Health survey. *Journal of Adolescent Health, 55,* 93-99.

Coogan, C., Bennett, S., Hooper, R., & Dickinson, P. (2003). Association between bullying and mental health status in New Zealand adolescents. *International Journal of Mental Health Promotion, 5* (1), 16-22.

Crawford, T., Geraghty, W., Street, K., & Simonoff, E. (2003). Staff knowledge and attitudes towards deliberate self-harm in adolescents. *Journal of Adolescents, 26,* 619-629.

Curtis, C. (2017). Non-suicidal self-injury: Suicide risk or social activity. *New Zealand Journal of Psychology 46*(3), 106-114.

Deliberto, T. L., & Nock, M. K. (2008). An exploratory study of correlates, onset, and offset of non-suicidal self-injury. *Archives of Suicide Research, 12*(3), 219-231.

Duggan, J. M., Heath, N. L., Toaste, J. R., & Ross, S. (2011). School Counsellors' Understanding of Non-Suicidal Self-Injury: Experiences and International Variability. *Canadian Journal of Counselling and Psychotherapy, 45*(4), 372-248.

Esposito, C., Bacchini, D., & Affuso, G. (2019). Adolescents non-suicidal self-injury and its relationship with school bullying and peer rejection. *Psychiatry Research, 274,* 1-6.

Evans, E., Hawton, K., & Rodham, K. (2005). In what ways are adolescents who engage in self-harm or experience thoughts of self-harm different in terms of help-seeking, communication and coping strategies? *Journal of Adolescents, 28,* 573-587.

Fazio, R. H., & Roskos-Ewoldsen, D. R. (2005). Acting how we feel; When attitudes and how we feel guide behaviour. In T.C. Brook & M. C. Green (Eds). *Persuasion: Psychological Insight and Perspectives* (pp.41- 62). Thousand Oaks, CA: Sage.

Fitzgerald, J., & Curtis, C. (2017). Non-suicidal self-injury in a New Zealand student population: Demographic and self-harm characteristics. *New Zealand Journal of Psychology 46*(3), 158-163.

Fortune, S., Sinclair, J., & Hawton, K. (2008a). Help-seeking before and after episodes of self-harm: a descriptive study in school pupils in England. *BMC Public Health*, *8,* 369.

Fortune, S., Sinclair, J., & Hawton, K. (2008b). Adolescents' views on preventing self-harm: A large community sample. *Social Psychiatry and Psychiatric Epidemiology, 43,* 96-104.

Foster, T., Gillespie, K., & McClelland, R. (1997). Mental disorders and suicide in Northern Ireland. *British Journal of Psychiatry, 170*(5)*,* 447-452.

Garish, J. A., & Wilson, M. S. (2015). Prevalence, correlates, and prospective predictors of non-suicidal self-injury among New Zealand adolescents: cross-sectional and longitudinal survey data. *Child and Adolescent Psychiatry & Mental Health.* DOI 10.1186/s13034-0055-6.

Gini, G., & Pozzoli, T. (2009). Association between bullying and psychosomatic problems: a meta-analysis. Paediatrics, 123, 1059–1065

Gong, T., Ren, Y., Wu, J., Jiang, Y., Hu, W., & You, J. (2019). The associations among self-criticism, hopelessness, rumination, and NSSI in adolescents: A moderated mediation model. *Journal of Adolescents, 72,* 1-9.

Gratz, K. L. (2003). Risk Factors for and Functions of Deliberate Self-Harm: An Empirical and Conceptual Review. *Clinical Psychology Science and Practice, 10*(2), 192-205.

Groschwitz, R., Munz, L., Plener, P. L., Straub, J., & Bohnacker, I. (2017). Strong schools against suicidality and self-injury: Evaluation of a workshop for school staff. *School Psychology Quarterly,32* (2), 188-198.

Guhn, M., Schonert-Reichl, K.A., Gadermann, A.M., Hymel, S., Hertzman, C. (2013). A population study of victimization, relationships, and well-being in middle childhood. Journal of Happiness Studies, 14, 1529–1541.

Hall, S., 2010. Supporting mental health and wellbeing at a whole-school level: listening to and acting upon children's views. *Emotional and Behavioural Difficulties*, 15, 323–339

Hamza, C. A., Stewart, S. L., & Willoughby, T. (2012). Examining the link between nonsuicidal self-injury and suicidal behavior: A review of the literature and an integrated model. *Clinical Psychology Review, 32*(6), 482-495.

Hasking, P., Rees, C. S., Martin, G., & Quigley, J. (2015). What happens when you tell someone you self-injure? The effects of disclosing NSSI to adults and peers. *BMC Public Health, 15,* 1039.

Hasking, P., Whitlock, J., Voon, D., & Rose, A. (2016). A cognitive-emotional model of NSII: Using emotion regulation and cognitive processes to explain why people self-injure. *Cognition and Emotion,* DOI: 10.1080/02699931.2016.1241219.

Hawton, K., Rodham, K., Evans, E., & Harriss, L. (2009). Adolescents who self-harm: A comparison of those who go to hospital and those who do not. *Child and Adolescent Mental Health 14*, 24–30

Heath, N. L., Ross, S., Toste, J. R., Charlebois, A., & Nedecheva, T. (2009). Retrospective analysis of social factors and non-suicidal self-injury among young adults. *Canadian Journal of Behavioural Science, 41,* 180-186.

Heath, N. L., Toste, J. R., Sornberger, M. J., & Wagner, C. (2011). Teachers' perceptions of non-suicidal self-injury in the schools. *School Mental Health 3,* 35-43.

Hintikka, J., Tolmunen, T., Rissanen, M., Honkalampi, K., Kylmä, J., & Laukkanen, E. (2009). Mental Health disorders and self-cutting adolescents. *Journal of Adolescent Health, 44,* 464-467.

Horner, G. (2016). Nonsuicidal Self-Injury. *Continuing Education, 30*(3), 261-267.

International society for the study of Self-injury (2018). *Fast Fact; Overview.* Retrieved from https://itriples.org/

Jacobson, C. M., & Gould, M. (2007). The epidemiology and phenomenology of non-suicidal self-injurious behavior among adolescents: a critical review of the literature. *Archives of Suicide Research, 11*(2), 129-147, DOI: 10.1080/13811110701247602

Karmen, P., Kool, N., Gamel, C., & van Meijel, B. (2015). From judgement to understanding. Mental Health nurses' perceptions of changed professional behaviours following positively changed attitudes towards self-harm. *Archives of Psychiatric Nursing, 29,* 401-406.

Klineberg, E., Kelly, M. J., Stansfeld, S. A., & Kamaldeep, B. S. (2013). How do adolescents talk about self-harm: a qualitative study of disclosure in an ethnically diverse urban population in England. *BMC Public Health, 13*, 572.

Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the empirical evidence. *Clinical Psychology Review, 27,* 226-239.

Klonsky, E. D., & Muehlenkamp, J. J. (2007). Self-Injury: A research review for the practitioner. *Journal of Clinical Psychology, 63,* 1045-1056.

Kumar, G., Pepe, D., & Steer, R. A. (2004). Adolescent psychiatric inpatients' self-reported reasons for cutting themselves. *Journal of Neurodevelopmental Disorders 192*(12), 830–836.

Lereya, S.T., Copeland, W. E., Costello, E. J., & Wolke, D. (2015). Adult mental health consequences of peer bullying and maltreatment in childhood: Two cohorts in two countries. *Lancet Psychiatry, 2*(6), 524-531.

Lewis, S. P., Heath, N. L., Hasking, P. A., Hamza, C. A., Bloom, E. L., Lloyd-Richardson, E. E., & Whitlock, J. (2019). Advocacy for improved response to self-injury in schools. A call to action for school psychologists. *Psychological Services.* Advance online publication. http://dx.doi.org/10.1037/ser0000352.

Libbey, H.P., 2004. Measuring student relationships to school: attachment, bonding, connectedness, and engagement. Journal of Social Health, 74, 274–283.

Laye-Gindhu, A., & Schonert-Reichl, K. A. (2005). Nonsuicidal Self-Harm Among Community Adolescents: Understanding the "What's" and "Whys" of Self-Harm. *Journal of Youth and Adolescence, 34* (5), 447–457 DOI: 10.1007/s10964-005-7262

McAllister, M., Creedy, D., Moyle, W., & Farrugia, C. (2002). Nurses' attitudes towards clients who self-harm. *Journal of Advanced Nursing 40*(5), 578-586.

Madjar, N., Shabat, B. S., Elia, R., Fellner, N., Rehavi, M., Rubin, S. E., Segal, N., Shoval, G. (2017). Non-suicidal self-injury within the school context: Multilevel analysis of teachers' support and peer climate. *European Psychiatry 41,* 95-101.

Mariu, K. R., Merry, S. N., Robinson, E. M., Watson, P. D. (2011). Seeking professional help for mental health problems, among New Zealand secondary school students. *Clinical Child Psychology and Psychiatry, 17*(2), 284-297.

Marshall, E., Claes, L., Bouman, W. P., Witcomb, G. L., Arcelus, J. (2016). Non-suicidal self-injury in trans people: A systematic review of the literature. *International Review of Psychiatry, 28*(1), 58-69.

Messer, J. M., & Fremouw, W. J. (2008). A critical review of explanatory models for self-mutilating behaviours in adolescents. *Clinical Psychology Reviews, 28,* 168-178.

Ministry of Education. (n.d). *Education Count.* Retrieved from http://educationcounts.govt.nz.

Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6,* 1-9.

Muehlenkamp, J. J., & Gutierrez, P. M. (2007). Risk for suicide attempts among adolescents who engage in Non-suicidal Self-injury. *Archives of Suicide Research, 11*(1), 69-82.

Muehlenkamp, J.J., Xhunga, N., and Brausch, A. M. (2018). Self- Injury age of onset: A risk factor for NSSI severity and suicidal behaviour. *Archives of Suicidal Research, 0,* 1-13.

Noble, R. N., Sornberger, M. L., Toste, J. R., Heath, N. L., & McLouth, R. (2011). Safety first: The role of trust and school safety in non-suicidal self-injury. *McGill Journal of Education 46*(3) 423-441.

Nock, M. K. (2009). Why do people hurt themselves? New insights into the nature and functions of self-injury. *Current Directions in Psychological Science, 18*(2). 78-83.

Nock, M. K., & Favazza, A. R. (2009). Nonsuicidal self-injury: Definition and classification. In Nock, Matthew K. (Ed); *Understanding nonsuicidal self-injury: Origins, assessment, and treatment*. Washington, DC: American Psychological Association; 2009, pp. 9-18.

Nock, M. K., Joiner, T. E., Jr, Gordon, K. H., Lloyd-Richardson, E., & Prinstein, M. J. (2006). Non-suicidal self-injury among adolescents: Diagnostic correlates and relation to suicide attempts. *Psychiatry Research, 144,* 65-72.

Nock, M. K., & Prinstein, M. J. (2004). A functional approach to the assessment of self-mutilative behaviour. *Journal of Consulting and Clinical Psychology, 72*(5), 885—890.

Oberle, E., Guhn, M., Gadermann, A. M., Thomson, K., & Schnert-Reichl, K. A. (2018). Positive mental health and supportive environments: A population-level longitudinal study of dispositional optimism and school relationships in early adolescents. *Social Science and Medicine, 214,* 154-161.

Ozer, E. J., & Weinstein, R. S. (2004). Urban adolescents' exposure to community violence: The role of support, school safety, and social constraints in a school-based sample of boys and girls. *Journal of Clinical Child and Adolescent Psychology 33*, 463-476.

Pianta, R.C., Hamre, B.K., 2009. Classroom processes and positive youth development: conceptualizing, measuring, and improving the capacity of interactions between teachers and students. *New Dir. Stud. Leadership*, 33–46 2009.

Prinstein, M. J., Heilbron, N., Guerry, J. D., Franklin, J. C., Rancourt, D., Simon, V., & Spirito, A. (2010). Peer influence and nonsuicidal self-injury: Longitudinal results in community and clinically referred adolescent samples. *Journal of Abnormal Child Psychology, 38,* 669-682.

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teachers perception of needs, roles and barriers. *School Psychology Quarterly, 26*(1), 1-13.

Robinson J, Gook, S., Yuen, H. P., McGorry, P. D., & Yung, A. R. (2008). Managing deliberate self-harm in young people: An evaluation of a training program developed for school welfare staff using a longitudinal research design. *Bio Med Central Psychiatry, 8*, doi:10.1186/1471-244X-8-75.

Rowe, S., French, R. S., Henderson, C., Ougrin, D., Slade, M., & Moran, P. (2014). Help-seeking behaviour and adolescent self-harm: A systematic review. *Australian and New Zealand Journal of Psychiatry, 48*(12) 1083-1095.

Saunders, K.E., & Smith, K.A. (2017). Interventions to prevent self-harm: What does the evidence say? *Evidence Based Mental Health*, 19(3), 69-72.

Selby, E. A. & Joiner T.E Jr. (2009). Cascades of Emotion: The Emergence of Borderline Personality Disorder from Emotional and Behavioural Dysregulation. *Review of General Psychology, 13*(3), 219-220.

Shapiro, S. (2008). Addressing self-injury in the school setting. *The Journal of School Nursing, 24*(3), 124-130.

Sher, L., & Stanley, L. (2009). Biological models of nonsuicidal self-injury. In M. K. Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, assessment and treatment* (pp. 99–116). Washington, DC: American Psychological Association.

Skegg, K., (2005). Self-harm. *The Lancet, 366(*9495), 1471-1483.

Sornberger, M. J., Heath, N. L., Toste, J. R., & McLouth, R. (2012). Nonsuicidal self-injury and gender: Patterns of prevalence, methods, and locations among adolescents. *Suicide and Life-threatening Behaviour, 42*,266-278.

Staats, C. (2015). Understanding implicit bias: What educators should know. *American Educator,* 29-43.

Stanford, S., & Jones, M. P. (2009). Psychological subtyping finds pathological, impulsive, and 'normal' groups among adolescents who self-harm. *The Journal of Child Psychology and Psychiatry, 50*(7) 807-815.

Stanford, S., Jones, M. P., & Hudson, J. L. (2017). Rethinking pathology in adolescent self-harm: Towards a more complex understanding of risk factors. *Journal of Adolescence, 54,* 32-41.

Steinback, J., & Stoeger, H. (2016). How primary school teachers' attitudes towards self-regulated learning (SRL) influence instructional behavior and training implementation in classrooms. *Teaching and Teacher Education, 60,* 256-269.

Steinberg, L., & Morris, A. S. (2001) Adolescent development. *Annual Review of Psychology, 52,* 83-101.

Swannell, S. V., Martin, G. E., Page, A., Hasking, P., & St John, N. J. (2014). Prevalence of Nonsuicidal Self-Injury in Non-clinical samples: Systematic review, Meta-Analysis and Meta-Regression. *Suicide and Life-Threatening behaviour, 44*(3).

Taylor, J. D., & Ibanez, L. M. (2015). Sociological approaches to self-injury. *Sociology Compass, 9*(12), 1005-1014.

Taylor, P.J., Jomar, K., Dhingra, K., Forrester, R., Shahmalak, U., Dickson, J. M. (2018). A meta-analysis of the prevalence of the different functions of non-suicidal self-injury. *Journal of Affective Disorders, 227*, 759-769.

Thapa, A., Cohen, J., Guffey, S., & Higgins-D'Alessandro, A. (2013). A review of school climate research. *Review of Educational Research, 83,* 357-385.

Timson, D., Priest, H., & Clark-Carter, D. (2012). Adolescents who self-harm: Professional staff knowledge, attitudes and training needs. *Journal of Adolescents 35,* 1307-1314.

Van Geel, M., Goemans, A., & Vedder, P. (2015). A meta-analysis on the relation between peer victimization and adolescent non-suicidal self-injury. *Psychiatry Research, 230,* 364-368.

Walsh, B. W. (2012). *Treating self-injury: A practical guide.* New York, NY: Guilford Press.

Whitlock, J., Eckenrode. J., &, Silverman, D. (2006). Self-injurious behaviors in a college population. *Pediatrics, 117*(6), 1939-1948; DOI: 10.1542/peds.2005-2543

Whitlock, J., Muehlenkamp, J., Purington, A., Eckenrode, J., Barreira, P., Baral Abrams, G., & Knox, K. (2011). Nonsuicidal self-injury in a college population: General trends and sex differences. *Journal of American College Health, 59* (8), 691-698.

Whitlock, J., Rodham, K. (2013). Understanding nonsuicidal self-injury in youth. *School Psychology Forum: Research in Practice, 7*(4), 93-110.

Wright, K. B. (2005). Researching Internet-Based Populations: Advantages and Disadvantages of Online Survey Research, Online Questionnaire Authoring Software Packages, and Web Survey Services. *Journal of Computer-mediated Communication 10*(3).

World Health Organisation (2013). *Mental Health Action Plan 2013-2020.* Geneva, Swizerland: *WHO Press.*

Ystgaard, M., Arensman, E., Hawton, K., Madge, N., Heeringen, K., Hewitt, A., Jan de Wilde, E., De Leo, D., & Fekete, S. (2009). Deliberate self-harm in adolescents: Comparison between those who receive help following self-harm and those who do not. *Journal of Adolescence 32*(4), 875-891.

Zielinski, M. J., Hill, M. A., & Veilleux, J. C. (2018). Is the first cut really the deepest? Frequency and recency of nonsuicidal self-injury in relation to psychopathology and dysregulation. *Psychiatry Research, 259,* 392-397.

Appendix A: Staff Attitudes, Beliefs and Knowledge of Non-Suicidal Self-Injury Questionnaire

Non-Suicidal Self-Injury in New Zealand: A study of Staff Attitudes and Beliefs Within High Schools.

Information Sheet

I would like to invite you to take part in this research project.

Introduction

My name is Courtney Wall. I am a psychology student at Massey University, undertaking a research project as part of the Master of Science degree. I am being supervised by Dr John Fitzgerald.

The aim of this study is to investigate the beliefs, attitudes and current knowledge of Non-suicidal Self-injury (NSSI) held by high school staff across New Zealand. In the following study, Non-suicidal Self-injury is defined as the intentional, culturally unaccepted, self-inflicted, immediate and direct destruction of body tissue, absent of lethality and suicidal intent. Therefore, NSSI does not include bodily piercing, tattoos', the use of substances (drugs and alcohol) and self-injurious behaviour, which would cause bodily damage over time (such as eating disorders).

What is involved

Completing a questionnaire, which will take approximately between five to fifteen minutes of your time. The actual time will depend on how you answer some of the questions.

Who can participate

To participate, you need to be a current staff member in a New Zealand high school. We are interested in

responses from staff in all positions throughout New Zealand high schools.

Participants rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

Results will be aggregated so no individual person or school will be identifiable in the reporting of results.

The information you provide will be used in my master's thesis and submitted for assessment.

- decline to answer any question;
- withdraw from the study during the questionnaire stage by closing your browser;
- ask questions at any time during participation;
- provide information on the understanding that your name will not be gathered.

If you find this questionnaire upsetting, please do not hesitate to seek advice and/or assistance. Options could include seeking counselling via your GP or talking to your school guidance counsellor, senior colleague or trusted friend/ family member.

Project contacts

If you have any further questions, please do not hesitate to contact the researcher or supervisor.

A detailed report outlining the findings of this research study will be distributed to all participating schools. If you would like a personal copy of this report, please indicate this at the completion of the questionnaire. Any contact information will be isolated from the questionnaire data and collected in a separate survey after the main questionnaire is processed.

Researcher

Courtney Wall

Extramural student

School of Psychology

Massey University

Wall.courtney@hotmail.com

Supervisor

Dr John Fitzgerald

School of Psychology

Massey University

+64 (04) 801 5799 ext. 63620

J.M.Fitzgerald1@massey.ac.nz

Thank you for taking the time to read this information. We would really appreciate your contribution to this important research.

Massey University School of Psychology – Te Kura Hinengaro Tangata

Wellington, New Zealand

T +64 4 801-5799 ext 85071

W psychology.massey.ac.nz

This research project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees.
The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director (Research Ethics), email humanethics@massey.ac.nz.

Consent I have read and understood the information sheet for this study and consent to collection of my responses.

(Please click on the 'Yes' choice if you wish to proceed.)

- ○ Yes
- ○ No

Demographic information

1) How old are you?

_____

2) What is your gender?

- ○ Male
- ○ Female
- ○ Other

3) Which ethnic group do you belong to? *(Please indicate which one you consider to be your primary ethnicity).*

- ○ New Zealand European / Pākehā
- ○ Māori
- ○ Pacific peoples
- ○ European
- ○ Asian
- ○ Other

4) What is your role within the school?

_____

5) Years of professional experience in the school environment.

_____

Section 1: Self-injury behaviours

As we start this questionnaire, we would first like to ask you about the relationship between self-harm and suicidality.

6) Students who self-injure are most often suicidal.

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Information

Although some individuals self-injure with suicidal intent, there is also a percentage of individuals who self-injure without intending to suicide. This non-suicidal self-injury (NSSI) is the topic of this questionnaire.

The remaining questions relate to the non-suicidal form of self-injury which is defined as the intentional, culturally unaccepted, self-inflicted, immediate and direct destruction of body tissue, absent of lethality

and suicidal intent. Therefore, NSSI does not include bodily piercing, tattoos', the use of substances (drugs and alcohol) and self-injurious behaviour, which would cause bodily damage over time (such as eating disorders).

7) In your current position at a New Zealand high school, do you think it is part of your role to support student with NSSI?

- ○ Yes
- ○ No

8) I am knowledgeable about non-suicidal self-injury.

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

9) I would know how to respond if a student in my class and/or school or under my care appeared to be performing acts of non-suicidal self-injury.

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

10) Please indicate what this response would be:

_____

11) I believe I know how to identify non-suicidal self-injury behaviours.

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

12) Please indicate what signs you would be looking for:

_____

13) Please select your level of agreement with each statement.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I would feel comfortable if a student spoke to me about non-suicidal self-injury. (13)	○	○	○	○	○
I would be competent discussing non-suicidal self-injury with students. (14)	○	○	○	○	○

15) What would you say are the three most common methods of non-suicidal self-injury?

You can only choose three.

- [ ] Cutting
- [ ] Burning
- [ ] Self-hitting
- [ ] Scratching
- [ ] Biting
- [ ] Pinching

16) What age bracket would you say students are most likely to start Non-suicidal Self-injury?

- ○ 5-10 yrs
- ○ 11-15 yrs
- ○ 16-20 yrs

17) I don't believe high school students self-injure with non-suicidal intent.

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

18) I find the idea of a student cutting or burning their skin horrifying.

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

19) Why do you think a high school student would engage in non-suicidal self-injury?

_____

20) Please select your level of agreement with each statement.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Students who engage in non-suicidal self-injury are just trying to get attention. (20)	○	○	○	○	○
Students who self-injure with non-suicidal intent are doing it to manipulate other people. (21)	○	○	○	○	○
Students who self-injure with non-suicidal intent are almost always girls. (22)	○	○	○	○	○

Students who self-injure with non-suicidal intent are often from middle to upper-income families. (23)	○	○	○	○	○
Students who self-injure with non-suicidal intent often have poor communication skills. (24)	○	○	○	○	○

25) Please select your level of agreement with each statement.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Students who self-injure with non-suicidal intent often have low self-esteem. (25)	○	○	○	○	○
Students who self-injure are often suicidal. (26)	○	○	○	○	○
Non-suicidal self-injury is an indicator of a mental disorder. (27)	○	○	○	○	○
Non-suicidal self-injury is an indicator of difficulties in regulating emotions. (28)	○	○	○	○	○

Students who self-injure increase their risk of future suicide. (29)	○	○	○	○	○

30) What percentage of high school students do you believe self-injure with non-suicidal intent?

○ 0%

○ 1-20%

○ 21-40%

○ 41-60%

○ 61-80%

○ 81-100%

Section 2: Experience

31) Have you encountered a student presenting with NSSI?

○ Yes

○ No

Skip To: End of Block If Have you encountered a student presenting with NSSI

32) If you answered yes to the previous question, how did you become aware of this Non-suicidal self-injurious behaviour?

_____

33) How recent was this?

- ○ Last 3 months
- ○ Last 6 months
- ○ Last 12 months
- ○ More than a year ago

34) What were the general characteristics of this student/s?

(for example: age, gender, year level at school)

_____

35) How did you as a member of staff respond?

_____

36) Please indicate on the below scale how confident you felt in the situation?

- ○ Very confident
- ○ Confident
- ○ Neither confident nor unconfident
- ○ Unconfident
- ○ Very unconfident

Section 3: Training experience

37) Have you received training in the area of NSSI?

- ○ Yes
- ○ No

Skip To: TE5 If Have you received training in the area of NSSI

38) When did this occur?

_____

39) What did this consist of?

_____

40) How useful did you find this training in day to day interactions with students?

_____

41) Do you feel you would benefit from training in NSSI?

- ○ Yes
- ○ No

42) I have someone at work I can discuss non-suicidal self-injury if I am concerned about a student.

- ○ Yes
- ○ No

Thank you for contributing to this important research.

Clicking the Submit button below will lodge your responses and transfer you automatically to another independent form to enter your email address if you would like a personal copy of this research study's research findings.

If you found this questionnaire upsetting, please do not hesitate to seek advice and/or assistance. Options could include seeking counselling via your GP or talking to your school guidance counsellor, senior colleague or trusted friend/ family member.

Appendix B: Rationale for specific questionnaire items

Question 2.

In your current position at a New Zealand High school, do you think it is part of your role to support student with NSSI?

Yes or no answer required. This question was deemed essential to determine the attitudes and beliefs of staff members in supporting students with NSSI within their role. Results from this question will preliminarily indicate possible response rates in staff members implementing future protocols or initiatives aimed at NSSI throughout New Zealand secondary schools.

Question 11.

I find the idea of a student cutting or burning their skill horrifying.

Is scored by participants on a 5-point Likert scale, ranging from strongly agree to strongly disagree. This was taken directly from Health et al. (2006) with permission. Although the term *horrifying* has subjective meaning for individuals, this question was deemed by the researcher to express an individual's strong attitude towards NSSI behaviour. The original questionnaire item developed in Heath et al. (2006) was utilised in a study related to both suicidal and non-suicidal self-harm. However, this question relates to the act of self-harm rather than to the intent of non-suicidal or suicidal self-harm; therefore, in this case, it is appropriate to draw comparisons. Therefore, a direct comparison between the findings of this item in Health et al. (2006), Heath et al. (2011) and the current study can be made.

Question 24.

Have you encountered a student presenting with NSSI?

Yes or no answer required. The addition of this question can provide insight into current prevalence rates of NSSI in New Zealand secondary schools while providing a preliminary indication of staff rates of noting NSSI.

Question 25.

If you answered yes to the previous question, how did you become aware of this non-suicidal self-injurious behaviour?

Open-ended question. The addition of this question aims to provide a preliminary indication of how staff members are likely to discover NSSI in student; observations, referrals from other staff, disclosure from individual exhibiting NSSI behaviour, disclosure from friends of individuals etc.

Question 27.

What were the general characteristics of this students/students (for example age, gender, year level at school)?

Open-ended question. The addition of this question was for a preliminary indication of the characteristics of New Zealand students with current/ past NSSI behaviour.

Question 28.

How did you, as a member of staff respond?

Open-ended question. This question provides evidence of current responses of staff to NSSI in New Zealand secondary schools as well as any current protocol in schools regarding NSSI.

Staff training section.

Was included as an additional section to gather an indication of rates of staff training in NSSI throughout New Zealand. This section also aims to indicate if staff training aided staff members in supporting students with NSSI and in collecting data indicating how many staff in this study would like to receive training in the area of NSSI.

Appendix C: Information Sheet

Non-Suicidal Self-Injury in New Zealand: A study of Staff Attitudes and Beliefs Within High Schools.

Information sheet

Introduction

My name is Courtney Wall. I am a psychology student at Massey University, undertaking a research project as part of the Master of Science degree. I am being supervised by Dr John Fitzgerald.

The aim of this study is to investigate the beliefs, attitudes and current knowledge of Non-suicidal Self-injury (NSSI) held by high school staff across New Zealand.

What is involved

Completing a questionnaire, which will take approximately between five to fifteen minutes of your time. The actual time will depend on how you answer some of the questions.

Who can participate

To participate, you need to be a current staff member in a New Zealand high school. We are interested in responses from staff in all positions throughout New Zealand high schools.

Participants rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to; decline to answer any question, withdraw from the study during the questionnaire stage by closing your browser, ask questions at any time during participation, provide information on the understanding that your name will not be gathered. Results will be aggregated, so no individual person

or school will be identifiable in the reporting of results. The information you provide will be used for the purpose of completing the discussed thesis and any potential publication in academic journals.

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director (Research Ethics), email humanethics@massey.ac.nz

If you find this questionnaire upsetting, please do not hesitate to seek advice and/or assistance. Options could include seeking counselling via your GP or talking to your school guidance counsellor, senior colleague or trusted friend/ family member.

Project contacts

If you have any further questions, please do not hesitate to contact the researcher or supervisor. If you would like a copy of the report outlining the findings of this research study, please indicate this at the completion of the questionnaire. If you include your contact information, this will be isolated from the questionnaire data and stored in a separate file before the questionnaire is processed.

Researcher	Supervisor
Courtney Wall	Dr John Fitzgerald
Extramural student	School of Psychology
School of Psychology	Massey University
Massey University	+64 (04) 801 5799 ext. 63620
wall.courtney@hotmail.com	J.M.Fitzgerald1@massey.ac.nz

Thank you for taking the time to read this information. We would really appreciate your contribution to this important research.

Appendix D: Email to Secondary School principals

Tēnā koe

My name is Courtney Wall, a student of Massey University. I am currently undertaking a research project as part of the Master of Science (Psychology) qualification. For this project, I have developed an investigation into school staff's beliefs and attitudes towards Non-Suicidal Self-Injury. I am currently recruiting participants, and your school has been chosen at random from a list of NZ schools. The project would be greatly enhanced by the participation of your school. I would be appreciative if you would consider assisting this project by personally completing my survey and supporting the staff at your school to also participate.

Introduction

Non-suicidal Self-injury (NSSI) is the intentional, culturally unaccepted, self-inflicted, immediate and direct destruction of body tissue, absent of lethality and suicidal intent. NSSI commonly occurs in adolescence; almost 65% of documented NSSI occurs within the teenage years. In New Zealand, NSSI is a behaviour which has an impact on our taitamariki, young people. Recent studies indicate between one third and one-half of New Zealand students leaving high school have self-injured.

This research is proposed as the first step in identifying the needs of teaching staff and schools throughout New Zealand in supporting staff and students with NSSI behaviour within the school environment. Understanding the current knowledge, beliefs and attitudes of New Zealand high school staff towards NSSI will be instrumental in supporting any future resources in schools as staff members are critical to their implementation.

Procedure

Participating involves completing a brief online survey which will take between five to fifteen minutes, depending on how questions are answered. Individual participants and schools will not be identified within the data, and no individual schools will be identified in any reporting of this research.

Results from this study will be used for the purpose of completing the discussed thesis. Data will be kept in a secure environment and will be disposed of by the researcher's supervisor after the requisite period. Upon completion of this study, your school will receive a summary of the findings.

An information sheet is attached, which outlines further information regarding the study. This research is supervised by a senior member of the Massey University staff. It has undergone peer review and received ethics approval through Massey University. If you have any further questions regarding this study, please do not hesitate to contact myself or my research supervisor.

Researcher:

Courtney Wall

wall.courtney@hotmail.com

Supervisor:

Dr John Fitzgerald

Massey University

(04) 801 5799 extn: 63620

j.m.fitzgerald1@massey.ac.nz

I understand this time of year is busy for schools and staff; however, your contribution to the cause and your participation would be greatly appreciated. If you are interested in your school and staff participating in this research, please distribute the attached documents containing the information sheet and survey access code to all staff members (teaching assistants, support workers, guidance counsellors, teachers etc.) and use the link to participate in the survey yourself.

Thank you for taking the time to read this information.

Ngā mihi nui,

Courtney Wall

Appendix E: Email to Secondary School staff members

Tēnā koe

My name is Courtney Wall. I am a student of Massey University, undertaking a research project as part of the Master of Science (Psychology) qualification. I have developed a brief survey looking at school staff's beliefs and attitudes towards Non-Suicidal Self-Injury. I am recruiting participants to take part, and your contribution would be highly valuable.

This survey is intended for any current member of staff in a New Zealand high school. It is very brief, easily accessed on all devices, involves no personal information and is strictly confidential. It will only take approximately five minutes of your time, yet your knowledge and beliefs of Non-suicidal self-injury in schools can have a great impact on the outcome of this study.

Why you should take part:

Non-suicidal Self-injury (NSSI) is the intentional, culturally unaccepted, self-inflicted, immediate and direct destruction of body tissue, absent of lethality and suicidal intent. In New Zealand NSSI it is a behaviour which has a huge impact on our taitamariki, young people. Recent studies indicate between one third and one-half of New Zealand students leaving high school have self-injured.

This research is proposed as a first step in identifying the needs of teaching staff and schools throughout New Zealand in supporting staff and students with NSSI behaviour within the school environment.
An information sheet is attached, which outlines further information regarding the study. Please note that participation in this study is strictly confidential, and answers to this questionnaire will not be linked to yourself or your place of employment in any way.

If you wish to participate in this study, please follow the link below to the online questionnaire.

https://qasiasingleuser.asia.qualtrics.com/jfe/form/SV_bjEgseQfGR40hs9

Carefully read the information at the beginning of the survey to ensure you are thoroughly informed and understand your rights as a participant. If you find the questionnaire upsetting, please do not hesitate to seek advice and/or assistance. Options could include talking to your school guidance counsellor, senior colleague or trusted friend/ family member or seeking counselling via your GP.

Thank you for taking the time to read this information.

Ngā mihi nui,

Courtney Wall

Appendix F: Blog and Education Facebook site entry

In New Zealand, research indicates up to 50% of adolescents have engaged in self-injury before the end of high school. Non-Suicidal Self-Injury (NSSI) is the intentional, culturally unaccepted, self-inflicted, immediate and direct destruction of body tissue, absent of lethality and suicidal intent. It is often a sign of psychological distress, intense emotions, maladaptive coping strategies or behavioural responses to unhealthy environments. NSSI commonly starts for individuals in the adolescent years.

Although help and support are predominantly sought through parents and peers, teachers and school staff have also been identified as those at times trusted with disclosure of NSSI. School staff are also in one of the best positions to identify possible NSSI in students. Particularly for those students who do not feel comfortable or ready to seek help and support have limited support systems.

In New Zealand, one of the places where responsibility has fallen is to schools, more specifically onto teachers and support staff, to support students with NSSI behaviour and the knock-on effect it has on being in the school environment and learning. Presently training and education in this area is on a school by school basis. This means that students and staff supporting those with NSSI behaviour who attend a school which has not had training or additional supports in place can be limited by the support and understanding they receive from staff.

I am a student of Massey University currently undertaking research for my master's thesis. I have created a brief survey which aims to take the first step in understanding NSSI beliefs, attitudes and knowledge of high school staff in New Zealand. Understanding the current knowledge, beliefs and attitudes of high school staff towards NSSI will be instrumental in supporting any future resources in schools as staff members are critical to their implementation. Research also indicates that training and experience with NSSI increases staff confidence and understanding towards students with NSSI.

I am hoping to hear from staff in a range of positions in high schools, so we hear not only the voices of the teachers but also the staff in the office, the support staff helping in the classrooms etc. NSSI is a behaviour which can be distressing for both the individual as well as those who witness and support those with the

behaviour. So, this research is more about the bigger picture and how best to support those supporting our students.

Participating involves simply completing a brief online survey which will take between five to fifteen minutes, depending on how questions are answered. No personal information is requested in this survey, answers are strictly confidential and in no way connected to individuals or their place of employment. An information sheet is attached at the beginning of the survey outlining further information for participants.

Survey link

Non-Suicidal Self-Injury Questionnaire

I can be reached on my email:

Wall.courtney@hotmail.com

Appendix G: Advertisement across the Facebook platform

Ad details

==========

Name: NSSI in Secondary Schools

Id: 23843279563890486

Target URL: https://qasiasingleuser.asia.qualtrics.com/jfe/form/SV_bjEgseQfGR40hs9

Ad content

==========

Title: New Zealand Non-Suicidal Self-Injury

Description: Do you work in a New Zealand High School? Take part in this 5-minute research survey to have your say on self-injury in our schools.

Headline: Up to 50% of New Zealand students leaving high school have self-injured.

Appendix H: Classification of Secondary School staff roles

Multiple roles were coded as the most senior position. For example, a participant who identified as a teacher and dean was classified as a dean.

Management

Principal

- School Principal, Principal and Tumuaki were categorised as Principal/ Tumuaki.

Middle Management

Deputy Principal

- Assistant and deputy principal were categorised as deputy principal

Dean

- A dean's role within a secondary school is often a role which is split between classroom teaching and additional support for students through the role of Dean. Depending on the size and structure of the secondary school; however, a dean may not have teaching responsibilities. The majority reported in this study, identified as both a teacher and dean, therefore this categorisation recognises deans as both teaching staff and middle management.

Teacher

Teacher-HOD

- Head of department was classified as teacher-HOD. This was to recognise the seniority of being head of department. It is categorised separately from dean as a dean within the secondary school environment generally has administrative and supportive roles with students within a year, gender or cultural group. A head of a department, however, is a curriculum-based leader, who has responsibilities over the staff and curriculum within the department.
- It is recognised that a head of department generally partakes in this role in addition to teaching hours and is therefore categorised within the teaching team for analysis purposes.

- HOD, Kaiako and Kaahui Ako was categorised as Teacher-HOD.

Teacher

- Specific subject teachers (e.g. biology, sports, arts, mathematics) were for this research study categorised as teachers.
- Part-time teachers were categorised as teachers for this research. The role of the teacher does not change due to part-time hours.
- Assistant Head of the department was categorised as a teacher for this research. This was due to teaching being their key role within the school.

Additional staff roles

Special Education Needs Coordinator (SENCO)

- Any role in addition to SENCO was classified as such. For example; Teacher and SENCO. This was to identify SENCO staff members, who are at times tasked with seeking or providing additional support for students needing additional assistance and presenting with emotional distress and behaviour such as NSSI.

Guidance Team

- Pastoral care, Counsellor and Guidance Counsellor was categorised within the Guidance Team for this research. This was due to the shared roles of guidance staff and pastoral care staff.
- Kāhui Ako lead has been categorised for this research within the Guidance Team category. This was due to the role a Kāhui Ako takes in supporting students within their learning pathways and themselves to help them achieve their full potential. This role is deemed to be supportive to students directly and more than an administrative role within a secondary school.

School Nurse

- School Nurse was categorised solo due to the differentiated role of a school nurse and any other member of staff.

Support Staff

- Teaching assistants, teacher support and teacher aides were coded in the overall category of support staff. This categorisation recognises roles which support staff and students within a learning setting such as a classroom and special education facilities.
- Careers advisors were categorised in the support staff role. This classification was made to recognise the role of careers advisors in supporting students directly, with contact and discussions a key part of this role. This differs from an administrative support staff who have been assessed as generally having less direct roles with students.
- Special needs co-ordinator was categorised as support staff. This categorisation was due to the direct support staff in this position give to students within a school. This was deemed to be generally on a student-level rather than administrative.

Administrative Support Staff

- Executive managers, office staff, librarian were categorised for this study as administrative Support Staff. This categorisation recognises the role of supporting the school, staff members and students within the school through more administrative roles. It is recognised that they may at times be tasked with finding support for students when they are referred to the student centre/office

Head of Boarding

- Boarding Houseparent and Head of Boarding were categorised as Head of Boarding. This was deemed to be a separate category as it is one of administration and possibly additional support for students, particularly for those students living/boarding at the school facilities.

Appendix I: Coding of open-ended responses

Years in position/education

Years in position/education rounded down. For example, 1.3 years was rounded down to 1 year. First-year teachers were documented as 0.5 years. Where non-numerical additions were added, these were coded in the following ways:

- Explanation of years in different role- years was added together
- Responses with an additional sign (+) for example, 40+ years were rounded down to the numerical value as there was no indication how much more experience there was, e.g. one year, two years.

Experience section

Exp2: If you answered yes to experience of students with NSSI, how did you become aware of this NSSI behaviour?

Categories of responses

All categories were coded on a personal staff member response basis. This meant that reports of other staff members seeing scars and referring to the participating staff member were classified as a *referral/reported from another staff member.*

- Self-disclosure from Student.
    - self-disclosure, for this research, has been categorised as verbal and behavioural self-disclosure. This is inclusive of responses such as *"student told me", "student showed me scars"* and *"student showed me cuts".*
    - Responses such as "*She told me by writing in her book"* were also deemed to be self-disclosing behaviour.
- Disclosure from another student/friend/family member
    - It is noted friend/ another student was the most reported person identified close to the individual with NSSI behaviour seeking help on their behalf. This was followed closely by a parent.

- Within this group was reports of peers/other students pointing out worrying behaviour (such as students excessively covering themselves) to members of staff. This was deemed to be other students 'reporting' of behaviour which could be linked to NSSI rather than staff members noting this behaviour under their observation.
- No other individuals or groups (apart from other staff) were identified through this item as seeking help for an individual with NSSI.

- Noticed physical signs of NSSI (marks, scratches, blood).
    - This category includes staff members reporting sightings of both recent injuries, historic physical signs (such as healing/faint scars) an item such as bandages to cover open wounds.
    - This category included instances where NSSI behaviour was directly witnessed. Such as *"Saw it happen".* This is included as the physical sign of NSSI was noticed. It is not included in the self-disclosure category for the sole reason that some individuals with NSSI behaviour may be witnessed involved in the behaviour, while others might choose to undertake the behaviour (such as cutting oneself) in-front of someone as a way of help-seeking and disclosing the behaviour. There is no way of knowing in which situation NSSI was witnessed, however.
    - It is noted that the most frequently reported physical sign of NSSI in a student was cut marks/ scars from cutting on arms/forearms. Scaring and bloody dripping/ seeping through clothing was noted as a highly reported physical sign noted by staff.
    - Some responses included how NSSI was discovered as well as the response the staff member took after this notification; for example, *"I saw one of my students with repeated scars on her legs. I talked to her about it after class."* If the response indicates staff member noticed physical signs and then the student was queried or referred, this has been categorised as *'noticed physical signs'* as it was this physical evidence of NSSI which first alerted the staff member to the behaviour.
    - This category included instances reported by staff members of noticing student *"showing off their injuries to peers"* and *'showing them to other students'.* The

behaviour is understood as a self-disclosure to friends/other students, yet not to staff members. This is the rationale for this categorisation as students/friends also did not disclose this behaviour to members of staff; this interaction was merely overseen.

- Noticed changes in behaviour and queried/ referred student
    - Within this category behaviours such as emotional outbursts, covering of arms/limbs, and excessive covering of oneself in unsuitable weather (e.g. very hot day but student covering themselves excessively).
    - An overheard conversation of death, suicide and NSSI were included in this category.
- Referral/reported from other member of staff
    - Deans have been noted as the most identified source of referrals/reports of NSSI to the guidance team.
    - Teachers were noted as the most identified source of referrals/reports of NSSI to Deans (when referrals were noted as the source of disclosure of NSSI)

Some participants answered with multiple responses due to multiple cases of student NSSI. These responses were categorised by being placed in more than one category according to the above classifications.

Appendix J: Relationship between staff training and staff attitudes and beliefs of NSSI

Appendix J

Relationship between training and staff attitudes of and beliefs about NSSI

Questionnaire statement	Strongly agree		Agree		Neither agree nor disagree		Disagree		Strongly disagree	
	Training %	No Training %	Training %	No training %	Training %	No training %	Training %	No training %	Training %	No training %
I am knowledgeable about NSSI.	38.0	2.5	48.0	29.6	12.0	24.3	2.0	36.5	0	7.1
I would feel comfortable if a student spoke to me about NSSI.	66.0	21.5	28.0	52.9	0	15.7	6.0	8.4	0	1.0
Students who engage in NSSI are just trying to get attention.	2.0	0.5	6.0	11.1	22.0	30.6	48.0	43.0	22.0	14.4
Students who self-injure with non-suicidal intent are most always girls.	0	0.3	4.0	12.9	24.0	31.9	54.0	41.0	18.0	13.2
Students who self-injure with non-suicidal intent are doing it to manipulate other people.	0	0.5	4.0	6.3	20.0	29.4	52.0	49.1	24.0	14.4
Students who self-injure with non-suicidal intent are often from middle to upper-income families.	0	0.3	6.0	12.7	26.0	42.3	42.0	36.5	26.0	8.1
Students who self-injure with non-suicidal intent often have poor communication skills.	0	0.5	10.0	10.9	16.0	31.6	48.0	45.8	26.0	10.9
Students who self-injure with non-suicidal intent often have low self-esteem.	2.0	6.1	64.0	60.8	16.0	21.5	14.0	9.9	4.0	1.5
Students who self-injure are often suicidal.	0	0	2.0	7.8	28.0	37.7	62.0	49.6	8.0	4.3
NSSI is an indicator of a mental disorder.	4.0	3.0	18.0	30.1	28.0	32.7	38.0	28.9	12.0	4.8
NSSI is an indicator of difficulties in regulating emotions.	16.0	13.4	58.0	61.5	18.0	18.0	4.0	6.1	4.0	0.8