Response to nonsuicidal self-injury: The critical role of school leaders

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Abstract

Nonsuicidal self-injury (NSSI) is a critical issue among school-aged youth, yet school staff often feel ill-equipped to appropriately respond. This is concerning as NSSI is associated with adverse mental health outcomes, including significant increased risk for suicidal behaviours. School leaders (e.g., school principals) are a central determining factor in effective school-wide response to self-injury among students, yet there is currently no existing research on their experiences of NSSI in schools and thus their perspectives are entirely unknown. Therefore, the aim of this dissertation was to explore school leaders' perspectives, current approaches and self-reported involvement in response to NSSI in schools and to determine their reported needs around training. A two-part mixed-method exploratory sequential design was used whereby principals completed semi-structured interviews (Part 1; *N*= 13) and an online survey (Part 2; *N*= 32). In Part 3, findings were combined with best-practice guidelines to pilot a professional development workshop (*N*= 40). Results showed that school leaders had frequent and recent experience and were actively involved in responding to NSSI disclosures among students; however, they demonstrated limited knowledge, held misconceptions, lacked confidence and often responded without a school NSSI protocol or training. Specific training needs were in line with participants' self-identified roles and included the need for clear guidelines, psychoeducation and information around parent disclosure. The largest identified barriers to effective response were lack of training and limited mental health resources in the community and school. Results from the training showed a positive impact on perceived knowledge and confidence with respect to NSSI response. Furthermore, participants were motivated to make system-level changes in their schools, highlighting the benefit of NSSI-specific protocols combined with training among school principals. Limitations and implications for school psychologists are discussed.

Résumé

L'automutilation non suicidaire (ANS) est un problème critique chez les jeunes d'âge scolaire, cependant le personnel scolaire se sent souvent mal équipé pour y répondre de manière appropriée. Cette situation est préoccupante, car l'automutilation non suicidaire est associée à des conséquences négatives sur la santé mentale, notamment un risque accru de comportements suicidaires. Étant en charge de décisions scolaires, les directeurs d'école sont un facteur déterminant dans la réponse efficace à l'automutilation chez les élèves. Actuellement, il n'y a pas de recherche existante sur les perceptions des directeurs d'école en matière d'ANS dans les écoles et donc leurs perspectives sont entièrement inconnues. Ainsi, le premier objectif de cette thèse était d'explorer les perspectives des directeurs d'école, leurs approches actuelles et leurs implications dans la réponse à l'ANS dans les écoles et de déterminer leurs besoins en matière de formation. Une méthode mixte en deux parties, exploratoire et séquentielle, a été utilisée. Les directeurs d'école ont répondu à des entretiens semi-directifs (*N*= 13) et à un questionnaire en ligne (*N*= 32). Les résultats d'entretiens ont été combinés avec les recommandations des meilleures pratiques pour piloter un atelier de développement professionnel pour les directeurs d'école (*N*= 40). Les résultats ont montré que les directeurs d'école avaient une expérience fréquente et récente et qu'ils étaient activement impliqués dans la réponse aux divulgations d'ANS chez les élèves. Cependant, ils ont démontré des connaissances limitées, des perceptions erronées, un manque de confiance et ont souvent répondu sans protocole ni formation sur l'ANS dans les écoles. Les besoins spécifiques en matière de formation correspondaient aux rôles que les directeurs d'école avaient eux-mêmes identifiés et comprenaient le besoin de directives claires, de psychoéducation et d'informations sur le contact avec les parents. Les principaux obstacles à une réponse efficace étaient le manque de formation et les ressources limitées en

matière de santé mentale dans la communauté et à l'école. Les résultats de la formation ont démontré un impact positif sur la perception des connaissances et de la confiance en ce qui concerne la réponse à l'ANS. De plus, les participants étaient motivés à apporter des changements au niveau du système dans leurs écoles, soulignant l'avantage des protocoles propres à l'ANS combinés à la formation des directeurs d'école. Les limites de la recherche et les implications pour les psychologues scolaires sont discutées.

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Statement of Authorship

I am the primary author of this dissertation. My doctoral supervisor, Dr. Nancy Heath (McGill University), provided assistance and consultation throughout the entire dissertation process. Dr. Cindy Finn, (Director General of the Lester B. Pearson School Board), Dr. Stephen Lewis (University of Guelph) and Dr. Jeffrey Derevensky (McGill University) served as my doctoral thesis Advisory Committee approving the dissertation's conceptual framework, methodology, and proposed statistical analyses. I was responsible for conducting the interviews and creating the online survey. I developed the NSSI training for school leaders in consultation with Dr. Nancy Heath and with the Self-Injury Outreach and Support (SiOS) team. I have received editorial support from Dr. Nancy Heath and my committee in writing the dissertation. Dr. Penelope Hasking (Curtin University) also served as a consultant. Natalie Perkins (Miami University) served as an independent researcher assisting in the qualitative analyses. Lastly, Amanda Argento, a member of the DAIR research team (McGill University) helped in the delivery of the NSSI professional development training and recruitment of participants who took part in this study.

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CHAPTER I

Introduction

Over the past decade, nonsuicidal self-injury (NSSI; e.g., self- cutting, scratching, burning, bruising of the skin) has drawn widespread attention and emerged as a significant mental health concern in schools (Hamza & Heath, 2018; Hasking, Bloom, Lewis, & Baetens, 2020; Hasking et al., 2016; Lewis & Heath, 2015; Lewis et al., 2019; Toste & Heath, 2010). This is undoubtedly related to the adolescent developmental period during which NSSI commonly begins and most frequently occurs (Garisch & Wilson, 2015; Plener et al., 2016). In a large-scale comprehensive review of the research on NSSI prevalence in nonclinical samples, it was found that approximately 1 in 5 students have engaged in NSSI (Swannell, Martin, Page, Hasking, & St John, 2014). Furthermore, there are several reports of groups of students who self-injure (i.e., socialization effects) within different school contexts, including individual classes, grade levels, and peer groups (Lewis et al., 2019; Prinstein et al., 2010; Walsh & Muehlenkamp, 2013; You, Lin, Fu, & Leung, 2013). Students who engage in NSSI report more mental health (e.g., depression, anxiety, eating disorders) and interpersonal difficulties (e.g., bullying, lower school connectedness, lower levels of social support) compared to peers who do not self-injure (Barrocas, Giletta, Hankin, Prinstein, & Abela, 2015; Garisch & Wilson, 2015; Madjar et al., 2017; Rotolone & Martin, 2012; Tatnell, Kelada, Hasking, & Martin, 2014). Perhaps of most concern is that NSSI has been found to be a reliable and unique risk factor for suicide risk (Franklin et al., 2017; Kiekens et al., 2018; Riberio et al., 2016). Inadequate responses by formal services, including schools, can hinder help-seeking among students who self-injure (e.g., through feelings of shame or fear of rejection) and can even result in further escalation of the level of self-injury (Lewis et al., 2019; Rosenrot & Lewis, 2020). Accordingly, there is a

pressing need for schools to prioritize self-injury and ensure that they are prepared to effectively manage such cases among students (De Riggi, Moumne, Heath, & Lewis, 2017; Hasking et al., 2020; Hasking et al., 2016; Heath, Toste, & MacPhee, 2014).

The current dissertation uses Bronfenbrenner's Ecological Systems Theory (EST) as a theoretical framework. Bronfenbrenner (1977) defined EST as the study of the multiple interconnected environmental systems that influence individual development, which for youth includes the school environment (Bronfenbrenner, 1977). Schools are ecological service systems and there is strong evidence of the importance of the school climate in influencing student mental health and supporting health promotion (Aldridge & McChesney, 2018; Kratochwill et al., 2012; Short, 2016). Implementing an EST framework in schools can help provide effective mental health services by addressing systemic issues and increasing the capacity of the school system to address the needs of all students (Burns, Warmbold-Brann, & Zaslofsky, 2015; Gutkin, 2012). Indeed, using an EST framework to effectively manage NSSI in schools has been recommended by experts in the field through the development of a school NSSI protocol with clearly articulated roles for all staff (e.g., teachers, mental health professionals, principals) and professional development training around how to identify and respond to self-injury within schools (De Riggi et al., 2017; Hamza & Heath, 2018; Hasking et al., 2020; Hasking et al., 2016; Heath & Toste, 2009; Lewis et al., 2019; Lieberman, Heath, & Toste, 2009; Walsh & Muehlenkamp, 2013). The use of a collective school-wide protocol and training for school staff increases the likelihood that school staff will recognize warning signs, increase knowledge and skills in responding, and improve the consistency of care provided to youth who self-injure (Groschwitz, Munz, Straub, Bohnacker, & Plener, 2017).

Despite major advances in research and increasing clinical awareness of NSSI among students over the past decade, there is evidence that school systems continue to feel underprepared, lack understanding and are struggling to intervene when NSSI is suspected or confirmed (e.g., disclosed by peers, recognized by teachers; Pierret, Anderson, Ford, & Burn, 2020). Contributing to this problem is that school staff report working in schools that do not have specific protocols for responding to students who self-injure (Berger, Hasking, & Reupert, 2015; Crowe, Townsend, Miller, & Grenyer, 2020; Duggan, Heath, Toste, & Ross, 2011; Garisch, Robinson, & Wilson, 2020). As a result, responses to student NSSI has been inconsistent between and within schools (Berger, Hasking, & Reupert, 2014b; Hasking et al., 2020; Lewis et al., 2019; Matthews, Townsend, Gray, & Grenyer, 2021). Furthermore, school staff report having received little education regarding NSSI and many have never received any training in this regard (Berger, Hasking, & Reupert, 2014a; Berger, Hasking, & Reupert, 2014b; Berger, Reupert, & Hasking, 2015; Duggan, Heath, Toste, & Ross, 2011; Heath, Toste, & Beettam, 2006; Kelada, Hasking, & Melvin, 2017). Inadequate knowledge and a lack of training can contribute to inappropriate responses to disclosures and inadequate referral, follow-up, and intervention (De Riggi et al., 2017; Hasking et al. 2016; Hamza & Heath, 2019). These findings highlight a significant research to practice gap in what school staff know and how schools are managing self-injury when it is discovered at school. Therefore, there is a critical need to ensure that schools are prepared to identify and respond appropriately to students engaging in NSSI.

Researchers have demonstrated that the effectiveness of mental health prevention and intervention activities in schools are directly linked to the role played by the school principal (Adams & Olsen, 2017; Anyon, Nicotera, & Veeh, 2016). As school leaders, principals establish foundations for quality, consistency, and sustainability in school mental health (School Mental

Health ASSIST, 2013). In fact, the Education Act in Québec outlines that school principals must ensure that all educational services at the school meet proper standards of quality (Ministère de l'Education du Québec [MEQ], 2020). In the absence of school-based services for students (e.g., health, social services) principals have an obligation to seek out such services. Hence, the decision to prioritize professional development for NSSI typically occurs at administrative and systems levels. Accordingly, international lead researchers and clinicians in the field suggest that a key factor in prioritizing NSSI in schools is to obtain support from school principals (e.g., Lewis et al., 2019; Hasking et al., 2020). Consistently, reports from school staff suggest that principals play a key role in shaping the context of NSSI services and practices in schools and are a critical variable in facilitating or impeding such services (Berger et al., 2014b; Groschwitz et al., 2017; Roberts-Dobie & Donatelle, 2007). However, to date, no study has specifically examined school leaders, and thus their understanding and beliefs around NSSI in schools and their training needs remains unknown.

Dissertation Aim, Study Design and Outline

The overarching aim of this dissertation was to address the gap in the literature on NSSI response in schools by exploring school leaders' perspectives on school response to self-injury among students. Specifically, the first objective was to qualitatively explore school leaders' perspectives, self-reported involvement in response to NSSI in schools and to determine their reported needs around NSSI professional development training. The second objective was to quantitatively provide a broader investigation of school leaders' perspectives, self-reported involvement in response to NSSI in schools and to determine their reported needs around NSSI professional development training. To achieve these two objectives, a two-phase exploratory sequential mixed-method framework was utilized, whereby qualitative semi-structured

interviews were conducted among school leaders (Part 1) and used to drive the development of a quantitative survey used to conduct a broader investigation among school leaders across Québec (Part 2). The third objective was to compile observed knowledge gaps, self-identified training needs, and training delivery preferences. These findings were combined with a review of the literature and best practice guidelines in order to develop, pilot, and evaluate a professional development workshop for school leaders (Part 3). This was a central component of the dissertation as professional development and training for school staff is critical in creating change within the school system and ensuring an effective response to self-injury in schools.

This dissertation is written in accordance with McGill University's Graduate and Postdoctoral Studies thesis guidelines. Chapter 1 provides an introduction to the dissertation. Chapter 2 provides a comprehensive review of the literature on understanding NSSI among school-aged youth, outlines best-practice guidelines on responding to self-injury in schools, explains the rationale for examining school leaders' perspectives, and ends with an overview of the research objectives. Chapter 3 provides a description of the research design and data analytic plan. Chapter 4 describes the methodology and results of the qualitative component of the dissertation (Part 1). Chapter 5 provides the methodology and results of the quantitative component of the dissertation (Part 2). In chapter 6, the research design, methodology and results of the professional development training (Part 3) are presented. Finally, chapter 7 concludes with a summary of the integrated findings and discussion of the implications of the research.

Please note that language used to discuss NSSI in this dissertation is in accordance with the recent recommendations proposed by Hasking and colleagues (2021). These recommendations highlight the need to move away from medical, deficits- and disease-based language (e.g., "self-injurers", "cutters", "contagion") to more respectful and person-centered

discourse when speaking of individuals who self-injure (Hasking, Boyes, & Lewis, 2021). Individuals with a history of self-injury already experience a significant level stigma (Burke, Piccirillo, Moore-Berg, Alloy, & Heimberg, 2019). Using stigmatizing language perpetuates myths and misunderstandings about self-injury (e.g., people who self-injure do not deserve help) which may invalidate the person with lived experience, further alienate them and negatively impact help-seeking (Hasking, Boyes, & Lewis, 2021; Lewis, 2017). More appropriate terminology includes: someone with lived experience, someone with a history of NSSI, recovery from NSSI, on-going NSSI, recurrence of NSSI and coping phrases (Hasking et al., 2021). It is also recommended that a value-laden framing is adopted rather than "maladaptive coping", which can be pejorative and counterproductive when fostering incentives to learn alternate ways of coping (Hasking, Lewis, & Boyes, 2019). These recommendations were developed in order to help researchers and service providers be mindful of the language used when speaking about people who self-injure, and ensure that we adopt a de-stigmatizing and empathetic approach that may facilitate help-seeking for people wishing to reduce their self-injury.

Contribution to Original Knowledge

This dissertation demonstrates original scholarship and is a significant and important contribution to the field of NSSI and school response. Schools are uniquely positioned to respond to student mental health concerns (Hasking et al., 2016; Short, 2016). While there have been significant advances made over the past decade, much of what is known around NSSI response is only beginning to be translated into the school context and many schools remain uninformed (e.g., De Riggi, Moumne, Heath, & Lewis, 2017; Lewis et al., 2019). In an effort to help bridge the research to practice gap, this research program consists of three distinct parts which solely focus on the experiences of school leaders, a needed contribution as the attitudes

and beliefs held by school leaders can substantially influence the direction of schools in terms of NSSI management. School leaders that understand the importance of addressing NSSI among students can ensure that best-practices are implemented in their schools, including the use of school-wide protocols, and can prioritize professional development for all staff, increasing the likelihood of positive outcomes for students who self-injure.

CHAPTER II
Review of the Literature

This chapter comprises a review of the literature that is relevant to NSSI in schools. In order to provide an understanding of NSSI among youth, an operational definition of NSSI is stated. Empirical research is then presented on prevalence rates, ages at onset, gender differences, reasons why students may engage in self-injury, risk factors, co-morbid mental health difficulties, and the association between NSSI and suicidal behaviours. Next, an overview of best-practice guidelines on effective response to NSSI in schools is provided within an Ecological Systems Theory (EST) framework. The role of the school leader and what is currently known around NSSI and school staff knowledge is reviewed in greater detail and gaps in the literature are identified. The chapter concludes by outlining the research objectives of the current dissertation.

Defining NSSI

Nonsuicidal self-injury (NSSI) is defined as the direct and deliberate damage to one's own body tissue without suicidal intent, and commonly includes behaviours such self-cutting, burning, head-banging, and severe scratching (International Society for the Study of Self-Injury [ISSS], 2018). By definition, NSSI excludes tattooing and body piercing as these behaviours are deemed socially acceptable. Further, NSSI differs from deliberate self-harm (DSH), a broader term that does not distinguish whether suicidal intent is present and includes indirect forms of self-harm such as substance use (Duarte et al., 2020). NSSI is also distinct from self-injurious behaviours (SIBs), such as stereotypic and repetitive behaviours seen among youth with developmental disorders, and instead often occur in typically developing youth (Klonsky,

Muehlenkamp, Lewis, & Walsh, 2011). Consistent with many conceptualizations in the field, this research focuses on NSSI that occurs among typically developing youth.

Prevalence and Onset

Prevalence studies within community samples indicate that rates of NSSI are highest among adolescents with approximately 12% to 28% of adolescents having engaged in NSSI (Baetens, Claes, Muehlenkamp, Grietens, & Onghena, 2011; Garisch & Wilson, 2015; Ross & Heath, 2002; Muehlenkamp, Claes, Havertape, & Plener, 2012). The variation in prevalence rates likely stems from differences in study settings (e.g., community versus clinical) and types of methodologies used by researchers (e.g., checklist, single item, or open-ended questions). Specifically, higher rates are typically reported in studies using a clinical sample of participants, a broader definition of NSSI (e.g., inclusion of nail biting and picking at wound) and a checklist method rather than open-ended questions (Nock, 2010). In a recent large-scale comprehensive review of the research on NSSI prevalence, it was found that the average prevalence of NSSI among adolescents across studies was 17% (Swannell et al., 2014). This finding suggests that approximately 1 out every 5 adolescent students have engaged in NSSI at least once. Research among NSSI in school-aged children is sparse, yet preliminary studies indicate that as many as 8% of pre-adolescents (ages 10-14; Barrocas, Hankin, Young, & Abela, 2012; Hankin & Abela, 2011) have been also been found to engage in self-injury. Bem and colleagues (2017) recently pointed out the presence of NSSI in children as young as six (Bem, Connor, Palmer, Channa, & Birchwood, 2017).

Engagement in NSSI commonly begins in early to mid-adolescence, at 11-14 years of age (Hankin & Abela, 2011; Heath, Toste, Nedecheva, & Charlebois, 2008). Indeed, when students are asked to retrospectively report when they first started engaging in self-injury, most students

report the early adolescent years are when they first tried the behavior (Whitlock et al., 2011). In one longitudinal study, the rate of NSSI engagement doubled as youth entered the adolescent years (13 years of age and above; Hankin & Abela, 2011). Of note, although early adolescence is when NSSI typically has its onset, research has shown that late adolescence and early adulthood also represent periods of increased risk for NSSI engagement (Heath et al., 2008; Whitlock et al., 2011). Therefore, an important consideration relevant to schools is that transition periods (e.g., from elementary to high school or high school to university) may be especially critical periods for NSSI prevention and intervention.

Gender Differences

Studies examining gender differences within community samples of youth who engage in NSSI have been inconsistent. NSSI has often been documented as more common among adolescent girls than boys (e.g., Muehlenkamp, Williams, Gutierrez, & Claes, 2009; Nixon, Cloutier, & Jansson, 2008; Plener et al., 2016; Ross & Heath, 2002). Yet, some studies report no gender differences in adolescent prevalence rates (e.g., Baetens et al., 2011; Muehlenkamp & Gutierrez, 2004). In a longitudinal study examining the effect of gender and age on NSSI engagement, Barrocas and colleagues (2012) found no gender differences in the lifetime prevalence rates of NSSI among children in late childhood and early adolescence (Grades 3 and 6), yet found that girls were more likely to engage in NSSI than boys as they reached mid-adolescence (Grade 9) (Barrocas et al., 2012). Moreover, the gender difference in prevalence observed in adolescence appears to diminish by young adulthood, with comparable rates between by young adulthood (Heath et al., 2008; Serras, Saules, Cranford, & Eisenber, 2010; Whitlock et al., 2011). Therefore, developmental periods may partly explain these mixed findings.

Mixed findings of NSSI behaviours among adolescent girls and boys may reflect a number of concerns. One consideration is the reluctance among adolescent boys to report self-injury (Bresin & Schoenleber, 2015; Heath, Schaub, Holly, & Nixon, 2009). Another consideration is that past measures of NSSI have primarily assessed cutting and scratching behaviours (Heath et al., 2009; Klonsky & Glenn, 2009) that are more commonly reported among girls on areas such as the arms and legs, whereas boys are more likely to report self-burning, punching or hitting on the chest and face or an object such as a wall (Andover, Primack, Gibb, & Pepper, 2010; Bresin & Schoenleber, 2015; Claes et al., 2010; Heath et al., 2008; Sornberger, Heath, Toste, & McLouth, 2012; Whitlock et al., 2011). These key differences in location and mode of self-injury among boys may have previously been overlooked or classified as behaviourally different from NSSI (Sornberger et al., 2012). Notably, much of past work conflates sex (i.e., female or male) and gender (i.e., girl or boy) and therefore marginalises gender variant groups.

In general, individuals of gender and sexual minority groups may be more at risk for engaging in self-injury compared to heterosexual and/or cisgender individuals (with transgender and bisexual populations being at greatest risk; Testa et al., 2016) due to stigma, discrimination, victimization and prejudice related to their minority status. In a study of 286 transgender youth 46.3% reported having previously engaged in NSSI and 29% reported current engagement (Arcelus et al., 2016). A limitation of most NSSI studies is that they approach gender differences with an exclusively binary lens. This is problematic both empirically and clinically as it assumes that the issues faced by binary and non-binary individuals are largely the same; similar to how studies on LGBTQ+ populations often fail to address the differences between LGB and T populations. Although one preliminary study found no significant differences in the likelihood of

engaging in NSSI between transgender youth identifying as binary and those who identify as non-binary, non-binary youth were significantly more at risk of developing anxiety, depression, and low self-esteem (Thorne et al., 2019). This may reflect even greater discrimination and barriers faced by youth whose identity falls outside of the societal binary gender norm among both cis- and transgender individuals. There is consequently a need for more research to support and understand the unique needs of non-binary youth, which in itself is a diverse group of various different gender identities and expressions.

Motivations for Engaging in NSSI

In the past, NSSI was often regarded as a form of attention-seeking behaviour, or misconstrued as a suicidal attempt (Best, 2006; Carlson, DeGeer, Deur, & Fenton, 2005). Major advances in research have been made around the underlying motivations for NSSI among students (Chapman et al., 2006; Hamza & Willoughby, 2015; Klonsky & Glenn, 2009; Nock & Prinstein, 2005, 2004). Research findings and theory suggest that NSSI is most often used as a coping behaviour to reduce, manage or escape from underlying emotional pain (e.g., distress, anxiety, negative self-views; Hamza & Willoughby, 2015; Klonsky, 2007; Klonsky & Glenn, 2009). In fact, emotion regulation is the most documented function of NSSI and difficulties and the most empirically supported precursor to NSSI initiation (e.g., Andover & Morris, 2014; Klonsky, 2007). Literature on the neuro-biological correlates of NSSI through imaging, psychophysiological studies and exploration of neurotransmitter activity in individuals who engage in NSSI further supports the notion that NSSI is primarily used to down-regulate aversive emotions (Groschwitz & Plener, 2012; Plener, 2019). Other intrapersonal motivations include self-directed anger or self-hatred, self-criticism, self-punishment, reducing feelings of numbness

or dissociation, to generate a feeling when feeling emotionally empty, and averting suicidal impulses or urges (Klonsky, 2007; Nock & Prinstein, 2004).

Although less common, there is growing consensus in the literature to acknowledge the role of social functions and factors of NSSI. In some cases, students report that NSSI serves to reduce overwhelming social or interpersonal distress (e.g., to obtain help or support, to fit in with peers, to get others to leave them alone; Hamza & Willoughby, 2015; Klonsky & Glenn, 2009; Nock, 2010; Turner, Chapman, & Layden, 2012; Zetterqvist et al., 2013). Specifically, it is theorized that youth who engage in NSSI habituate themselves to turning difficult emotions inward rather than communicating their difficulties outward, and use self-injury as a means to manage emotional pain resulting from interpersonal problems (Andrews, Martin, Hasking, & Page, 2014). Social functions of NSSI are characterized by perceived deficits in social support from others in one's environment. Compared to peers who do not self-injure, adolescents who engage in NSSI report higher levels of alienation, lack of connectedness to peers and family and higher levels of conflict (Hamza & Willoughby, 2013; Khan & Kausar, 2020; Muehlenkamp, Brausch, Quigley, & Whitlock, 2013; Taliaferro & Muehlenkamp, 2015; Whitlock, Prussien, & Pietrusza, 2015). Notably, students who engage in NSSI have been found to have difficulties with communication, help-seeking behaviour and resolving interpersonal problems compared to peers who do not self-injure (e.g., Claes et al., 2010; Nock & Mendes, 2008). Furthermore, there is evidence that online NSSI activity is in part driven by social motivations, including seeking support, connecting, and disclosure (e.g., Brown, Fischer, Goldwhich, & Plener, 2020; Lewis & Seko, 2016). In a study on Internet use among adolescents (N=142), participants with recent engagement in NSSI reported higher levels of online social support-seeking (and sharing NSSI content) compared to adolescents with a history of NSSI or no lifetime engagement in self-injury

(De Riggi, Lewis, & Heath, 2016). These findings are consistent with the notion that NSSI primarily serves as an emotion regulation strategy used to regulate intrapersonal and interpersonal distress and is reflective of attempts to cope with overwhelming distress (Hasking, Whitlock, Voon, & Rose, 2017; Klonsky & Glenn, 2009; Muehlenkamp et al., 2013; Nock & Prinstein, 2004; Zetterqvist et al., 2013).

Irrespective of underlying motivations, research shows that at least one third of youth conceal their engagement in NSSI (e.g., from friends, family and formal sources of support) and do not tell anyone (Armiento, Hamza, & Willoughby, 2014; Hasking, Rees, Martin, & Quigley, 2015; Heath, Baxter, Toste, & McLouth, 2010; Rosenrot & Lewis, 2020; Simone & Hamza, 2020; Turner, Cobb, Gratz, & Chapman, 2016). In a qualitative study on barriers to NSSI disclosure, individuals who self-injure identified feeling intense shame around behaviour and concern regarding the impact of disclosure on others (e.g., did not want to burden friends or family) (Rosenrot & Lewis, 2020). Other barriers to NSSI disclosure include the fear of negative reactions (e.g., trivialization and judgement), further stigmatization (e.g., labelled as attention-seeking), as well as fear of being misunderstood or embarrassed (Fortune et al., 2008; Klineberg, Kelly, Stansfeld & Bhui, 2013; Long, 2018; Wadman et al., 2018) and feelings of unworthiness (e.g., Rodham et al., 2016; Sheehy et al., 2019). As such, youth who self-injure are often reluctant to seek help due to fear of the possible repercussions that would transpire if their private behaviour became public knowledge (Armiento et al., 2014; Long, Manktelow, & Tracey, 2015; Rosenrot & Lewis, 2020). When adolescents were asked about how NSSI could best be prevented in schools, self-injuring adolescents noted that being able to talk about NSSI with a non-judgmental individual served as an important first step (Berger et al., 2014). Accordingly, it is important that staff demonstrate a “respectful willingness to listen in a non-

judgmental fashion" (Lieberman, Toste, & Heath, 2009, pg. 205) and remain calm when NSSI is shared or discovered.

Co-Occurring Mental Health Difficulties

For many years, NSSI was seen primarily as a symptom of borderline personality disorder (BPD; e.g., Zetterqvist, 2015). A number of scholars have challenged this view and provided evidence that NSSI is not a behaviour endorsed exclusively by individuals who have a psychiatric diagnosis of BPD. In fact, in community samples of youth who self-injure the majority do not meet diagnostic criteria for BPD (Muehlenkamp, Ertelt, Miller, & Claes, 2011; Nock, 2010; Swannell et al., 2014). Nevertheless, mental health challenges are common among youth who engage in NSSI and many experience some degree of underlying distress or impairments in their life- whether social, emotional, and/or academic (Burke, Ammerman, Hamilton, Stange, & Piccirillo, 2020; Kiekens et al., 2016; Nock, 2010). In both community and clinical settings, researchers have demonstrated that self-injury most often co-occurs among youth who struggle with emotion regulation (e.g., Hasking, Whitlock, Voon, & Rose, 2017; McKenzie & Gross, 2014), which is also a core diagnostic criterion for various mental health difficulties (American Psychiatric Association, 2013). Certain comorbid psychiatric disorders that have been found to co-occur with NSSI and include mood disorders (e.g., depression, dysthymia), anxiety disorders (e.g., post-traumatic stress disorder), eating disorders (with higher risk among those diagnosed with bulimia), and substance abuse (Claes et al., 2015; Ford & Gómez, 2015; Jacobson, Muehlenkamp, Miller, & Turner, 2008; Muehlenkamp, Brausch, & Washburn, 2017). Importantly, however, even though NSSI has been associated with mental health difficulties, self-injury does not necessitate the presence of any particular psychological

diagnosis and oftentimes, these diagnoses are not appropriate for the majority of youth who engage in NSSI (Klonsky et al., 2011; Lewis & Heath, 2015; Walsh, 2012).

Risk Factors

As previously stated, NSSI does not necessitate the presence of any particular psychological diagnosis and is not an inevitable symptom of an underlying mental health disorder (e.g., Klonsky et al., 2013; Lewis & Heath, 2015; Walsh, 2012). However, students who engage in NSSI often experience mental health difficulties that have a significant impact on academic, social and interpersonal functioning. Compared to peers who do not self-injure, adolescents who do self-injure report more negative emotions, depressive symptoms, anxiety, self-criticism, hopelessness and lower levels of body satisfaction, self-esteem, self-worth (e.g., Bresin, Carter, & Gordon, 2013; Gong et al., 2019; Heath, Carsley, De Riggi, Mills, & Mettler, 2016; Hankin & Abela, 2011; Rotolone & Martin, 2012). Moreover, students who engage in NSSI report lower levels of social support, school connectedness and more difficulties with friends (e.g., Garisch & Wilson, 2015; Hasking, Rees, Martin, & Quigley, 2015; Rotolone & Martin, 2012). Being bullied by peers or victimized in school environments has also been directly identified as a risk factor for engaging in NSSI in adolescence (Esposito, Bacchini, & Affuso, 2019; Klomek et al., 2016; Noble, Sornberger, Toste, Heath, & McLouth, 2011). While a number of studies indicate that NSSI seems to be elevated by the experience of adverse childhood events (e.g., Muehlenkamp, Kerr, Bradley, & Larsen, 2010), Thomassin and colleagues (2016) found that only child emotional abuse remained significantly associated with NSSI when different types of adverse childhood experiences were analyzed simultaneously. Further, in a review by Brown and Plener (2017), childhood sexual and physical abuse showed much weaker evidence as risk factors for NSSI (Brown & Plener, 2017). Many youth who

engage in NSSI report that they come from loving and caring families, yet report lower parent relationship quality, including family dysfunction, high levels of alienation, attachment difficulties, frequent parental criticism, conflict, loss and childhood abuse (Garisch & Wilson, 2015; Muehlenkamp et al. 2013; Tatnell et al., 2014). Furthermore, many adolescents who engage in NSSI report frequent difficulties communicating their emotions with their parents (Crowell et al., 2013). Although lack of support has been related to the onset of NSSI (e.g., Brausch & Gutierrez, 2010), family support has been found to facilitate the cessation of self-injury (Rotolone & Martin, 2012).

Overall findings suggest that students who engage in NSSI are at heightened risk for intrapersonal and interpersonal distress. School staff should have an understanding of NSSI risk factors, including school-related factors, in order to identify students at risk and support those who are already self-injuring. Positive responses to NSSI disclosures among students that have been highlighted in existing literature include and providing emotional support and encouraging the individual to seek formal support (Ammermann & McCloskey, 2021; Heath et al., 2009; Nielsen & Townsend, 2018). Thus, having school staff who convey support and acceptance can act as a protective factor for youth who experience mental health difficulties and can increase well-being and success in school.

NSSI and Suicidal Behaviours

The association between NSSI and suicidal behaviours (e.g., suicidal attempt) is complex and frequently misunderstood. The misunderstandings around the distinction between the two behaviours occurs just as frequently in clinical practice and entails improper treatment and therefore it is important to understand the distinction (Halicka & Kiejna, 2018). NSSI and suicidal behaviours can be distinguished on the basis of their underlying motivations. For

example, underlying motivations for suicidal behaviours include to end one's life and to end one's level of psychological pain, whereas NSSI motivations refer more typically to affect regulation, self-punishment, and cessation of dissociative experiences (Klonsky, 2007; Lewis & Heath, 2015; Walsh, 2012). For some individuals, NSSI is a way to decrease and avoid suicidal urges (Klonsky & Muehlenkamp, 2007; Zetterqvist, Lundh, Dahlström, & Svedin, 2013). NSSI and suicidal behaviours are also typically distinguished by their severity. Specifically, whereas suicide is highly lethal and requires medical attention, NSSI has low lethality and rarely requires medical attention (Halicka & Kiejna, 2018; Muehlenkamp, 2005; Nock & Favazza, 2009).

Although identified in current literature as distinct, NSSI and suicidal behaviours are often interconnected. There is strong evidence that NSSI is a risk factor for suicidal behaviour and often co-occurs among youth (Griep & MacKinnon, 2020; Guan, Fox, & Prinstein, 2012; Hamza, Stewart, & Willoughby, 2012; Klonsky, May, & Glenn, 2013; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). In fact, youth who engage in NSSI may be 2-4 times more likely to experience suicidal thoughts and behaviours compared to their peers, even when other mental health disorders (e.g., major depressive disorder, generalized anxiety disorder) are controlled (Guan et al., 2012; Hamza & Willoughby, 2016; Kiekens et al., 2018). Therefore, although NSSI is not a suicide attempt, engaging in NSSI may indicate that a student is experiencing suicidal ideation or behaviours, or may in the future.

Several researchers have suggested that NSSI and suicidal behaviours exist along a continuum of self-harm behaviours, with NSSI at one extreme and completed suicide at the other extreme (Brausch & Gutierrez, 2010; Singh, Kunnavil, & Thyloth, 2017). A recent review of the literature indicates that there is in fact a potent gateway effect whereby NSSI precedes suicidal attempts (Griep & MacKinnon, 2020) and increases the risk of transitioning from suicide

ideation to suicide attempt (Kiekens et al., 2018). The experience of emotional distress and the experience of inflicting pain on oneself are two important risk-factors believed to reduce the inhibition to suicide if someone is thinking about ending their life (Joiner, Ribeiro, & Silva, 2012). Despite what literature has already identified, it is still uncertain as to who will progress from the non-suicidal to suicidal behaviour (Park & Ammerman, 2020). As such, there is a need to implement suicide risk assessments among students who engage in NSSI.

Best-Practice Guidelines for NSSI in Schools: An Ecological Systems Approach

Bronfenbrenner (1992) defined Ecological Systems Theory (EST) as the study of the multiple interconnected environmental systems that influence individual development. To understand the child, psychologists must fully examine the environment in which the child lives (Bronfenbrenner, 1992). Beyond the home, schools are among youths' microsystems, their most immediate developmental contexts and how youth perceive their school environment can greatly influence their development, emotional well-being and ability to cope (Gutkin, 2012). Indeed, there is strong evidence of the importance of the school climate in influencing student mental health and supporting health promotion (Aldridge & McChesney, 2018). Furthermore, there has been a push to move school psychology practice from a medical model, in which the source of student difficulties is believed to be inherent within the child, toward an ecological approach that interprets student difficulties as a breakdown between the individual student and the contexts in which they function (e.g., Sheridan & Gutkin, 2000). Schools play a key role in delivering services related to positive mental health and a comprehensive school mental health framework involves a whole school approach (Centre of Excellence for Mental Health [CEMH], 2020).

Using an EST approach in schools has been demonstrated by effectiveness of school NSSI protocols (Hasking et al., 2015; Hasking et al., 2020). A school NSSI protocol helps to

ensure an informed, collaborative and consistent response to self-injury among students and can also promote confidence among school staff in situations that they may find uncomfortable or unable to manage. Several authors have offered guidelines for schools around developing policies for identifying and responding to NSSI in schools (e.g., Berger et al., 2015; De Riggi et al., 2017; Hamza & Heath, 2018; Hasking et al., 2020; Hasking et al., 2016; Matthews et al., 2021). The key elements that have been identified in the literature include: (1) aims of the protocol; (2) information about NSSI; (3) clearly outlined roles and responsibilities of all staff for identifying and responding to NSSI (e.g., establishing a point person and/or team to coordinate case management); (4) policies to guide risk assessment (i.e., by school mental and/or medical health professional); (5) guidelines for appropriate referral (e.g., internal vs. external services); (6) guidelines for parent/guardian notification and involvement; (7) how to manage socially influenced NSSI among groups of students (e.g., school and peer communication); (8) and finally, there should be acknowledgement that the protocol will be reviewed annually or biannually to meet current evidence-informed practice (see Table 1 for description of key elements to include in school NSSI policy). Some literature has also included information on responding to students showing scars or wounds (e.g., Hasking et al., 2016; Lewis et al., 2019) and provides school mental health professionals with guidelines to assess and intervene with students around NSSI activity online (e.g., Duggan, Heath, Lewis, & Baxter, 2012; Lewis, Heath, Michal, & Duggan, 2012; Mahdy & Lewis, 2013).

While a school NSSI protocol may share similar elements to school suicide protocols, it is recommended that the school NSSI protocol be separate and specific to NSSI (e.g., Hasking et al., 2016; Lewis et al., 2019). As mentioned by Hasking and colleagues (2016), conflating NSSI and suicide policies can have damaging impact for the student, his or her family members and

school staff. For example, although suicide-focused policies indicate sending a student at high suicide risk directly to a hospital for emergency intervention, this is rarely warranted for NSSI and may decrease the likelihood that a student who self-injures seeks assistance when injuries are in need of medical attention (Hasking et al., 2016). Having a school NSSI protocol not only ensures that NSSI is effectively addressed, but also makes self-injury prevention and intervention significant priorities in schools.

In order for any school protocol on NSSI to be effective, there is strong agreement among researchers and clinicians that everyone within the school must understand their role and be able to initiate the protocol procedures as necessary (Hamza & Heath, 2018). School staff (e.g., teachers, principals) are most likely to identify students who self-injure and are often the first point of contact (Glennon, Viola, & Blakely, 2020; Hasking et al., 2016; Heath, Toste, Sornberger & Wagner, 2011; Toste & Heath, 2010). In fact, it is much less common for the school mental health professional to be the first point of contact. This may be due to a shortage of school psychologists, or limited availability as school psychologists often cover over multiple schools and hold a variety of responsibilities and roles (National Association of School Psychologists [NASP], 2017). Furthermore, students are less likely to disclose NSSI to formal sources of support (Heath et al., 2010; Rosenrot & Lewis, 2020; Simone & Hamza, 2020). Thus, in keeping with an ETS framework, all school-based professionals, including school leaders, require specific training regarding how to identify and respond to NSSI (Berger et al., 2014b; De Riggi et al., 2017; Heath, et al., 2011; Hamza & Heath, 2018; Hasking et al., 2016; Lewis et al., 2019; Walsh 2012). Learning objectives for NSSI training among school staff should include increased knowledge and awareness of NSSI, recognition of potential warning signs and risk factors, knowledge of how to respond to students who self-injure, strategies for utilizing a team

approach, guidelines for parent contact and disclosure, strategies for talking to students in a calm and respectful manner, and information for peers (Glennon et al., 2020; Hasking et al., 2020; Lewis et al., 2019).

As previously noted, many youth who self-injure conceal their self-injury, often out of fear of receiving negative reactions (Armiento, Hamza, & Willoughby, 2014; Hasking, Rees, Martin, & Quigley, 2015; Heath, Baxter, Toste, & McLouth, 2010; Rosenrot & Lewis, 2020; Simone & Hamza, 2020; Turner, Cobb, Gratz, & Chapman, 2016). Poor responses to NSSI can have detrimental effects on students who self-injure, such as exacerbating feelings of isolation and stigma, reluctance to seek support and can even increase the chance of engaging in self-injury again and have the potential of developing into suicidal behaviours (De Riggi et al., 2017; Hasking et al., 2016; Manktelow & Tracey, 2015; Muehlenkamp et al., 2010; Rosenrot & Lewis, 2020; Toste & Heath, 2010; Walsh 2012; Simpson et al., 2010). Therefore, it is imperative school staff are trained and equipped to respond to disclosures effectively. Overall, using an EST approach to address NSSI in schools, through school policies for responding to NSSI, together with training for school staff in the area can encourage an informed and collaborative response to self-injury in schools, promote self-confidence among staff and increase the well-being of students who self-injure.

The Role of the School Leaders

Previous works indicate that an NSSI protocol and training is needed in helping schools support students who self-injure (Berger et al., 2015); however, a central determining factor in effective school-wide response (i.e., ecological-systems response) hinges on school leadership. School leaders (e.g., school principals and vice-principals) make crucial decisions related to whether and how school staff members prioritize mental health services, the selection of school-

based services that maximize school mental health and the types of functioning and training school staff are provided (e.g., Han & Weiss, 2005; Lyon et al., 2018; Short, 2016). The attitudes and beliefs held by these individuals can therefore substantially influence the direction of schools in terms of NSSI management. Accordingly, international lead researchers and clinicians in the field suggest that a key factor in prioritizing NSSI in schools is to obtain support from school leaders (Lewis et al., 2019; Hasking et al., 2016). Yet, there is no existing research on the perspectives of school leaders on NSSI in schools.

School staff have also reported that principals play a key role in shaping the context of NSSI practices in schools (Berger et al., 2014; Groschwitz et al., 2017; Roberts-Dobie & Donatelle, 2007). In a study by Roberts-Dobie and Donatelle (2007), school counselors were surveyed and identified a lack of protocols on self-injury and a need for school principals to be more informed on the topic. Participants also noted that support and cooperation from school administrators would help alleviate barriers to successful NSSI response (Roberts-Dobie & Donatelle, 2007). Consistent with this, in a study by Berger and colleagues (2015) school staff, including teachers and mental health professionals, were asked to review the suitability of a school NSSI protocol. While participants acknowledged the utility of the protocol, they felt that it could only be implemented and effective if there was commitment from higher administrative staff (Berger et al., 2015). Most recently, Groschwitz and colleagues (2017) evaluated a workshop on NSSI and suicidality in adolescents among a German sample of teachers, school social workers and school psychologists. Overall, confidence and perceived knowledge improved significantly after the workshop and at 6-month follow-up, particularly for individuals with less experience in the field of NSSI (Groschwitz et al., 2017). However, school staff reported more

behavioural change on an individual level than on a school level, which they attributed mainly to lack of support from school administration (Groschwitz et al., 2017).

Research to Practice Gap

Despite a growing body of research and clear guidelines in the literature around best-practices in responding to self-injury in schools, the majority of school staff report having only superficial knowledge about NSSI and feel ill-equipped to respond to students who self-injure (Berger et al., 2014a; Berget et al., 2015; Carlson et al., 2005; Duggan, Heath, Toste, & Ross, 2011; Heath et al., 2011; Kelada, Hasking, & Melvin, 2017; Roberts-Dobie & Donatelle, 2007). Unfortunately, as many as 80% of school staff report that they have never received any formal training or education on NSSI (Berger, Hasking, & Reupert, 2014; Berger, Reupert, & Hasking, 2015; Carlson et al., 2005; Duggan, et al., 2011; Heath, Toste, & Beettam, 2006). Furthermore, most school staff in Canada report that their respective schools lack protocols for responding to cases of NSSI, or are unaware if their school has a protocol in place (Duggan et al., 2011). Thus, there is a substantial research-to-practice gap in what school staff know and how schools are addressing the behaviour.

Although school staff feel uninformed and underprepared to respond to student NSSI, they express a willingness and desire to receive additional training to enhance management of NSSI and to better meet the needs of students in need (Berger, et al. 2014; Carlson et al. 2005; Heath, Toste, & White Kress, 2007; Heath et al., 2006; 2007). School staff who have knowledge of NSSI also tend to have more positive attitudes toward NSSI and are more confident in their abilities to identify and respond appropriately (Berger et al., 2015). Further, there is preliminary evidence that training efforts aimed at equipping school staff with information about NSSI can increase knowledge and skills to help students who engage in NSSI, clarity school staff roles,

and the process for supporting these students, dispel myths and produce behavioural changes in responding to NSSI when it is discovered at school (Groschwitz et al., 2017). These findings highlight the benefits and positive impact of increasing NSSI literacy in schools (Berger et al., 2014; Carlson et al., 2005; Heath, Toste, & White Kress, 2007; Heath et al., 2006).

In the past, studies have found that school staff often hold misconceptions and negative attitudes about NSSI. For example, teachers and school-based mental health professionals have expressed shock, anxiety, repulsion and panic towards students who engage in self-injury and misinterpret self-injury as attention-seeking and manipulative (e.g., Heath et al., 2006; Heath et al., 2011; Simpson, Armstrong, Couch, & Bore, 2010). Further, school staff tend to underestimate the rates of NSSI among school students (Carlson et al., 2006; Heath et al., 2006; Roberts-Dobie & Donatelle, 2007). As mentioned, this inaccurate knowledge, negative attitudes, and uncertainty when it comes to addressing NSSI with students may interfere with the ability of school staff to effectively respond to these students and may also reinforce the student's belief that others (e.g., adults) do not understand them (Heath et al., 2011). As the majority of studies were published over a decade ago, it could be argued that perceptions and attitudes have changed significantly. Furthermore, the perceptions of school leaders have yet to be examined, even though the beliefs held by school leaders can substantially influence the direction of schools in terms of NSSI management.

Principal Aims of the Research Program

In summary, there is a growing amount of literature indicating that effective NSSI school response requires a school-wide effort and that school leaders are a key factor in bridging the research to practice gap (e.g., Berger et al., 2015; Hamza & Heath, 2018; Hasking et al., 2016; Lewis et al., 2019). Given the highly influential role and the greater responsibilities of school

leaders in determining and implementing school policy, management and prevention efforts, it is important to examine the perceptions, involvement and training needs of school leaders. Furthermore, the literature has consistently noted low perceived confidence and knowledge across a range of school staff regarding NSSI behaviours among youth (Darosh & Lloyd-Richardson, 2013; Duggan et al., 2011; Hasking et al., 2016; Heath et al., 2006; Roberts-Dobie & Donatelle, 2007; Simpson et al., 2010). Professional development can provide school leaders with the knowledge and necessary skills to make informed choices in response to NSSI in schools. However, there is no research that has specifically targeted school leaders to date and thus their perspectives, involvement and training needs around NSSI response remains unknown.

Thus, the overarching aim of this dissertation was to address the gap in the literature on NSSI response in schools by exploring school leaders' perspectives on school response to self-injury among students. The dissertation has three research objectives, accomplished in three distinct parts:

Objective 1: To qualitatively explore school leaders' perspectives, self-reported involvement in response to NSSI in schools and to determine their reported needs around NSSI professional development using semi-structured interviews. Given the exploratory nature of this project, no a priori hypotheses were made.

Objective 2: To quantitatively provide a broader investigation into school leaders' perspectives, self-reported involvement in response to NSSI in schools and to determine their reported needs around NSSI professional development using an online survey. Given the exploratory nature of this project, no a priori hypotheses were made.

Objective 3: To develop, pilot and evaluate a focused training for school leaders on response to NSSI in schools. The professional development training was developed based on the

findings from the semi-structured interviews, online survey and best-practice literature on NSSI response in schools.

Mixed-Method Research Design

As highlighted by the literature review, there is no existing research which has attempted to understand school leaders' perspectives, involvement and training needs in response to NSSI in schools. Given the exploratory nature of the study, an exploratory sequential mixed-method research design was chosen. Creswell and Plano Clark (2011) explain that in this two-phase sequential design, qualitative data is first collected and analyzed. These findings help inform subsequent quantitative data collection to further explore the research problem (Creswell & Plano-Cark, 2011). This design is based on the premise that an exploration is first needed in a given research area (e.g., measures or instruments are not available, the variables are unknown, or there is no guiding framework or theory) and the primary purpose is to generalize qualitative findings from the first phase to a larger sample gathered during the second phase (Creswell & Plano-Cark, 2011).

There are four major steps in an exploratory sequential design. As stated above, the design begins with the collection and analysis of qualitative data to explore a research area. In the next step, the researcher builds on the results of the qualitative phase by developing an instrument, identifying variables, or stating propositions for testing (Creswell & Plano Clark, 2011). These developments connect the initial qualitative phase to the subsequent quantitative strand of the study. In the third step, the researcher implements the quantitative strand of the study to examine the salient variables using the developed instrument with a new sample of participants. Finally, the researcher interprets in what ways and to what extent the quantitative results generalize or expand on the initial qualitative findings (Creswell & Plano Clarke, 2011).

Thus, Part 1 of the current study was a qualitative exploration of school leaders' perspectives, involvement and self-reported training needs around NSSI response in schools using semi-structured interviews. Findings generated from the qualitative findings informed the development of an online survey that was used to collect data from a larger sample of school leaders. Specifically, themes identified in Part 1 were used to create survey items in the online survey. Part 2 of the study therefore expanded on findings from Part 1 through a quantitative description of school leaders' perspectives, involvement and self-reported training needs around NSSI response in schools. In Part 3, the combined results from the individual semi-structured interviews and the quantitative online survey were summarized and used in the development of training specifically for school leaders on effective management of NSSI in schools. Best-practice guidelines were used to create the training content and adapted based on the current role and self-reported training needs from school leaders in Part 1 and 2 of the dissertation. Evaluation of the effectiveness and acceptability of the training occurred at the end of the professional development training.

CHAPTER III

Part 1: Exploratory Semi-Structured Interviews

Participants

The overall sample consisted of thirteen school principals and vice-principals (N= 13; 54% female; 46% male) drawn from thirteen schools from eight English language school boards across Québec, Canada. The researcher was explicit in wanting to recruit school leaders (i.e., elementary and high school leaders or vice-principals) and no other school staff. One interview (fourteenth interview) could not be included in the final sample because the audio file was corrupt. Responses provided by both elementary (n= 3) and high school (n= 10) principals were comparable, therefore, they were considered as falling under one homogenous group or 'type' of participant (Braun & Clarke, 2006) and were included in the same analyses. Furthermore, data saturation, which refers to redundancy in the data, or the point when additional data fails to generate new information (Braun, Clarke, Hayfield, & Terry, 2019; Onwuegbuzie & Leech, 2007; Saunders et al., 2018) was reached through this sample of data. Specifically, data saturation was based in relation to the data provided by individual participants (i.e., achieved at a particular point within a specific interview). As explained by Legard and colleagues (2003), probing needs to continue until the researcher feels they have reached saturation, a full understanding of the participant's perspective (Legard, Keegan, & Ward, 2003). Thus, in this model, the process of saturation is located principally at the level of data collection and is thereby separated from a fuller process of data analysis, and hence from theory (Sauders et al., 2018).

Measures

Semi-structured interviews. In Part 1 of the study, the qualitative data collection design was accomplished through semi-structured interviews. Semi-structured interviews are a flexible

technique suitable for gathering individual's opinions, exploring people's thinking and yielding rich information (Braun & Clarke, 2006; Onwuegbuzie & Leech, 2007). Given the lack of research on school leaders' role in NSSI school response and the exploratory purpose of this study, the flexibility of this technique was complementary and allowed for the gathering of detailed individual narratives (Kvale & Brinkmann, 2007). The flexible nature of the semi-structured interviews also provided opportunities for the researcher to clarify participants' views, check their understanding of what was said immediately and to ask further questions, where appropriate. Other data collection approaches were considered, primarily focus groups. However, due to the sensitive nature of the subject matter, semi-structured interviews were deemed the most appropriate method of data collection. The semi-structured interviews (see Appendix A) included the following areas of exploration: NSSI in schools (e.g., Tell me about NSSI in your school); Response to NSSI (e.g., tell me about your school's response to NSSI; tell me about your specific role as a school principal); Specific challenges/facilitators (e.g. What specifically do you see as the biggest barriers or challenges to responding to NSSI in your school?); School leaders' training needs (e.g., What, if any, workshop or training do you think would be helpful for you as a school leader?); Other (i.e., Is there anything that we have not spoken about or asked about that we should know as it pertains to NSSI and schools?).

Procedure

After McGill Institutional Review Board (IRB) and the Association of Administrators of English Schools of Quebec (AAESQ) approval of the project, members of the AAESQ were approached via e-mail. Specifically, an invitation to participate in the interviews (see Appendix B) was sent through the AAESQ listserv to all members with a detailed summary of the three-part study at different periods during the Winter, Spring and Fall of 2017. As an incentive to

participate, administrators were offered free resources on best practices for effective school-wide NSSI response. In addition, school leaders were offered the opportunity to receive a free training from leading experts in the field on how to ensure effective NSSI response in their schools. School leaders who expressed interest were contacted by a follow up e-mail and provided a consent form (see Appendix C). Following their consent to participate in the study, individual phone interviews were scheduled with each school leader. All interviews were conducted by a doctoral level graduate student in a private room at McGill University. Each interview was audio-recorded. Upon completion of each individual interview, participants were thanked and de-briefed, which included verbally outlining the researchers' next steps with regards to the study. Interviews lasted between 30 and 45 minutes and were later transcribed; identifiable data (e.g., school name, school board name, school staff names) were removed from the transcripts and each participant tape was identified by a number and kept confidential.

Data Analysis

The semi-structured interviews were analyzed qualitatively using thematic analysis, one of the most commonly used methods of qualitative analysis. In particular, this approach is used for identifying broad patterns of meaning in the data. This method was chosen due to its flexible approach which is not constrained by any particular theoretical framework (Braun & Clarke, 2006; Braun & Clarke 2013). Themes were identified through and inductive approach; the researcher's analysis focused on explicit surface meanings found within the data and identified semantic themes based on what interviewees said. As such, the themes identified are strongly linked to the data themselves and the subsequent analysis is data-driven rather than researcher-driven (Braun & Clarke, 2006). While thematic analysis has been criticized due to a lack of clarity and consistency in the procedures used, one clear and replicable model of thematic

analysis is outlined by Braun and Clarke (2006). The 6-stage process outlined by Braun and Clark (2006) is described below:

Stage 1: Familiarization with the data. During stage one of analysis, each of the 13 audio-recordings were actively listened to multiple times. While listening to the audio-recordings, the researcher (MD) made notes of initial impressions, ideas and patterns.

Stage 2: Generating initial codes. Stage two involved the identification of initial codes within data extracts. NVivo12 software was chosen to analyze the data. While data can be analyzed directly from the audio-recordings through this software, the researcher decided to use both audio and written extracts; the entire dataset was transcribed and segments of audio-recordings of the emerging themes were noted in order to develop a more thorough understanding of the data and facilitate the analysis. While re-reading the transcripts the researcher listened to the audio-recordings of the interviews again to check for accuracy. Data extracts were then read and reread several times before organizing and collating data into meaningful groups or initial codes.

Stage 3: Searching for themes. Stage three involved further categorization of data extracts/codes into themes. This involved considering how different codes may combine to form an overarching theme. These initial themes were established based on groups of initial codes that were most prevalent and similar. This process was facilitated by writing each code on a separate piece of paper to help organize and reorganize into theme-piles and an initial thematic map (visual representation). In order to collate codes into potential themes, a semantic, rather than a latent approach to identifying themes was adopted. Braun and Clarke (2006) assert that with a semantic approach, the themes are identified within the explicit or surface meanings of the data and the analyst is not looking for anything beyond what a participant has said or what has been

written and they do not begin to interpret the broader meanings of themes until later in the analytic process. Therefore, themes were identified through the explicit surface meaning of the data and the researcher did not attempt to make an interpretation of what participants said.

Stage 4: Reviewing themes. During stage four the researcher returned to the coded transcripts and considered how well they worked within the themes developed in the previous phase. Themes were removed when there was not sufficient data to support them and other themes were merged together or split up (e.g., into other themes or sub-themes). The researcher's intention was for the coded extracts within each theme and sub-theme to form a coherent pattern. Themes were also examined in relation to the dataset at large to ensure validity and consistent representation of the broader story. Consultation occurred between the lead researchers (MD & NH) throughout the coding process to ensure that mutual agreement on all matters of interpretation and that the themes depicted participant responses. Themes were cross-checked and discrepancies between both researchers were settled through discussion before agreeing on final themes. Inter-rater reliability was calculated using Cohen's kappa coefficient. An independent researcher within the same field (NP) repeated the analysis process by independently reviewing the audio files and coding 5 transcripts. The amount of agreement between the two researchers was $\kappa = 0.76$, indicating a substantial level of agreement between researchers that is not due to chance alone (Franzen, 2011; McHugh, 2012).

Stage 5: Defining and naming themes. During the fifth stage the researcher went back to the description of each theme to ensure it accurately matched the themes and sub-themes. Although it is unlikely that divisions and interpretations will be made identically by all researchers, there is enough rigor built into the methodology that researchers of similar expertise and training will arrive at similar themes (O'Connor & Joffe, 2020). The same independent

researcher (NP) read the descriptions of each theme to make sure the name clearly expressed what the theme or subtheme was describing.

Stage 6: Producing the report. The sixth and final stage involved the write up of this thematic analysis. Direct quotations were used to provide sufficient and detailed evidence for the analytic narrative.

Results Part 1: Exploratory Semi-Structured Interviews

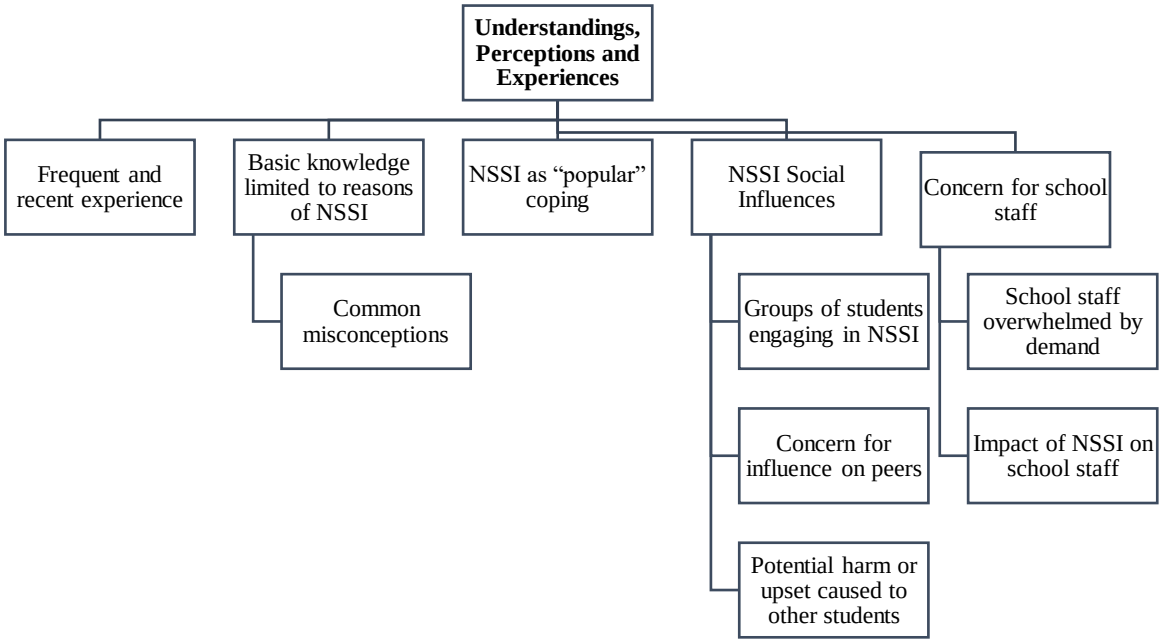
For ease of interpretation, the findings from the thematic analysis were grouped based on five core areas of inquiry that were closely linked to the areas of interest in the semi-structured interviews; namely: (A) Understandings, perceptions, and experiences; (B) Current school response; (C) School leader role; (D) Barriers and facilitators; and (E) Training needs. Themes and sub-themes identified under each core theme are discussed in turn and example excerpts from participant interviews are used to facilitate and further the data analysis.

Area A: Understandings, Perceptions and Experiences

This area of inquiry centers around participants' understandings of NSSI, their perceptions and their general experience with student NSSI in their schools. In response to questioning around describing NSSI in their schools in general, the following themes emerged (see Figure 1):

Figure 1

Thematic map of predominant themes and subthemes observed in area of inquiry A



Note. Themes are organized around the core area of inquiry of school leaders' understandings, perceptions and experience with student NSSI in their schools.

Theme A1: Frequent and recent experience with NSSI: All participants reported being aware of students in their schools that were engaging in self-injury, either currently or in recent years. Furthermore, all participants expressed having personally responded to NSSI on at least one occasion as the school leader (i.e., some participants had other school roles prior to becoming a principal).

> So self-injury is a big situation in our school. Mostly there's been a lot of cutting… there seems to have been bigger reporting this year compared to last year. (Participant 13)

> This is my second year as principal. Before that, I was a teacher here, so I had some experience with it as a teacher, and more so as a principal. I would say it's more prevalent than I expected, more than what I realized was happening, and that it's almost the point where I would almost say it's common. (Participant 10)

> I mean I have just under 70 students, and I would say probably four I've dealt with this year…I find that's kind of high. (Participant 2)

When participants gave examples of experiences with NSSI in their schools, the stories provided were predominantly situations that occurred during the past few weeks or current academic year.

Theme A2: Basic knowledge limited to reasons of NSSI. In general, participants demonstrated a basic understanding of NSSI among students, that was limited to reasons for engaging in self-injury. NSSI was conceptualized as both a way to cope with emotional pain and a method of alerting others to the pain the student was experiencing.

> My understanding is that there's a relief involved in self-injury, so like a buildup of emotions that's somehow released by doing that. (Participant 10)

> It [NSSI] can be a cry out for help…and it's something that is more internal, an internal pain that they are dealing with. (Participant 5)

> Well, the students are experiencing difficult emotions and they're looking for a way of coping with that emotion or that stress or that anxiety and they're finding ways to relieve it. (Participant 9)

Beyond expressing reasons for engaging in NSSI, participants expressed not knowing more about the behaviour (e.g., unaware of methods of NSSI other than “cutting”) and feeling as though they had very limited understanding.

Subtheme A2.1 Common misconceptions. As participants described their understanding of NSSI, a wide range of misunderstandings and misconceptions were revealed. For example, some participants expressed perceiving NSSI as an attention-seeking behaviour.

> There are some kids who don't get any attention, whatsoever, unless they cut and then they get buried with attention, like, "What's the matter? What's the matter? What's the matter?" and all their friends go, "Oh, my God. Oh, my God. Look at you cutting. You're cutting."(Participant 5)

> There is often an attention-seeking piece. It's kind of popularized. I hate even saying that but I do believe that this is true. It’s a call for attention, it’s a call for look at me I’m hurt. (Participant 3)

Other misconceptions were noted, such as being primarily a female behaviour, occurring primarily among students of lower socioeconomic status, rarely occurring in elementary schools or existing solely within the context of mental illness.

> Last week, we had a kid just take a ton of Ativan. I don't know where she got it from, and it wasn't to get high; it was because she was just so depressed. That's [taking Ativan] self-injury and that means sending them immediately to the children's hospital. Lucky enough to have an administrator around that drove her and sat there with her. (Participant 5)

> There are less circumstances and cases of it in elementary schools. It's truly an exception if it happens in elementary schools. (Participant 2)

> I was not versed in that at all because I came from a very high socioeconomic status elementary school and I had worked their grade six for nine years, and my job even before that was in a very high socioeconomic school in elementary. So, I hadn't been in high school at that point, so it was an area for me to learn and I need to continue to learn. (Participant 1)

> I don't think that it's [NSSI] necessarily linked to suicide. I do perceive or believe that in some cases, and I guess this is why we don't really have a protocol because it's so nuanced. (Participant 3)

Although most participants expressed knowing that NSSI and suicidal behaviours are distinct, they often spoke of them interchangeably and showed confusion around the two behaviours. Some school leaders gave examples of students who expressed suicidal behaviours after explicitly speaking of NSSI.

Theme A3: NSSI as "popular" coping. Participants noted that NSSI was seemingly becoming more "popular" than it had been in previous years and a more common method of coping with stress or pain.

> Now we have several students and it's almost like it's becoming a popular thing to do which worries me and a "go-to" to try to solve the pain or solve the issues. (Participant 1)

> It's almost like it's becoming the trendy way to take care of teenage pain. (Participant 6)

> If I look back to when I was a teenager, nobody did this, it was unheard of…It just seems to be very popular right now, like it's something that everybody knows about, it's all over YouTube you know it seems very trendy and that concerns me. (Participant 3)

Given the perceived "popularity" of NSSI among their student populations, participants expressed concern that in general, NSSI behaviours have become more prevalent within the past several years.

Theme A4: **NSSI Social Influences.** A prominent theme that arose when discussing NSSI in schools was around NSSI and social influences. Throughout the interviews, participants spoke of different ways in which social influences of NSSI was a concern for them as school leaders. These concerns have been outlined as subthemes below.

***Subtheme A4.1: Groups of students engaging in NSSI*.** Participants spoke about having groups of students (i.e., two or more) in their schools who were engaging in self-injury. These groups of students were described at times as being friends, and/or within the same class or school grade.

> Just yesterday we had two girls that had both been hospitalized, friends that are part of a little group that encourages each other to participate in NSSI. They devote Instagram pages to doing that. They talk to each other about being clean, how many days clean they are from engaging in that kind of behaviour. (Participant 3)

> …we have another student cutting who we never would have suspected, but she's in a group of four students and two of the four were cutting. (Participant 1)

> …These students that I was just talking about, this little ring of students that we have, it's something that they're doing sort of socially, which from what I understand about NSSI, you know, it's usually a very private act and it's becoming less and less private. It's all over social media with these kids taking photos of themselves and putting it up. (Participant 6)

Participants expressed that seeing two or more students engaging in NSSI within the same peer group was something that they felt has been more noticeable in recent years.

Subtheme A4.2: Concern for influence on peers. A key subtheme that was expressed among participants was their impression that students could be influencing each other to engage in NSSI.

> It [NSSI] comes in waves because, I think, what happens is sometimes, one kid does it and then other kids go to do it, too. It runs in packs. (Participant 5)

> … the student returned to school and although they claim that they've stopped the behavior [NSSI], what they're doing is showing their peers photos of their injury that they've taken. Right, and so that perpetuates the cycle. (Participant 7)

> It often spreads like wildfire and that was one of our main concerns when we found out we had two girls doing it. We really needed to prevent it from going further. (Participant 4)

Specifically, participants were concerned that peers that were not engaging in self-injury might start to self-injure after being exposed to the behaviour.

Subtheme A4.3: Potential harm or upset caused to other students. Another subtheme that arose around social influences was the idea of the potential harm or upset caused to other students by awareness of or exposure.

> The scarring was visible, it was very obvious to the other students in the school who had no idea before that and then we had to deal with the questions of the other students. (Participant 4)

> We find out from other students…it's a lot of peers coming to us concerned about their peers. (Participant 1)

> When we have a student who's cutting and they're doing it in the bathroom and there's blood on the ground…how as a school do you manage that? How do you get them the support? It creates a problem because then you also have other students in the school who witness it and they have the trauma associated with that. (Participant 9)

> It causes other students to become distressed. Yesterday we had a situation where students were showing photos and other students were getting angry about it. And so then, sort of yelling ensued and some kind of aggressive behaviour in response. And so, the carry-over from an administrative perspective from this type of behaviour is significant. (Participant 8)

Participants expressed a desire to understand how to respond to non-self-injuring students when they are aware of the behaviour among their peers. Some discussed this specifically in the context of visibility of scars or wounds.

Theme A5: Concern for school staff. Many participants made note of their concern for school staff who were most involved when responding to NSSI among students (e.g., teachers, school mental health professionals). Two main specific areas of concern for staff were noted among participants. These two areas are presented as sub themes below.

Subtheme A5.1: School staff overwhelmed by the demand. Participants expressed that school staff were feeling overwhelmed by the demand of NSSI among students.

> Our guidance department is feeling quite overwhelmed with the number of students that are reporting this [NSSI] to them and they are seeing increased severity of it as well. (Participant 3)

> I've spoken with other colleagues and they're experiencing the same thing so I think that people are feeling overwhelmed, I feel like our guidance teams are overwhelmed. (Participant 12)

> We're so lucky we have such talented mental health professionals that work here in our guidance team, they're so excellent and they're doing everything I think right. But it's all day. It's a constant, right? (Participant 1)

Many participants expressed concern that given the number of students who were engaging in NSSI, school staff were unable to continue to meet the demands within their school.

Subtheme A5.2: Impact of NSSI on school staff. Participants made note of the potential impact that responding to NSSI could have on school staff responding to and interacting with students who engage specifically in self-injury.

> I often feel like there's not very much emotional support for administrators and other staff members who are coping with this stuff on a daily basis, so we have some very serious things happen in our school and we manage these things and then we come back to work the next day. It's very difficult. (Participant 3)

> This is just what we do right, we just come back to work and keep supporting our staff and students...so we're always just left to just cope which does take its toll. (Participant 5)

> You know, when I talk to people that work in other industries, it's very different. Right? Like if they had to deal with a very serious crisis like that [NSSI], there would be people that would come in, I think to support the employees. (Participant 11)

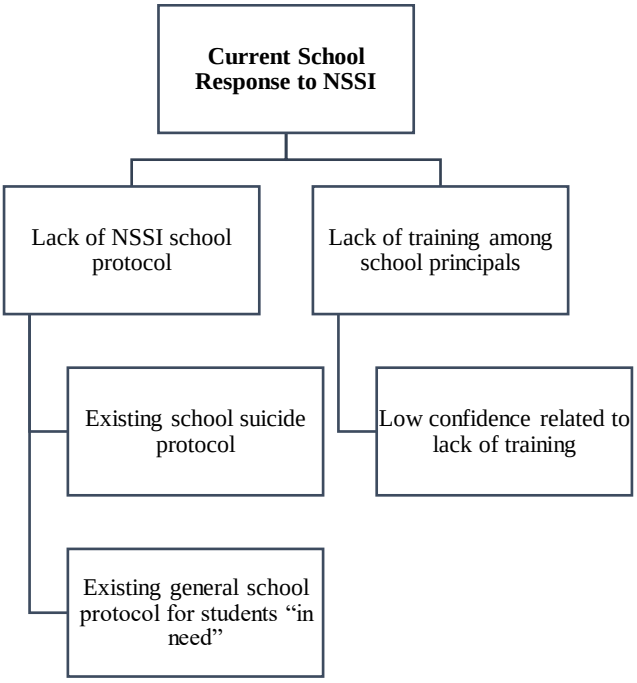
They noted the emotional toll on staff and concerns around how they can cope. Thus, participants expressed wanting support for school staff who may be personally impacted by working with students who are self-injuring.

Area of Inquiry B: Current School Response to NSSI

This area of inquiry pertains to how schools are currently addressing NSSI when it is discovered in their schools. Participants were asked how their schools generally respond when they are made aware of self-injury among student (s) and if they had a protocol around NSSI behaviours in their school and/or school board (see Figure 2).

Figure 2

Thematic map of predominant themes and subthemes observed in area of inquiry B



Note. Themes are organized around the core area of inquiry of school leaders' current school response to NSSI.

Theme B1: Lack of NSSI school protocol. No school represented in the interviews expressed having a specific NSSI policy/protocol in place. Some participants were unsure of whether they had such a protocol or needed clarification around what was meant by a school NSSI protocol.

> No we don't have any NSSI protocol, we don't have any protocol, it's all about how we feel about the situation. Generally speaking, it's a multi-headed decision. We look at the

> situation, "Okay, what's the story as far as we know? What is the student claiming as being the issue?". (Participant 11)

> We don't have a protocol for NSSI at our school board nor do we at our school at this moment. (Participant 1)

> I don't believe on NSSI, we have a few staff members, our guidance team and another administrator that's trained in suicide risk assessment so we have quite a bit of good expertise in our schools for that [suicide risk assessment] but not for NSSI. (Participant 3)

Several participants mentioned common practices that existed in their school's response, such as notifying parents and connecting the student with student services or an external mental health professional. However, none of these practices were written in a formal protocol nor was there a standardized process of addressing self-injury within the student body.

Subtheme B1.1: Existing school suicide protocol. A key subtheme that arose around school policies was around guidelines for suicidal behaviours (e.g., when a student expresses suicidal ideation). All participants expressed that their school or schoolboard had a suicide-specific protocol in place.

> There are times when we find out it's very serious and she [guidance counselor] does that assessment for suicide right away with the student just to see where they are at, and that we have a very strict protocol for it in our school board. (Participant 1)

> I know we all have the exact same protocol if a student says they're going to kill themselves. The protocol is written as if it's yellow this is 1,2,3,4,5 this is what the principal needs to do whereas I feel like we don't have that protocol in any of our schools for cutting and things that are maybe less serious than suicide. (Participant 12)

In general, participants aware of their school suicide protocol (e.g., what to do when a student expresses suicidal ideation) and seemed more confident or had a clearer understanding of how to respond in such situations.

Subtheme B1.2: Existing general school protocol for students "in need." Participants spoke about other policies that existed in their respective schools, including general policies for "students at-risk." Although these varied by school, participants expressed that these general

policies addressed issues including, student safety, bullying, crises, etc. Within these general school policies, some had a section that included self-harm (i.e., including NSSI and suicidal behaviours), however these sections did not include specific information on how to address NSSI.

> Not specific to NSSI. We have a policy for students in need, we consider that a need but it can be any type of crisis, following a divorce or even a relationship break up, or failing a test it can be as minor as that, it can be an eating disorder all those kinds of distress signals we receive. (Participant 4)

> I'll have to see if we have an NSSI policy or not. I'll double check that. We do have a policy for anti-bullying, anti-violence, but it is for a lot of things. (Participant 2)

> Um not specific to self-injury but it's part of the crisis intervention. We've sort of built it into our Bill 56 policy which is an intervention violence protocol. (Participant 7)

Some participants stated that this protocol was consulted when a student presented with NSSI to a staff member but noted that these policies did not quite meet the unique needs of a student engaging in NSSI.

Theme B2: Lack of training among school leaders. Most participants reported never having received training around responding to self-injury among students. A minority of participants expressed having attended workshops that incorporated NSSI among various topics, yet felt that the training they received was not sufficient. Others felt that although some staff members received training, the information was not being transferred to the rest of the school team.

> We've had a couple of workshops at the school board level. We have not had one at all on cutting... I've read a lot about that but I haven't had training on it. (Participant 1)

> We as administrators have received zero training on NSSI…Guidance has a lot of this information, but they also don't have time or opportunities to then explain to staff or talk to me about the subject with staff. So, they receive all this training but they receive it kind of like in a tunnel, right? No one else gets to benefit from this training. (Participant 13)

> We've had some informal conversations with the psychologists that are part of our mental health team at the schools…. I've had other training or meetings with the Local

> Community Service Centres (CLSCs), so I don't know if I'd necessarily call it a workshop so we need more. (Participant 9)

Notably, lack of training was a repeated theme that came up multiple times, including when discussing NSSI in schools generally as well as in barriers to responding effectively (see section below).

Subtheme A6.1: Low confidence related to the lack of training. Participants expressed low confidence in responding to NSSI and an inability to respond appropriately. As participants expressed responding either directly or indirectly with students who engage in NSSI, many reported a concern that they were unqualified, and therefore unintentionally "making things worse" or not responding "correctly".

> I have made those phone calls… but the parents often are shocked and don't know what to do and ask for advice and I'm clearly not prepared to give them [parents] any of that. (Participant 13)

> I'm always then wondering, maybe I shouldn't be asking those questions. Am I qualified to ask those questions? And it's coming from a good place in your heart but you don't want to cause more harm than good. (Participant 10)

> We've got too many hats on you know, mental health it's something that we've become familiar with but are we trained? Do we have backgrounds? No, we're not by any means a social worker or a doctor you know. That makes it very hard. (Participant 9)

> I'm hoping that I'm following the proper protocol to make sure that if I needed to call I did call, I didn't mistake the way something was said as not something to call 911 for but it could have been a cry out for help and I missed it. Those types of things. As a person I want to make sure that I'm doing the best I can. (Participant 2)

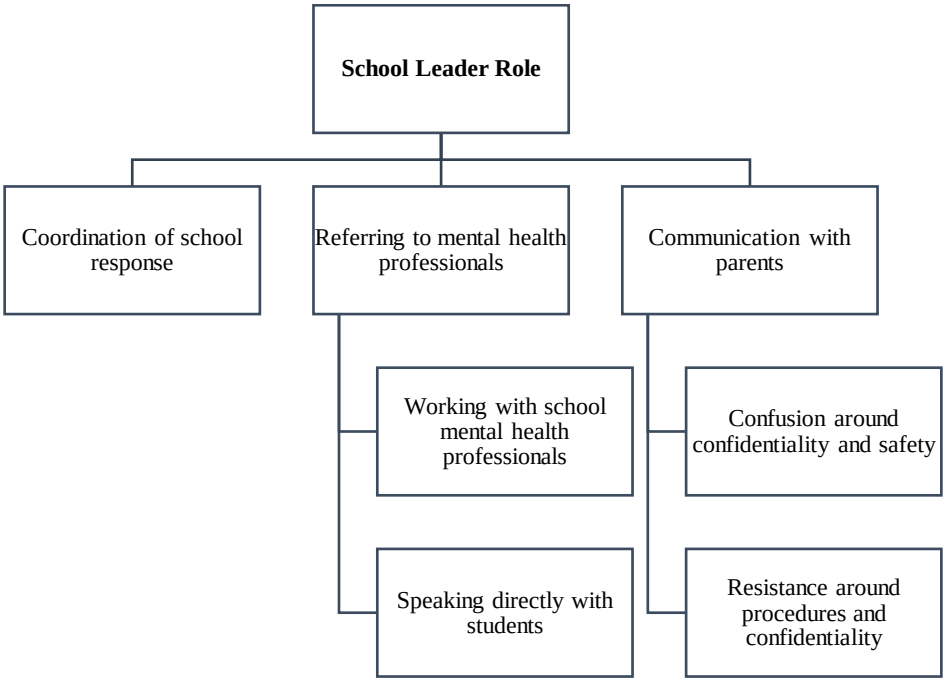
Participants related this worry to a lack of training and being uncertain of their role; others felt that it was not part of their role to respond as they were not mental health professionals.

Area of Inquiry C: School Leader Role

This area of inquiry centers around what school leaders expressed was part of their current role when addressing NSSI in their respective schools (see Figure 3). Although their role was administrative in part, participants also expressed active roles in responding to self-injury among students.

Figure 3

Thematic map of predominant themes and subthemes observed in area of inquiry C



Note. Themes are organized around the core area of inquiry of school leaders' role in NSSI response.

Theme C1: Coordination of school response. There was a general consensus that the school leader's role was to coordinate the response when it is discovered that a student is engaging in self-injury.

> My role is to get services and all the people going in the same direction. Making sure that we have a follow-up, we have a plan. (Participant 9)

> We're pretty involved as administration, so we are always meeting with the counselor or the psychologist or our social worker or our resource team, speaking with the families. (Participant 6)

> One of the things I think the administrator should be doing is coordinating…they need to coordinate, and at the same time, being kept in the loop of what goes on and provide a supporting role to the staff. (Participant 12)

Coordinating the school response involved informing the school mental health professional (in cases that they were not yet aware), speaking with the school mental health professional and/or other staff (e.g., teacher), and ensuring there was a plan (e.g., to call parents, set up services within or outside of the school).

Theme C2: Referring to mental health professionals. As anticipated, all participants reported that their role was to refer to the school mental health professional. Often this was a school guidance counsellor, psychologist or social worker.

> My role is to ensure the guidance counsellor is aware and then they follow-up. The guidance counselor will follow-up to either speak with the parents and or get in touch with 911. (Participant 2)

> Well, typically, if it's known about, it would come to me as the principal, and I would do a referral for social services, for the school social worker. I will right away put in a form referring them to the social worker because I feel like it's something that is beyond my training. (Participant 10)

> I guess our protocol within our school is to pass it [information about students engaging in NSSI] on to me, and then I fill out the form and do the referral for social services. (Participant 11)

For some, this was the primary role. Often participants related to having little to no training and feeling that addressing NSSI was beyond their expertise. Others thought that making a referral was their only role as school leaders, and not mental health professionals.

***Subtheme C2.1: Working with school mental health professionals*.** A number of participants expressed working closely with the school mental health professional and making on-going decisions collaboratively when responding to student NSSI.

> We meet with them. We have Ms. [name removed] assess them, then I meet with them, we call the parent in if necessary. If they are 14 and above, we ask them if we can get their parents involved. (Participant 6)

> …so she [guidance counselor] feeds me what's happened to who it is, what the background is, what I should know, and once we decide how to proceed I take over...the follow-up is always through me. (Participant 8)

> We made arrangements...and then I offered to parents a specific line of follow-up so either I follow-up with them on my own in 2-3 weeks to see how it's going, either we make a referral to the social worker...so if they get involved with the social worker I'll do maybe 1 or 2 follow-ups but then I'll stop. (Participant 9)

Participants described that typically they were more heavily involved when it was first discovered that a student was engaging in NSSI and would generally diminish their involvement once mental health services were in place.

***Subtheme C2.2: Speaking directly with students*.** When discussing their role or school response to NSSI among students, a few school leaders reported speaking directly with students who had engaged in self-injury.

> Usually they [students engaging in NSSI] get referred to either myself, the vice principal, or the behaviour technician here at the school and we try to dig a little further and support the student and ask questions, how long it's been happening, if they're willing to show it to us. And then, once we've established that some sort of self-mutilation is happening, we immediately inform the social worker…usually it's a handoff to the social worker and he deals with it from that point forward. (Participant 11)

> It was agreed that the student would talk to me. I got all the information. Once I had all the information I called the parents. (Participant 6)

> I do know a little bit about what questions to ask. I guess I just still don't feel comfortable assessing the student's answers to those questions, like whether or not they're truthful, they're just telling me what I want to hear. (Participant 10)

Various scenarios and reasons for speaking to students about their self-injury were described, including feeling a responsibility to ensure the student's safety, deciding as a school team that they would be the most appropriate adult to do so, or limited access to mental health services. In

doing so, some participants expressed discussing with the study their self-injury in order to make decisions on how to proceed.

Theme C3: Communication with parents. A prominent theme that arose was the role of parent communication. For some participants, the decision to contact parents was made in consultation with the school mental health professional or team. Other participants thought that as the school leader, communicating all information with parents was an essential role.

> Very often, because, as I said, I don't have the confidentiality piece. Obviously, my first and most important priority is the safety of the child but then I also make sure the parent is aware, is being communicated with, has a role to play... I'm not saying mental health professionals don't do that but, very often, when something comes to them, their role is to deal exclusively with the child and mine is to communicate and make sure that the parent is involved. (Participant 5)

> When parents become involved…I think that anytime any serious mental health issue comes to the surface, and other resources are necessary to help the child to heal, that's always the principal's job. (Participant 1)

> Number one is to contact the family. So I generally meet with the family and then I'll initiate the CLSC and DPJ (youth protection). (Participant 3)

> As soon as we inform the parents in terms of liability we've done what we have to do. (Participant 6)

> It depends on the individual student and how severe we think the situation is but I would say three out of four times we actually do contact the parents. (Participant 11)

In general, the communication with parents involved informing parents/guardians that their child was engaging in self-injury and to explain the school plan.

Subtheme C3.1: Confusion around confidentiality and safety. When discussing the role to contact parents, the majority of participants expressed confusion around when it was appropriate to do so.

> I don't feel comfortable making the decision on when do I call the parent? Because I know when it's, when it is suicidal, I have an obligation to call the parents. This is, I almost view it as pre suicidal, if you want, and so I'm a little uncomfortable in making that decision. (Participant 10)

> I think we need a better understanding of the legalities I guess of who do we have to tell and when, so this whole thing around the age 14…right now I just tend to go on the safe side and always contact social services just in case so to clarify that...where do you draw that line of safety? (Participant 4)

> I would like to be made aware. I don't need to know all the gritty details, because some of it is personal and confidential but I do need to know if it's going to have an impact on other students in the school, or on the safety of the student population. (Participant 4)

Often, confusion around these procedures related specifically to students who are 14 years of age or older. Participants described being unclear about when it was appropriate to disclose self-injury to students' parents. Many believed that it was best to always call parents as a safety precaution.

Subtheme C3.2: Resistance around procedures and confidentiality. A subtheme that emerged was disagreement or frustration around the procedure for contacting parents.

> In any case, we don't hide anything from the parents. Any situation involving suicidal tendencies or ideations or NSSI we would let them know. (Participant 9)

> Well, in Quebec as you know, it's age 14. That magic, crazy number... whether or not they're 14, if it's for safety we have to call their parents in. For the most part the kids who are doing it are the younger ones, and they're not 14 yet, so we do get the parents involved. (Participant 1)

> …also there's the fact that even at 14 kids don't even have to tell their parents anything so even guidance, a lot of the time doesn't tell the parents because they don't have to so it's another issue. When I became an administrator I became very upset with that. Like how dare we not inform parents? (Participant 13)

> There is a confidentiality piece…. I don't have that piece you know, so I tell kids I tell everything to parents but I tell kids that if there's something you want to share with someone here, these are the people in the building to do it with. (Participant 5)

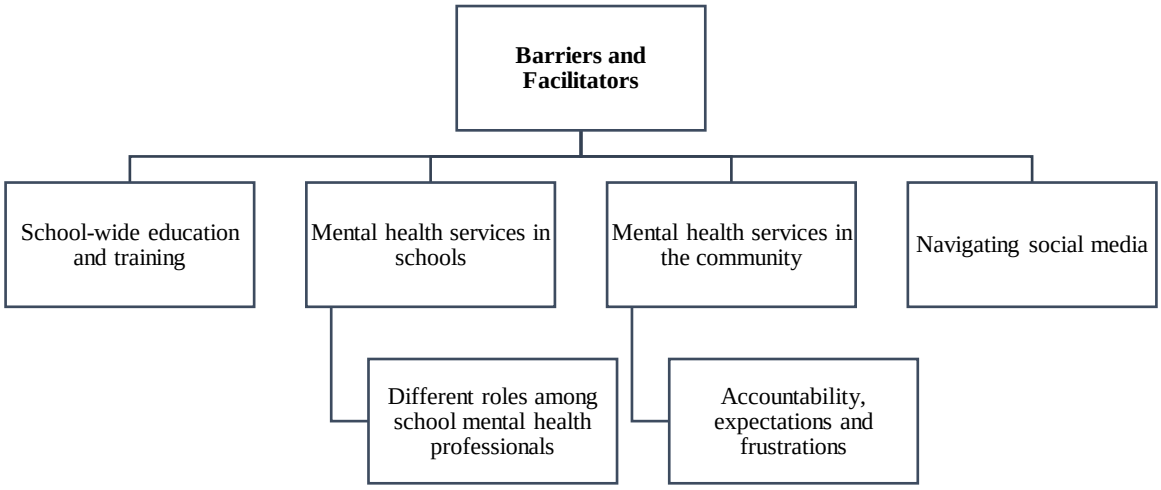
Some participants expressed that they did not keep any information private as they did not share the same code of ethics around confidentiality as the mental health professionals in the school. Others expressed that while they were not bound by confidentiality, they did make these decisions in consultation with the school mental health professional.

Area D: Barriers and Facilitators

This core theme represents the barriers and facilitators that administrators identified when asked about challenges in responding to NSSI in their schools (see Figure 4). During the interviews, school leaders were first asked to identify what they saw as the biggest barriers or challenges to responding to NSSI in schools. School leaders were then asked to state what they saw as potential facilitators to effective response to NSSI in their schools. Apart from utilizing a school-wide approach, the identified barriers and facilitators were opposite to one another (e.g., more resources would facilitate a lack of resources) and therefore grouped together as themes.

Figure 4

Thematic map of predominant themes and subthemes observed in area of inquiry D



Note. Themes are organized around the core area of inquiry of school leaders' self-identified barriers and/or facilitators in NSSI response in schools.

Theme D4: School-wide education and training. All school leaders expressed that and training for all school staff would facilitate the response to NSSI in schools.

> I'm hoping that the training is not just for the principals, because we need to have it as holistically. We need to have teachers, staff, everyone that's going to be in common contact with the students. Without that, you're just sort of isolating certain groups that are responsible for this particular issue. (Participant 12)

> Well ideally first and foremost we need to have training for all school staff. I think it's so important that we are all on the same page so that we provide the same approach same proactive approach, I think proactive approach is also key because we need to educate our young people. (Participant 5)

> I think training for all school staff. It's everyone together because we're all interacting with these kids every day, especially in a small school, and everyone needs to know how to respond or react. We need to all be on the same page. (Participant 1)

Participants saw that a lack of knowledge about NSSI and training among staff as a whole could impede implementation of the protocol within schools. They acknowledged that although each individual's role would likely differ, all staff needed to be aware of how to respond to NSSI and needed to work together in order to have an effective school response.

Theme D1: Mental health services in schools. Participants felt that the limited availability of mental health resources available to students in need was a significant barrier to effectively responding to students who self-injure. Despite most often having a school mental health professional assigned to their schools, participants reported that they needed more services to facilitate NSSI response in schools.

> Last year, we only had one and a half guidance counselors and our governing board petitioned the school board to give us a second one full time and we got it after years of fighting the issue. So, 450 kids per guidance counselor is insane. They are overworked, they can't take on all the cases. And a lot of parents expect guidance to also act as therapists and that's not their mandate. So, there's really not many services for these kids at all. (Participant 13)

> We have a school psychologist but she works 30% at our school and her office is not in our building, she's in the elementary school next door and we're connected by a tunnel so the kids can get there but it's just she's not super visible in the school, you know. The kids sort of know she's there so when kids come to see me and say I have a question about this I set up an appointment but it's difficult. (Participant 4)

> Our psychologist here is only here half time. So, one week he's here and then the next week he's not and so, he can't give sustained support. (Participant 11)

> We need services available on a more regular basis in the school, better access to services…we have a social worker, a nurse, and a doctor all on a part time, one to two day a week basis not just for my school, but for the whole building, which is like kind of like four schools. (Participant 2)

Participants suggested increasing services either through increasing the number of school mental health professionals and/or having those already assigned to their schools dedicate more time to their school, as most mental health services were provided on a part-time basis.

Subtheme D1.1**: **Different roles among school mental health professionals. School leaders noted that although they had a designated school mental health professional, this school professional did not always intervene with students who engage in self-injury or who had mental health difficulties in general.

> Generally, at the board if something like this happened we would reach out to our psychologist but even she has said this is out of [her] area of expertise...we're scrambling just to understand what's the right thing to do. (Participant 3)

> There's a difference in the mental health professional that you have, right? She's there to do testing and paperwork but she doesn't really have that training [NSSI]. (Participant 9)

> His role is more for looking at testing for learning difficulties, and so on. He does take care of cases where we're alarmed and that we're concerned about… but he can't give sustained support. (Participant 11)

> We have a guidance counselor who's really very much an academic guidance counselor. She does an amazing job but we need other people here who deal with the social-emotional piece. (Participant 5)

This was seen as an important barrier as services available to students within their schools were not meeting the needs of students who are engaging in NSSI. School leaders therefore expressed needing a school mental health professional who was trained in the area in order to facilitate their school response.

Theme D2: Mental health services in the community. A perceived barrier identified by all participants was about accessing mental health services in the community. Some expressed frustration around the process of accessing services, including the wait-time for students in need to be seen by professionals in the community.

> Right now in our area it's very hard-pressed to get any outside services. We have the school nurse that comes in once a week, um the social worker is new and it takes weeks and months to get a referral to her. I think that there is a lack of professional social services to help the students and families who are most in need. (Participant 1)

> I should be able to as a principal pick up the phone, call the CLSC and have people put into place to immediately support this family and help the child. That's not the case. It's months before you can get anyone. (Participant 7)

> …she'd cut herself at school, at home…There's no other interventions through a hospital setting or being in a hospital setting, which is probably truly what she needed. At the school, you're left just kind of picking up the pieces. (Participant 9)

> In a small school, we don't have that [several guidance counsellors] so it lands on my lap. At this point, I would say that I need to be able to count on outside services to help me to support the children and their families, and I can't be counseling parents. Even though I do it all the time in my role, I shouldn't be. Right? I'm not a professional counselor, so it should be that I have those services at my fingertips, which is a joke. (Participant 13)

Others expressed that it was difficult to access these services because of where they were geographically located (e.g., more rural), yet this barrier was expressed by participants in urban areas as well.

Subtheme theme D2.1: Accountability, expectations and frustrations. As participants described the limited mental health services, some expressed frustrations around who they believed was accountable for addressing NSSI among students.

> I think the biggest challenge is that kids like come forward and tell us that they're doing this and really there's not much that the school could do. Like again they speak with guidance, guidance could call the hospital and try to set up appointments or whatever but we're not involved as much as the students probably would like or even the parents would like. It's just because like logistically we can't be. (Participant 13)

> It's hard because I want to be understanding. I want to have a therapeutic handling of it but the thing is we're not a therapeutic institution. We're not a treatment facility, we don't have the resources to provide students with continuous therapy or interventions. It's just not what we do.

> The number one barrier is the lack of accountability by I guess the institutions that are supposed to be providing the support. There's no follow-up, not enough people, too much turnover within the staff over there [CLSC]…You're speaking with one social worker one day and then they're gone and they don't have the case anymore, they've been transferred, there's a different evaluation and then they got lost in the shuffle and then all of a sudden you're back at square one. (Participant 9)

> The real problem is, you have, especially in certain areas where our population comes from one of the poorest postal codes in Canada…So you've got a continuous set of problems that don't get better and the problem is you can provide all the short-term counseling at the school but if you're not going to access services through the CLSC or through the hospitals where it's not continuous or the family doesn't follow up, you've gone nowhere. (Participant 3)

> I can pull them in everyday, check in on them every day, that's not a problem. But, they need much more than that. These students need counseling, and I am not a counselor and I'm not a social worker. I am not a psychiatrist, and these are the services that these kids need, and I can't get a hold of them. (Participant 1)

Often participants explained that schools were not therapeutic facilities. Many thought that student NSSI ought to be addressed outside of school and in community settings (e.g., hospital or CLSC) and that having services available outside the school was necessary to facilitate the management of NSSI cases in their schools.

Theme D3: Navigating social media. Participants perceived social media as a negative influence on student well-being and a barrier to responding to NSSI. It was assumed that social media and Internet use in general was related to stress and mental health difficulties among students and therefore a contributing factor to self-injury.

> Ever since we had the movie that came out that glorified this type of direction [NSSI] ... it's difficult and obviously we didn't endorse it as a school but it's out there already.... that whole glorification that needs a lot of direction. (Participant 2)

> I would say that it's at a crisis point, especially with social media. I have constant issues with social media...and that has to be part of the conversation for principals. (Participant 1)

> The biggest challenge would be services and then social media. What's going on outside of school. We're more and more often being asked to patch things up that have happened outside of school and there are things that we're not really necessarily equipped to manage right or to consequence or to support. (Participant 3)

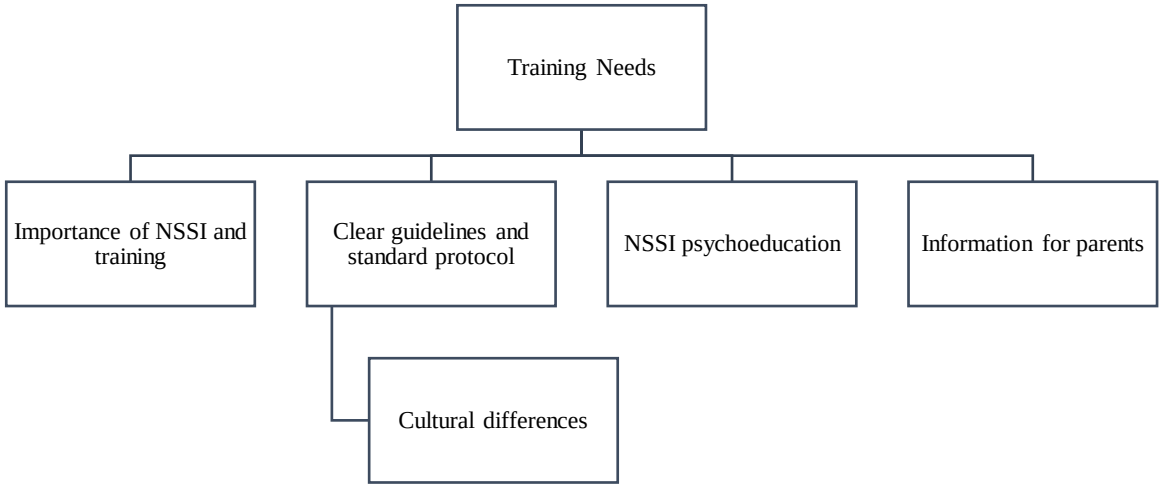
Some participants expressed concern that students were sharing harmful information about self-injury (among other mental health difficulties) through online platforms. Thus, they thought that it would be helpful for school leaders to gain a better understanding of how to navigate issues around social media and NSSI among students. Participants saw this as particularly challenging as Internet use was not something they could monitor outside of school but that they were left to manage the “consequences” at school.

Area of inquiry E: Training Needs

This area of inquiry centers around the perceived training needs of school leaders around NSSI among students (see Figure 5). Participants were asked if they thought a workshop or training would be helpful to them as school leaders and if so, what they thought the training should entail.

Figure 5

Thematic map of predominant themes and subthemes observed in area of inquiry E



Note. Themes are organized around the core area of inquiry of school leaders' self-identified training needs around NSSI response in schools.

Theme E1: Importance of NSSI and training. Participants acknowledged that addressing NSSI in schools was important and that there was a need for training among school leaders.

> We need more training on what to do and how to proceed and what supports are needed. I feel like I'm not nearly prepared. (Participant 1)

> Yes, we most definitely need training. We need to be comfortable talking about these things so that we can be more helpful for our students. (Participant 7)

> Absolutely we need training, I mean as a leader you need to put as many tools in your toolbox. (Participant 9)

> We don't want to believe that this can happen in our school. It isn't until it does that it hits home at how unprepared we are. As an elementary school principal, we all think the students are too young but it happens and we need to be better prepared to deal with the situations. (Participant 6)

The majority expressed that receiving education and/or specific training for school leaders would help them to feel better prepared to respond appropriately. In general, participants felt that receiving NSSI training was a timely matter.

Theme E2: Clear guidelines and standard protocol. A need for clear guidelines around the referral process was expressed by all participants. Specifically, they requested protocol that included step by step guidelines for all school professionals.

> It would be helpful to have some pre-created protocols so that we can see what other people are doing. Like a step-by-step response. (Participant 3)

> It would be nice to see a more uniform protocol. I don't want to see something that is too prescriptive that doesn't take in consideration the particular case or child, but we need more clear guidelines. (Participant 10)

> In many ways, each school is unique, but there needs to be a standard protocol. And then the individual schools can adopt parts of that, and add on a few things. And check with the board, see if that works or doesn't work. (Participant 12)

> I think we need a measured response because, if it is an attention-getting device you don't want to become that, and if it is a legitimate cry for help because it's really symptomatic of something really horrible going on in this student's life, then it absolutely has to be dealt with immediately and followed up on. (Participant 5)

Although participants expressed wanting a standard protocol across school boards, they thought it would be important that the protocol be adapted based on individual school needs.

Subtheme E2.1: Cultural differences. Few participants noted cultural differences that could be important to understand when addressing NSSI in schools. Still, it was considered an important subtheme to discuss. A minority of school leaders acknowledged the importance of

considering different cultures and individual needs of students, despite needing a uniform protocol.

> About 65% of my students are Mi'kmaq, First Nations, so we have to understand the cultural piece. We have to understand where they're coming from. So, the program [NSSI protocol] could very well work in a very general way, but miss the mark when it comes to dealing with people of different cultures. (Participant 12)

> I think it's important to understand that if there's going to be any educational pieces out there, that cultural component needs to be there too. (Participant 2)

Varied ideas about how to address and treat mental health issues gave school leaders more pause, as they were unsure how to maintain the safety of the students while staying mindful of the student's individual needs and beliefs.

Theme E3: NSSI psychoeducation. Participants expressed wanting NSSI psychoeducation in the training in order for them to better understand the behaviour, including but not limited to basic background information, do' and don'ts, and warning signs.

> Well I think we have to go through all the psychology of it all like pretty basic background...We need to be educated about it. Education on what's going on, what to look out for, do's and don'ts that kind of thing. (Participant 13)

> I would really like a workshop with somebody who's a professional or an expert in the field of NSSI or who has a background and can share and tell us what to look for and how to manage the initial moments...also how to manage the situation after. (Participant 9)

> Well, what are the different ways that people do it? What form can it take? The experience that I have was cutting, but what else is there? Is there hair-pulling, or scratching, or, I'm not aware of all the other ways that people can self-harm… the possible signs of this behavior, those would be helpful. (Participant 4)

The majority felt that having this background information would help them feel more confident when managing cases of NSSI and better support their students.

Theme E4: Information for parents. All participants requested information related to parent notification. Specifically, participants wanted a better understanding of when to contact parents, and how to do so appropriately.

> It would be helpful to have some training for administrators on how to support parents through this. (Participant 3)

> What should we be also saying to the parents, you know? What would be suggestions as to where they can seek help and what would be the next step?" (Participant 11)

> It takes a village to raise a child… so we need to work together with parents...maybe even regular sessions with parents just for them to know how to support them and to see certain cues that they're not picking up. (Participant 2)

Participants also wanted the training to include information on how to support parents and asked for resources that school leaders could be provided to parents upon notification.

Theme E5: In-person training delivery. The vast majority of participants expressed that they would find it beneficial to have the training with other school leaders in-person, as opposed to an online format (e.g., webinar), which many felt would be impersonal.

> Online is very, very impersonal. It's not the best way to have somebody live in a situation or go through it…especially if you're not with peers to discuss it's very different. (Participant 9)

> Maybe, in-person workshops and then some online resources that people can access when they need to. (Participant 3)

> It should be required that we'd have all the principals in our school board, attending this at the same time, taking this training. (Participant 9)

> For me, I like being with people. I like sitting around a table with people, I function best that way… So, I would prefer being with people in the same room and sharing, and you get a better contact that way. (Participant 4)

> I would prefer something that would be delivered to even a team of administrators at a specific location, then from there we can take it to our teams if that's the case and keep that going. (Participant 2)

> If I have to go to a workshop and sit there, then I'm going to pay attention. But if it's online, like I don't really take it as seriously and I feel like that's something that needs to be taken very seriously. So, I think in person. (Participant 13)

Furthermore, some participants commented on receiving information online would also be difficult to give their full attention to given their demands and limited time during the school day.

Summary

The goal of the qualitative interviews was to explore school leaders' perspectives, self-reported involvement in response to NSSI in schools and to determine their reported needs around NSSI professional development. Findings demonstrated that all school leaders believe that NSSI is a common method of coping among students and expressed concern for individual and groups of students engaging in self-injury (i.e., social influences). Overall, school leaders had little training and often did not have specific NSSI protocols in places in their schools. As such, school leaders lacked confidence and expressed confusion regarding appropriate next steps when identifying students who self-injure. Additional challenges described by school leaders included limited mental health resources available to students within and external to the school. As such, school leaders thought that training that incorporated specific guidelines and information for school leaders and the broader school community would be important to help improve their current responses to self-injury among students. In the following chapter, the results were used to develop a quantitative online survey in order to more broadly investigate these findings among a larger sample of school leaders.

CHAPTER IV

Part 2: Online Survey

Participants

The online survey sample was distinct from the interview sample. Participants from Part 1 of the study were explicitly instructed not to complete the online survey. Participants were recruited by word-of-mouth and members of the AAESQ were sent an e-mail invitation through a listserv. Thirty-six school principals and vice-principals completed the online survey. Data from three participants were excluded as they did not meet the inclusion criteria (i.e., not elementary or high school principals or vice-principals). Thus, the final sample consisted of thirty-three participants (*N*= 33; 72.7% female) drawn from English language schools across Québec, Canada. The majority of participants were high school principals or vice principals (*n*= 22), followed by elementary school principals or vice principals (*n*= 6), and principals of both elementary and high schools (e.g., K-grade 11; *n*= 5) (see Table 3 for descriptive characteristics of survey sample).

Measures

Online survey. The aim of the online survey was to further explore school leaders' beliefs and current approaches to NSSI school response and their perceived needs for training across Québec. The content of the quantitative online survey was based on the study objectives and informed by the results from the qualitative semi-structured interviews in Part 1 of the study. The survey comprised a mix of structured response formats (e.g., multi-option format, fill-in-the blank) that were based on the themes identified in the semi-structured interviews. The survey began with a consent form (see Appendix E), outlining the purpose of the study, what participants would be asked to do, the benefits and risks of participation and how the data would be protected. Participants were reminded that participation was voluntary and they could

withdraw from the study at any point. The following page was an introduction to the survey, explaining the purpose of the study approximate completion time (approximately 10 minutes) and what the results would be used for. Next, a definition of NSSI was provided for clarification and to increase validity and ensure participants' responses were made with reference to NSSI (i.e., *Nonsuicidal self-injury [NSSI], also referred to as self-injury or self-harm is the deliberate and direct damage of one's body tissue without suicidal intent and not for body modification purposes. Therefore, this definition does not include tattooing or piercing, or indirect injury such as substance abuse and eating disorders. Also, this type of self-injury is different than "self-injurious behaviours" such as stereotypic and repetitive behaviours which are commonly seen among individuals with intellectual and developmental disabilities, and instead occurs in typically developing individuals*). The survey was then broken down into four sections: (1) Demographic information and experience as school leaders (e.g., How many years of experience do you have working as a school principal/vice-principal?); (2) Current school approach to NSSI response (e.g., When it is discovered that a student is engaging in NSSI, who leads the response?); (3) School leader's role (i.e., which of the following is part of your role in response to NSSI at your school?); (4) Challenges in responding to NSSI in schools (e.g., The following is a list of potential barriers or challenges in effectively responding to NSSI in schools, please select all options that apply); (5) NSSI training needs (e.g., How interested do you think school leaders would be in receiving training around response to NSSI in schools?); (6) NSSI knowledge (e.g., In your opinion, how prevalent is NSSI in schools?). Some questions assessing knowledge, information and confidence of NSSI were adapted from earlier research examining school staff knowledge of NSSI (Heath et al., 2006; Heath et al., 2011). Cronbach's alpha scores in a previous study indicated moderate to strong internal consistency across items that assess

confidence (.65), perceived knowledge (.79) and information about NSSI (.40) (Heath et al., 2006). Given the limited number of items used to assess each construct, individual survey items were used in the analyses.

Procedure

Ethical approval was obtained for the online survey by McGill IRB and the AAESQ. An email invitation to participate was sent through the AAESQ listserv (see Appendix D). As an incentive to participate, school leaders were offered free resources and offered the opportunity to receive a free training from leading experts in the field on effective NSSI school response. Those who were interested in participating had access to the link to the online survey in the body of the e-mail. Qualtrics software was used to create and access the online survey (see Appendix E). Participants first read the consent form and accepted to participate before proceeding to the survey. Participants were able to skip any question or stop participation at any point. At the end of the survey, participants were thanked and provided with a link to access a guide on self-injury for school professionals (http://sioutreach.org/learn-self-injury/school-professionals/#ffs-tabbed-18).

Data Analysis

Given the exploratory nature of the study, the analytic plan was kept simple to provide a broader overview of school leaders' perspectives on NSSI response in schools. To this end, basic descriptive statistics were examined to investigate school leaders' perspectives, self-reported involvement in response to NSSI in schools and to determine their reported needs around NSSI professional development. There was a small amount of missing data for every question (n= 1-4); however, these data were not imputed given the descriptive and exploratory nature of the study. Knowledge about NSSI was assessed by summing the number of correct responses to 15

items about general NSSI with higher scores indicating greater knowledge. Weighted Chi square analyses (Cohen, 1972) were conducted to determine if the participants' responses significantly varied by various response options (e.g., gender, age, years of experience as a school principal/vice-principal).

Results Part 2: Online Survey

School leaders' experience, knowledge and confidence

The majority of participants had experience with responding to student NSSI on at least one occasion (93.8%, *n*= 30) and reported that NSSI was prevalent in their school (59.4%, *n*= 19). Participants reported that they typically became aware of student NSSI through peers/friends of the student engaging in NSSI (42.2%, *n*= 14), followed by school staff (27.3%, *n*= 9), the school mental health professional (15.2%, *n*= 5), the student disclosing their own self-injury (6.1%, *n*=2), or noticing student's self-injury (3.0%, *n*=1). Overall, participants were fairly knowledgeable about basic NSSI facts as more than half were able to correctly identify common self-injury characteristics (see Table 4). Despite being generally knowledgeable, 63.6% (*n*= 21) of participants underestimated the prevalence rate of NSSI among students and more than a third believed that NSSI was unrelated to suicide (36.4%, *n*= 12). A one-way ANOVA found that knowledge of NSSI did not differ based on gender, age, years as a school leader, or if the school leader had been trained in responding to NSSI ($F(50)$= 0.39-1.32, p >.05).

When asked about confidence in responding to NSSI, the majority of participants were either somewhat confident (36.0%, *n*= 12), while approximately 20% (*n*= 6) were not at all confident. Results of Chi-square tests examining level of confidence in responding to NSSI by presence of school NSSI protocol revealed a statistically significant association between groups, $\chi 2$ (4) = 11.15, p= .025, phi= .60. Specifically, participants who endorsed "moderately confident" or "very confident" were significantly more likely to have an established NSSI school protocol, compared to those who reported feeling "not at all confident" in responding to NSSI.

Chi-square analyses revealed no observed differences in level of confidence based on gender, age, years of experience, or previous training ($p > .05$).

Current school approach to NSSI response

Participants were asked about their current school approach to NSSI response. While the majority of participants believed that it was "very important" to have a school NSSI protocol (84.8%, *n*= 28) over half (54.8%, *n*= 17) reported working in schools without such a protocol or were unsure if such a protocol existed. Interestingly, 69.7% (*n*= 23) reported having a school suicide protocol (i.e., an explicit agreement among school personnel about how incidents or reports of suicidal behaviours will be managed). One-third of participants (30.3%; *n*= 10) reported that they had an NSSI school protocol that was combined with the school suicide protocol. Only a minority of participants reported personally having received training on responding to NSSI in schools (33.3%, *n*= 11). Of these participants who received training, about half (54.5%, *n*=6) reported that the training was specific to NSSI (i.e., training focused on only NSSI and not combined with other topics) (see Table 5).

Current school leader's involvement in NSSI response

Participants self-identified several specific roles as school leaders when responding to NSSI. Beyond referring to the mental health professional within the school (57.6%, *n*= 19) or in the community (45.5%, *n*= 15), approximately half of participants reported that their role involved coordinating response efforts among school personnel (48.5%, *n*= 16), making initial parent contact of students with self-injury (51.5%, *n*= 17) or having on-going communication with parents (51.5%, *n*= 17). As a part of this response, 27.3% (*n*= 9) answered that they "always" contact the parent(s) or legal guardian (s) of the self-injuring student. Participants also reported that their role included follow-up with the student (39.4%, *n*= 14) and at times speaking

with the students directly about their self-injury (30.3%, *n*= 10). Other roles involved development of an organizational school plan for responding to self-injury (27.3%, *n*= 9) and coordinating services external to the school (e.g., mental health services in the community (27.3.2 %, *n*= 9) and follow-up communication with external services (24.2%, *n*= 7) (see Table 6). Once it is learned that a student is engaging in NSSI, participants reported that typically the school leader and school mental health professional shared the lead response (42.4%, *n*= 14); 24.2% (*n*= 8) answered "other" (e.g., behaviour technician, adult who has the closest relationship with the child, special education consultant, school team); 15.2% (*n*= 5) reported that the school mental health professional leads the response; 12.1% (*n*= 4) reported that solely the school leader leads the response.

Challenges in NSSI response

The most common perceived barriers in addressing NSSI in schools were the lack of mental health services in the community (75.8%, *n*= 25) and school (69.7%, *n*= 23), followed by a lack of training for school staff (57%, *n*= 19) and for school leaders (54.5%, *n*= 18). Few participants identified lack of training among their school mental health professionals as a barrier to addressing NSSI in schools (9.1%, *n*= 3). Approximately forty percent (39.4%, *n*= 13) of participants reported that a lack of time was also a significant barrier. Approximately one third of participants (30.3%, *n*= 10) noted the limits around confidentiality as a barrier, as well as the lack of emotional support for school staff involved in responding to NSSI among students (27.3%, *n*= 9). Some participants identified NSSI among groups of students (21.2%, *n*= 7), parent contact/communication (18.2%, *n*= 6) and NSSI content online (12.1%, *n*= 4) (see Table 7).

NSSI Training Needs

Eighty-one percent of school leaders (81.8%, *n*= 27) believed that training around responding to NSSI in their schools would be beneficial for them as school leaders (*n*= 27) and 63.6% (*n*= 21) thought that other school leaders would be interested in receiving training around response to NSSI in schools. Participants identified specific content that they thought was important to include in the training: do's and don'ts (78.8%, *n*= 26), NSSI warning signs (75.8%, *n*= 25), information for school staff (75.8%, *n*= 25), information for parents (72.7%, *n*= 24), protocol examples (66.7%, *n*= 22), information for students (66.7%, *n*= 22), and education around understanding NSSI (60.6%, *n*= 20) (see Table 8).

Participants reported receiving information around NSSI from their respective school boards (51.5%, *n*= 17), followed by their school mental health professional (27.3%, *n*= 9), online (9.1%, *n*= 3), and medical professionals (3%, *n*= 1). Of note, 24.2% of participants reported that they had not received any information about NSSI (*n*= 8). The majority of participants reported having a school mental health professional (e.g., school psychologist, guidance counselor, social worker) designated to their school at least one day a week or more (60.6%, *n*= 20). Approximately one third of school leaders reported that their school mental health professional was trained in NSSI response (33.3%, *n*= 11) and 36.8% (*n*= 7) were unsure if their school mental health professional was trained. A minority of school leaders reported that their school staff was trained in NSSI response (18.75%, *n*= 6); 69.7% reported that their school staff was not trained (*n*= 23).

Summary

The goal of the quantitative survey was to further explore school leaders' perspectives, self-reported involvement in response to NSSI in schools and to determine their reported needs around NSSI professional development. Compared to the interviews, a higher number of school

leaders reported working in schools with NSSI protocols and receiving some training; however, this was still a minority of school leaders and training was rarely specific to NSSI. Findings added to the interviews by indicating that school leaders were significantly more confident if they worked in schools with an NSSI protocol. Consistent with the interviews in Part 1, findings showed that school leaders felt that training would be beneficial to them as school leaders. The most commonly reported barriers were limited mental health resources available to students within and external to the school. Finally, all training needs identified among school leaders in the interviews were also endorsed by school leaders who participated in the online survey (e.g., NSSI psychoeducation, clear guidelines to follow NSSI is identified, specific information around NSSI disclosure and information for parents).

CHAPTER V

Part 3: Professional Development Training

Research Design

NSSI Professional Development Workshop. The NSSI workshop was developed with reference to the literature on best practice guidelines the International Society for the Study of Self-Injury (ISSS) and International Consortium on Self-Injury in Educational Settings (ICES) with an emphasis on specific training needs identified by school leaders (e.g., NSSI psychoeducation, understanding of and implementation of school NSSI protocols, information around NSSI disclosure to parents, managing socially influenced NSSI among peers) and training preferences (i.e., in-person workshop) gathered from Parts 1 and 2 of the dissertation. The training was delivered as a 2-hour workshop and presented in-person based on school leaders' preference for delivery. School leaders' self-reported a need for basic information around self-injury among students. Accordingly, the first section of the workshop was an overview of basic information on self-injury in youth: what NSSI is (and is not), age of onset, prevalence rates, gender differences, risk and protective factors, motivations for engaging in NSSI, the association between NSSI and suicide and possible warning signs. School leaders requested clear guidelines and a step-by-step understanding of how to respond to NSSI. The next section was therefore guided by current research and clinical guidelines on response to NSSI and covered when to report a student suspected of self-injury and how to respond through the use of a school NSSI protocol. Participants were guided through the key elements of an NSSI protocol, including the roles and responsibilities of school staff members, establishing a response team and a designated point person. A brief overview of risk assessment was included in order for school leaders to understand when a risk assessment is warranted, yet details on how to conduct a risk assessment were omitted given that the risk assessment should be conducted by the mental health

professional or trained designated point person. Guidelines for the referral process were also reviewed (i.e., when a student should be referred to the school-based mental health professional, an external mental health professional or the hospital emergency room). School leaders wanted explicit guidelines on parent notification. Therefore, information on when and how to contact parents was reviewed. Sample protocols were provided and the process for establishing the protocol was discussed. This part of the workshop also included information on the importance of the first response and the “do’s and don’ts" when responding to a student who has engaged in NSSI. In addition, although not requested specifically by participants in Parts 1 and 2 of the dissertation, a rationale for why schools are suitable for NSSI response and the importance of the first response was explained. Next, based on school leader’s reported challenges and additional common challenges identified in the literature, recommendations were provided on managing socially influenced NSSI, responding to scars versus wounds and NSSI online. An additional element included in the workshop that is supported by the field was on appropriate school interventions with limited resources. Group discussions and activities were embedded within the workshop as findings from the interviews indicated that school leaders wanted time to discuss with other school leaders. Finally, school leaders requested information for school staff, students and parents. Therefore, in the final section of the workshop resources for school-staff, students who self-injure and their families (e.g., professionally-based websites, recommended books and articles) were presented. Online resources were specified and a package of compiled resources was also sent electronically to all participants following the workshop.

Participants

Participants were 40 school principals and vice-principals (77.5% female, *n*= 31). The overlap of participants across Parts 1-3 is unknown due to the anonymity of the survey. The

same workshop was provided on two separate occasions. First, the workshop was presented to a provincial organization representing school principals and board level administrators across the province of Québec working for Anglophone school boards. The workshop was one of three presented at a Summer Institute on addressing the challenges of mental health in education. School principals and board administrators (N= 35) attended the full day without specifically choosing to attend the NSSI professional development workshop. Attendees that agreed to participate in the workshop evaluation study (n= 28) completed the evaluation at the end of the training. The workshop was presented a second time to an English language school board in Québec. All elementary and high school leaders (i.e., principals and vice-principals) within this particular school board were emailed an invitation to participate (N= 37) and participants who showed interest signed up to attend the workshop (n= 12). While school guidance counsellors were not the intended audience, after several school leaders requested that their school guidance counsellor attend, it was permitted for guidance counsellors to attend with their school principal or vice-principal (i.e., not on their own). All attendees agreed to participate in the workshop evaluation. Evaluations from other school staff (e.g., guidance counsellors, special education consultants, adult education administrators, board directors) were removed from the dataset (see Table 9 for descriptive characteristics of training sample).

Measures

NSSI Professional Development Workshop Evaluation. Measures for evaluation were based on Kirkpatrick and Kirkpatrick's (2006) first three levels of their model for evaluation, namely: reaction, learning, and behaviour. One of the advantages of this model is that it allows flexibility in its use (Bates, 2004). The model also provides the trainer with a systematic method for training evaluation and simplifies the process by guiding questions that are appropriate for

the specific training, reducing the measurements of success to easily measure outcomes, and reducing the number of variables needed to measure success of the outcomes (Bates, 2004). Participants were asked to indicate their role (i.e., high school or elementary school principal/vice-principal), how many years of experience they have had in their role, and how often they dealt with NSSI in their position. Reaction was measured by participants rating their satisfactory level of the workshop (4 items, Cronbach's alpha= .69). Learning, which assesses what knowledge has been obtained and improved, was divided into the areas of perceived knowledge (2 items, Cronbach's alpha= .66) and confidence in own skills (2 items, Cronbach's alpha= .71). Behaviour was measured by participants rating the level of change that they thought would occur in their behaviour across different areas (e.g., approach to parent contact, interactions with students with NSSI; five-point Likert-scale from "a lot" to "not at all"). A section for general feedback and comments was included (see Appendix F). Given the limited number of items to assess each level, as well as alpha scores that were not strong (e.g., <.80), individual survey items were used in the analyses.

Procedure

Several English language school boards in Québec were approached about the study; two school boards expressed interest. After Institutional Review Board (IRB) approval, all school leaders were emailed directly with a summary of the workshop and an invitation for participation. Additionally, school board administrative agents helped to advertise the workshop. Two presentations were given, one for each school board. Attendees were informed that they would receive the resources on responding to NSSI in schools regardless of their participation in the research study (i.e., the evaluation of the workshop). Before the presentation, attendees were provided information regarding the research study. Evaluation of the effectiveness of the

workshop occurred at the end of the presentation. Attendees were asked to review the consent form (see Appendix H) and if they agreed to participate in the workshop evaluation study, they were instructed to sign the consent form, detach it from the anonymous workshop evaluation and to fill out the evaluation. A research assistant helped to collect the forms at the end of the workshop. Given that some school leaders attended the second workshop with their school guidance counsellor, attendees were reminded that only school leaders were to evaluate the workshop.

Results Part 3: Training Evaluation

Reaction/training satisfaction (Level 1). This level examines participants' reactions to and satisfaction with the content and delivery of the training (Kirkpatrick & Kirkpatrick, 2006). A large majority of participants (97.5%) strongly agreed or agreed (on a scale from 1= strongly agree to 5= strongly disagree) that, "Overall the training presentation was well done". Nine-five percent of participants strongly agreed or agreed with the statement, "The training was relevant and met my expectations." Furthermore, 97.5% strongly agreed or agreed that, "The training presented valuable strategies and techniques relevant for principals" and 95.2% of participants strongly agreed or agreed that, "The training was a valuable professional/personal development experience" (see Table 10 for percentage and mean distribution reaction/training satisfaction). Chi square analyses for all items revealed no significant differences based on gender, years of experience as a school principal, school level or how often participants dealt with NSSI.

Learning (Level 2). This level examines participants' skills, knowledge or attitude changes as a result of the training (Kirkpatrick & Kirkpatrick, 2006). Ninety percent of participants strongly agreed or agreed with the statement, "I feel knowledgeable in the area of NSSI as a result of the workshop". While 82.5% of participants strongly agreed or agreed with the statement, "I believe I would know how to identify NSSI behaviours among students", 17.5% reported that they were neutral. In response to the statement, "I would feel comfortable if a student spoke to me about NSSI", 87.5% of participants strongly agreed or agreed. Finally, 92.5% of participants strongly agreed or agreed with the statement, "I feel confident that I would know how to respond if a student in my school was engaging in NSSI" (see Table 11 for percentage and mean distribution of the workshop learning). Chi square analyses revealed no

significant differences based on gender, years of experience as a school principal, school level or how often participants dealt with NSSI.

Behaviour (Level 3). This level examines changes in behaviour as a result of training (Kirkpatrick & Kirkpatrick, 2006). Overall, 90% of participants felt that how they deal with NSSI in their school overall will change "a lot" or "moderately" as a result of the workshop Specifically, the majority of participants reported that they would change their approach school wide (e.g., protocol, teacher training; 92.1%), their understanding of NSSI (86.8%), their specific actions or roles in responding to NSSI (82.1%), their approach to parent contact (82.1%) and their interactions with students with NSSI (82%) either "a lot" or" moderately." Fewer participants reported that they would change their collaboration with the school mental health professionals (56.7%); 40% of participants reported that they would only change their collaboration with the school mental health professionals minimally or not at all. Finally, 20% of participants reported that they would change their school policy for scars/wounds minimally or not at all (see Table 11 for percentage and mean distribution of perceived change in practice and behaviour). No significant differences were found based on gender, years of experience, school level or how often participants dealt with NSSI.

General feedback and comments. A section for general feedback and comments was included at the end of the workshop evaluation. Participants noted a need for NSSI training in schools and an appreciation for the information presented

> This presentation was very informative and well done. The provision of resources to distribute to parents and school staff will be very beneficial! Thank you. (High school vice principal)

> I was so grateful to receive this training! The presenters were excellent. The practical tools and resources will certainly be used in my school and I am confident that our board

> will develop a policy in accordance with the research and suggestions given at the workshop. Thank you! (High school vice principal)
>
> Very concise, practical information to put in place with the school team. Good length, straight forward delivery. (High school principal)
>
> This presentation is needed for all our school principals. NSSI is ignored in elementary schools. Thank you. (Elementary school principal)
>
> Although I feel that we are responding in a very appropriate manner in my school, I am happy that the workshop has prompted a discussion at a board level. It also validated some of our practices in our school (i.e., informing parents) for which we have gotten pushback from the board in the past." (High school principal)
>
> Although this seems like an impossible topic to have definite responses or scripts, the presentation made me think differently. For instance, framing the topic to parents as self-harm being an unhealthy coping strategy is less alarming than telling a parent to take their child directly to the emergency room. The key is awareness through handouts, workshops and open dialogue. Not about suicide necessarily, but coping! (Elementary school principal)
>
> Your presentation made me reconsider the way I approach a student and parents when dealing with NSSI. (Elementary school principal)

The qualitative feedback provided add weight to the quantitative findings that the majority of participants believe they would change their approach to NSSI response in their schools as a result of this workshop.

CHAPTER VI

Discussion

According to Ecological Systems Theory (EST) and best-practice guidelines around self-injury among students, engaging school leaders is essential in facilitating an effective school-wide response. Thus, the purpose of this dissertation was to gain an understanding of school leaders' perspectives on school response to student NSSI. Objectives 1 and 2 were accomplished using a two-phase exploratory sequential mixed-methods design, whereby qualitative semi-structured interviews were conducted among a sample of school leaders and used to drive the development of a quantitative survey to more broadly investigate and accurately assess issues representative of school leaders' experiences; specifically, leaders' perspectives, self-reported involvement in response to NSSI in schools and to determine their reported needs around NSSI professional development. Objective 3 was to compile the findings around what school leaders identified as specific NSSI training needs and preferred method of delivery, combined with a review of the literature in order to develop, pilot, and evaluate a focused professional development training for school leaders when responding to NSSI in schools. In this chapter, the integrated findings from both the interviews and survey, and the professional development training are further discussed, followed by the study limitations and implications for school psychologists.

Integrated Findings: Interviews and Online Survey

School leaders' perspectives on NSSI response. Overall, the qualitative and quantitative data painted a similar picture. The vast majority of school leaders had personal experience with responding to cases of self-injury among students highlighting that school leaders are on the frontlines when cases of self-injury are identified. Despite personal experience with responding to NSSI and as in other studies among school staff (e.g., Heath et al., 2011), the

majority of school leaders underestimated the prevalence of NSSI. School leaders generally demonstrated basic knowledge of NSSI, yet the interviews highlighted that knowledge was limited to understanding self-injury (and specifically "cutting") as a way to regulate difficult emotions and many misconceptions were endorsed. Although misconceptions among the broader sample of school leaders in the Part 2 quantitative survey were fewer in number, those endorsed were still harmful and could have a significant impact on how NSSI is addressed within the school. For example, while it seems that there is a greater understanding that NSSI should not be mistaken for suicidal behaviours, as it often has been in the past (e.g., Lewis & Heath, 2015), approximately half of the participants believed that NSSI and suicide were unrelated or were confused about the relation. As noted in the field, NSSI and suicidal behaviours are not mutually exclusive (Klonsky et al., 2013) and viewing them as such can be harmful to students at-risk (e.g., may lead to inadequate evaluation or lack of suicide risk-assessment). A number of school leaders also had an understanding of NSSI as an "attention-seeking" behaviour and used judgmental language when describing NSSI, including the terms "popular" or "trendy". These terms assume a negative attitude towards students who engage in NSSI and can lead to poor understanding and response. Furthermore, using judgmental language contributes to the stigma that students who self-injure already endure (e.g., Burke et al., 2019; Hasking et al., 2021; Lewis et al., 2019). Again, such beliefs could have detrimental effects on evaluating and determining risk among the student body and may possibly allow distressed students to go undetected. These findings highlight that although NSSI knowledge among school staff seems to have improved within the past decade (e.g., Berger et al., 2015; Best, 2006; Heath et al., 2011), providing more education can help address misconceptions and further educate school staff. As all school leaders

expressed concern and care for their students, addressing such misconceptions would likely be a relatively easy, straightforward, and well-received intervention with great impact.

School leaders' involvement in NSSI response. School leaders in the current study were asked about their current approaches and involvement in NSSI response in schools. In the interview data, there was an overwhelming lack of specific NSSI protocols as all interviewees denied having an established protocol in their schools or were unsure if they had such a protocol within their school boards. Common practices included contacting parents and connecting students with support from a mental health professional, yet these practices were typically decided on a case to case basis with no standardized process. In the survey data, these findings were mixed, as approximately half of school leaders reported working in schools without an NSSI protocol. Still, a third of participants reported that the school protocol for NSSI and school protocol for suicidal behaviours were often combined. Recent work has outlined the importance of having an NSSI-specific protocol in schools in order to ensure appropriate response, referral and intervention (Hamza & Heath, 2019; Hasking et al., 2016; Hasking, et al., 2020; Lewis et al., 2019; Matthews et al., 2021). For example, without a structured response, schools may react to self-injury in a manner of panic and make inappropriate referrals to external emergency services (Crowe et al., 2020; Dowling & Doyle, 2016). While involving emergency services is necessary where there is imminent risk (Townsend, Hasleton, Marceau, Gray, & Grenyer, 2018), unnecessary referrals can result in a break of trust between students and staff and lead to future non-disclosure (Berger, Hasking, & Martin, 2013; Evans & Hurrell, 2016). A lack of specific NSSI protocols in schools has been previously documented (Berger et al., 2015; Hasking et al., 2020; Lewis et al., 2019; Matthews et al., 2021), thus the findings from the current study suggest

that school settings continue to struggle and need help at a systems level to implement such protocols.

In addition to a lack of NSSI protocols, the interviews and online survey confirmed that the majority of school leaders have not received any formal training around NSSI response. It is therefore unsurprising that most school leaders across both the interviews and survey data reported medium to low confidence in their responses. The interviews provided further insight into the specific difficulties that school leaders are facing due to their lack of training. For example, while many school leaders expressed concern for the well-being of their students, many did not know how to best approach the issue and were worried of unknowingly causing harm (e.g., saying the "wrong" thing to students or not knowing what to say to parents). In conjunction with lack of formal protocol, school leaders were often left to act and make decisions (e.g., speak to students, inform parents) with very limited knowledge around self-injury. The finding that most school leaders lack confidence in their responses to NSSI is consistent with previous work documenting that other school staff equally feel underprepared (e.g., Berger et al., 2014; Heath et al., 2011; Roberts-Dobie & Donatelle, 2007). An important finding was that school leaders who worked in schools with an NSSI protocol were significantly more confident in their response to NSSI. Confidence did not differ based on previous NSSI training in the survey data, however, no information regarding the quality or content of previous NSSI training was collected. Furthermore, due to the small number of school leaders who reported previous training it may be that a difference was not detected. Overall, the results suggest that providing school leaders step-by-step guidelines with outlined roles for school staff is likely to increase confidence when intervening and responding to NSSI among students.

An overwhelming majority of school leaders across the interviews self-reported that communicating with parents was one of their primary roles when responding to NSSI in schools. Most school leaders in the interviews noted making the initial disclosure to parents themselves and reported that they almost always contact the parent(s) or legal guardians of the student as student safety was their priority. The survey confirmed the finding that school leaders believed it was their role to contact parents, despite a lack of training. These findings suggest that parent contact is an area in which training may be particularly impactful. Decisions about disclosing to parents and student confidentiality were also a cause of frustration and seen as a barrier to effective response. Although involving parents is most often appropriate and helpful (Hasking, Rees, Martin, & Quigley, 2015; Kelada et al., 2016), researchers have demonstrated that the ways in which school staff speak to and educate parents about self-injury can have a significant impact both upon how the disclosure is received and how the behaviour is addressed following disclosure (i.e., counselling, family conversations and reactions, parenting; Hamza & Willoughby, 2016; Klonsky et al., 2013; Simone & Hamza, 2020). Generally, the decision process to contact a student's parents should be clearly outlined within an NSSI protocol and contingent on existing reporting laws that may vary by school and province (Hamza & Heath, 2018). School leaders are encouraged to work together with the school mental health professional when contacting student's parents about NSSI (e.g., when a student is deemed high risk for serious injury by the trained point-person) in order to reduce confusion and ensure that proper precautions are taken (e.g., resources are provided to parents). It is also recommended in the literature that students be involved and well-informed if parents are contacted (e.g., Hamza & Heath, 2019).

When asked about challenges when responding to students who self-injure, there was a significant focus on difficulty accessing mental health services within- and outside of schools. Many school leaders reported having a designated mental health professional within the school, yet often these individuals worked in multiple schools or only hired as half- or quarter-time. Furthermore, the school mental health professional was not always trained in NSSI response or had a different school role (e.g., mandated primarily for conducting psychoeducational assessments). In addition, school leaders noted a lack of external resources necessary to meet the needs of the students that school was not set-up to provide, particularly community mental health professionals. Nevertheless, school leaders unanimously believed that having more services and training for all staff would facilitate their ability to respond effectively to student NSSI. With limited resources within and outside of schools, and a lack of clear procedures, school leaders in the interview sample unsurprisingly expressed frustration around who they viewed as being accountable for addressing NSSI among students. Interestingly, the interview data highlighted that many school leaders thought that their role did not extend beyond identifying and referring students who engage in NSSI. For example, the participants commonly reported frustrations around a lack of mental health services and waiting for external resources to intervene. On the other hand, the majority of school leaders in the survey data reported that both the school and community had a responsibility to address self-injury among students. Schools are important sites for responding to student mental health concerns (e.g., Crowe, Townsend, Miller, & Grenyer, 2020; Hasking et al., 2016). Furthermore, when evidence-based practices in mental health promotion are adopted in a whole school manner, students show positive social emotional and academic benefits (Short, 2016). It is therefore imperative that schools understand the responsibility they have in addressing NSSI among students, including ensuring an appropriate

first response, intervention and follow-up/monitoring (e.g., De Riggi et al., 2017; Hasking et al., 2020). The school leader is a key factor in the organization and delivery of school-based services to students and in the absence of such services, there is an obligation for school leaders to seek out health and social services (MEQ, 2020). While an increase in professional services may not always be possible, taking a school-wide approach to NSSI response creates a culture of response and is a feasible way to counteract challenges related to limited resources schools. For example, school leaders can help implement prevention measures that focus on teaching healthy coping strategies (e.g., dialectical behavioural therapy [DBT] in schools) in order to create positive change for students who self-injure (Miller, Gerardi, Mazza, & Dexter-Mazza, 2020).

School leaders' NSSI training needs. Previous research suggests that school leaders play a critical role in facilitating NSSI services yet many studies have not included school leaders or found low response rate (e.g., Berger et al., 2014b). This is the first study to specifically target school leaders and document their training needs. The interview data highlighted that the majority of school leaders did not know how best to respond to NSSI and wanted clear guidelines (e.g., flow chart, protocol examples) in order to ensure that the appropriate actions were taken by all school professionals involved. A need for clear school guidelines was confirmed through the survey data and has been reported by other school staff in previous work (Berger et al., 2014; Heath et al., 2011; Matthews et al., 2021). If school leaders are to be encouraged to develop and implement these policies in their schools, it is imperative that they are first provided with proper training to ensure sound and evidence-based decisions in this process. Based on other self-reported needs across the interviews and survey, training for school leaders should also include psychoeducation, information on how to support and speak to parents/caregivers about self-injury, and when further intervention may be warranted.

The interviews shed light on school leaders' concerns around social influences of NSSI among peers. Although this concern was not as widespread in the survey findings, it raises an important topic in schools. Given that NSSI is often discussed among students, it is recommended that schools work toward influencing the nature of the communication and reduce communication that focuses primarily on the details of the self-injury (e.g., particular methods, what happens during an NSSI episode; De Riggi et al., 2017). Training should also include accurate information about responding to student's showing scars or wounds. Specifically, while wounds may be triggering (Baker & Lewis, 2013), there is evidence that scars do not have the same effects and in fact choosing to stop concealing one's scars is an important step to recovery (Lewis, 2016). At the same time, displaying one's scars can result in unintended consequences for students who self-injure (e.g., bullying, intrusive questions) and therefore it is recommended that the school mental health professional have a sensitive and compassionate discussion with the student upon their decision to stop concealing scars (Hasking et al., 2016).

Professional Development Training Findings

The third objective of the current dissertation was to develop, pilot and evaluate a professional development workshop on response to NSSI in schools. As summarized in Table 8, the reported concerns regarding training needs for school leaders from the interviews and survey were compiled and combined with best-practice knowledge to develop the workshop. Findings from the workshop evaluation indicated that overall, the workshop was viewed positively by the majority of school leaders. Specifically, most school leaders were very satisfied with the training and felt that it was a valuable experience for them as school leaders. These findings provide support for involving school leaders in NSSI school training and can encourage school policy

makers (i.e., school administration) to develop or re-examine their existing practices related to NSSI response.

The level of learning among school leaders was divided into the areas of perceived knowledge and confidence. The present study and other studies in the field have shown a lack of knowledge and confidence in dealing with NSSI among school staff (e.g., Berger et al., 2014a; Heath et al., 2011). After the current training, the majority of school leaders agreed that they saw themselves as knowledgeable in the area of NSSI among youth. Furthermore, the vast majority of school leaders felt confident in responding to NSSI among students immediately at post-training. These findings are in line with a study of a 2-day workshop that assessed confidence, perceived knowledge of NSSI and suicidality (Groschwitz et al., 2017) and indicate that brief workshops are an effective way to increase understanding of NSSI and positive practices in schools. Importantly, although the majority of school leaders believed that they would know how to identify NSSI behaviours among students, approximately one fifth of school leaders reported feeling neutral. As documented in the literature, self-injury among students is often a secretive behaviour and although there are warning signs that may be visible (e.g., unexplained cuts, bruises, burns) other warning signs are more covert (e.g., carrying around sharp objects) or less likely to be known by school leaders. It may be that other school staff (e.g., teachers) are more likely to first discover NSSI given the greater time spent directly with students.

Previous research in the field suggests that implementing changes in the school system through professional training may be difficult due to lack of administrative support (Groschwitz et al., 2017). Findings from this dissertation indicate that school leaders are in fact willing to make behavioural changes in their schools around NSSI response as a result of the professional development workshop. Specifically, school leaders reported being likely to change their specific

role (e.g., collaboration with other school staff), how they approach parent contact, and interactions with students around NSSI. While the training was targeted toward school leaders, during the second workshop many participants attended with their school mental health professional. Possible explanations might be that mental health professionals see more need for education in this field for themselves. Alternatively, the desire to have their school mental health professional attend the training may be related to the findings that school leaders often work collaboratively with the school mental health professional when responding to self-injury among students. As many school leaders in the current study reported already working closely with their school mental health professional, it may explain why a large portion of school leaders reported that they would only minimally change their collaboration with the school mental health professionals.

Limitations

While this exploratory dissertation makes an important contribution to the literature on school NSSI response, certain limitations should be noted. One limitation of the study is the self-selection bias of participants since the interviews and survey was not compulsory. It was therefore not possible to determine the response rate and representativeness of participants. It may be that only motivated school leaders with particular interest in NSSI participated. Another limitation is that behavioural changes from the professional development training were only assessed using self-report measures immediately post training and therefore the extent to which the training will yield changes in schools and the impact it will make on students is not known. Although participants were offered help through the Centre of Excellence for Mental Health (CEMH) to implement NSSI policies in their schools, the study did not include a measure of actual change and evaluation in the school setting. There is strong value in continued

collaboration among researchers and practitioners to enhance school mental health (Short, Weist, Manion, & Evans, 2012). Future directions include evaluating the implementation of NSSI protocols in schools and whether such protocols and training impact school staff and student behaviour, as well as outcomes for students who self-injure.

Implications for School Psychologists

School psychologists have a critical role to play when it comes to addressing NSSI in schools given their training in student mental health. Specific implications for school psychologists drawn from the dissertation focus on the importance of advocating for an effective response to students who self-injure. As a first step, school psychologists have a responsibility to inform themselves on current NSSI knowledge and to actively engage in their own professional development. Once this knowledge is obtained, school psychologists can disseminate current information on evidence-based response to NSSI in schools to school leaders (at the school and/or system level), for example, by sharing NSSI-related resources. In order for changes to occur at a school level, school leaders first need accurate information and an understanding of the importance of addressing NSSI appropriately within schools. School psychologists can then encourage school leaders to prioritize NSSI professional development for school staff. Based on the findings in this dissertation, a key knowledge domain to review with school leaders is parental involvement when responding to NSSI among students. Family support is a significant predictor of whether a young person ceases self-injury (Taliaferro, Jang, Westers, Muehlenkamp, Whitlock, & McMorris, 2020) and parents are likely to feel overwhelmed at first and need their own support. Given that school leaders reported often communicating with parents without any training, school psychologists can inform school leaders around decisions about *when* and *how* to contact parents. School psychologists can also help prepare resources in advance, including basic

information on NSSI in the broader context of coping, how to discuss with their child, and information on self-care and providing non-judgmental support. Along these lines, it is recommended that the school leaders and school psychologists work collaboratively to keep lines of communication open with parents. As school leaders reported being involved with directly speaking to students who self-injure, it would also be critical to provide school leaders with strategies for safely talking about self-injury with students (e.g., in a calm, empathic and respectful tone; Hasking et al., 2019) in order to promote help-seeking and to encourage professional help among students who self-injure.

Within an EST framework, all members of the school community would benefit from having a school-wide NSSI protocol in place for identifying and responding to NSSI. School psychologists can advocate for the development of a formal protocol in their schools, and work with the school leader to create the protocol and ensure that there is widespread understanding of it among the broader school community. Development should also be combined with training for all involved personnel to ensure consistent implementation. School leaders in the current study equally saw that school-wide training (e.g., including teachers) would be one of the most important facilitators in effective NSSI response. School leaders also showed improvements in learning and reported being likely to make school changes based on the training. Given these findings, school psychologists are encouraged to use the information provided in this dissertation around specific training needs and provide professional development training for their school leader(s) and/or school board.

Conclusion

In conclusion, NSSI is a prevalent and important concern among students that merits immediate attention in schools. The majority of literature and training on NSSI in schools has

focused on school staff (e.g., teachers) and school mental health professionals, however, school staff and mental health professionals themselves note that working in silos is not effective in supporting students who engage in NSSI. In order for training to be helpful, the school leader must support the appropriate NSSI school response. This dissertation further emphasizes the importance of actively including school leaders in our research and training in the area of NSSI. Effective school response comes from the top down, as do staff reactions to, and perceptions of NSSI. Increasing knowledge and implementing best-practice guidelines in school, including protocol and training, can result in positive changes in how youth who self-injure are perceived and addressed in the school setting. Therefore, it is important that school leaders be involved and aware of the overarching plan for addressing NSSI and consulted with across each step. School leaders consistently expressed care and concern for their students engaging in NSSI and were heavily involved in responses to NSSI but generally felt underprepared to address such concerns. The pilot training for school leaders was well received and viewed as important for school leaders. As school leaders exert significant influence over the culture, attitudes, and directions of their respective schools, ensuring that school leaders and by extension their schools are adequately trained and prepared to handle NSSI when it arises is crucial to ensure that appropriate assessment of NSSI behaviours, referral, and intervention are provided to students in need. Ultimately, promoting a school environment which promotes the physical, social and emotional well-being of their students can serve to support current students in need and prevent mental health challenges in the future.

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Table 1

Key elements to include in school NSSI protocol

Key element	Brief description
1. Aims	Clearly set out the aims at the start of the policy and identify who the policy is for, with an aim to support different parties including all school staff, students and parents/caregivers.
2. Information about NSSI	Clear definition of NSSI and the link and distinction between NSSI and suicide and psychoeducation, including warning signs, myths and at-risk groups.
3. Roles and responsibilities	Roles and responsibilities of all staff for detecting and responding to NSSI should be identified. This should include designating a point person and/or team to coordinate case management.
4. Assessment (including suicide risk)	The school mental health professional or trained designated point person/team must conduct a risk assessment of NSSI and of suicide risk. Risk assessment should be ongoing throughout the intervention stage and the student's progress should continue to be monitored.
5. Referral for intervention	Based on the assessment, referrals should be made as needed (i.e., external referral for intervention, external referral and school intervention, or only school intervention). Provision of NSSI-related resources should also be provided.
6. Parent disclosure and involvement	Parents should be notified as needed based on the assessment. This should include student knowledge and involvement. Support and resources for parents should be provided, including provision of relevant local contacts and referral services
7. Managing social influences	Include guidelines for reducing and/or altering communication about self-injury to focus on coping (i.e., not focusing on details of NSSI) and encourage help-seeking. Guidelines should be included on how to respond to wounds vs. scars.
8. Policy review	Acknowledgement that the protocol will be reviewed annually or biannually to meet current evidence-informed practice.

Table 2

Braun and Clarke's six stages of thematic analysis

Stage	Description of the process
1. Familiarization with the data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to redefine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Table 3

Descriptive characteristics of school leader survey sample (N = 33)

Demographic variable	Category	Sample size (%)
Sex	Female	24 (72.7)
	Male	9 (27.3)
Age (years)	26-35	4 (12.1)
	36-45	8 (26.7)
	46-55	11 (36.7)
	56-65	5 (16.7)
	Unknown	5 (15.2)
School level	Elementary school	6 (18.19)
	High school	22 (66.7)
	Both elementary and high school	5 (15.15)
Years in role	1-5	15 (45.5)
	6-10	5 (15.2)
	11-15	7 (21.2)
	16 and up	6 (18.2)
Geographic area of school	Urban	12 (36.4)
	Suburban	12 (36.4)
	Rural	9 (21.8)
School SES	Upper income	4 (12.1)
	Middle income	7 (21.2)
	Lower income	9 (27.3)
	Mixed	13 (39.4)

Table 4

Percentage distribution for observed NSSI knowledge

Statement	False % (n)	True % (n)	Unsure % (n)
NSSI is a suicide attempt or failed suicide attempt.	*84.8 (28)*	---	3.0 (1)
NSSI occurs predominantly in certain groups of students (e.g., "cutting clubs" or "emo"/"goth" students).	*66.7 (22)*	3.0 (1)	18.2 (6)
Nonsuicidal self-injury rarely occurs among students of high SES.	*66.7 (22)*	0.0 (0)	21.2 (7)
Students who engage in NSSI can stop at any point.	*60.6 (20)*	3.0 (1)	24.2 (8)
Students that engage in NSSI have often been sexually abused.	*36.4 (12)*	3.0 (1)	48.5 (16)
Nonsuicidal self-injury occurs primarily among students of low SES.	*48.5 (16)*	12.1 (4)	27.3 (9)
Nonsuicidal self-injury is often attention-seeking.	*60.6 (20)*	9.1 (3)	18.2 (6)
Nonsuicidal self-injury rarely occurs among elementary school students.	*48.5 (16*)	15.2 (5)	24.2 (8)
The majority of students that engage in NSSI have significant mental health challenges.	*60.6 (20)*	18.2 (6)	9.1 (3)
Nonsuicidal self-injury is almost always "cutting".	*45.5 (15)*	27.3 (9)	15.2 (5)
NSSI is unrelated to suicide.	*21.2 (7)*	36.4 (12)	30.3 (10)
Nonsuicidal self-injury is predominantly a female behaviour.	*60.6 (20)*	*9.1 (3)*	*9.1 (6)*

Note: Italicized numbers indicate the correct response; *n*=4 was missing for every question

Table 5

NSSI training experiences, response, and policy characteristics

Training and Response	Endorsed, *n* (%)
Do you feel that NSSI is prevalent in your school?	19 (59.4)
Have you personally responded to students who have engaged in NSSI?	30 (93.8)
Have you personally received training on responding to NSSI in schools?	11 (33.3)
Was this training specific to NSSI?	5 (45.5)
Do you feel that training around responding to NSSI in schools would be beneficial to you as a school leader?	28 (90.3)
Does your school have a specific NSSI protocol/policy?	14 (45.2)
Does your school have a suicide protocol/policy?	22 (73.3)
Does your school have a combined NSSI and suicide protocol/policy?	10 (30.3)

Note. Responses endorsed “yes”

Table 6

School leaders' current role and involvement in NSSI school response

Principal's role	Endorsed, n (%)
Referring to a school mental health professional	19 (57.6)
Initial parent contact of students who self-injure	17 (51.5)
Follow-up/on-going communication with parents	17 (51.5)
Coordinating response efforts among school personnel	16 (48.5)
Follow-up/on-going communication with the school mental health professional	15 (45.5)
Follow-up with the student	15 (45.5)
Referring to mental health professionals outside the school	14 (39.4)
Speaking with student(s) directly about their self-injury	10 (30.3)
Development of a school plan for responding to self-injury	10 (30.3)
Coordinating services external to the school	9 (27.3)
Follow-up/on-going communication with external services	8 (24.2)
Other	3 (9.0)

Note: Responses endorsed "yes"

Table 7

School leaders perceived barriers to NSSI response in schools

Perceived Barrier	Endorsed, n (%)
Limited mental health resources in the community	25 (75.8)
Limited school mental health resources	23 (69.7)
Lack of training for school staff	19 (57.6)
Lack of training for school administrators	18 (54.5)
Lack of time for administrators	13 (39.4)
Limits to confidentiality	10 (30.3)
Lack of emotional support for school personnel	9 (27.3)
NSSI among groups of students	7 (21.2)
Parent contact/communication	6 (18.2)
NSSI content online/social media	4 (12.1)
Management around scars/wounds	3 (9.1)
Lack of training for school mental health professionals	3 (9.1)
Other	2 (6.1)

Note: Responses endorsed “yes”

Table 8

School leaders' self-reported training needs on NSSI school response

Training Needs	Endorsed, n (%)
Risk factors	32 (97.0)
Do's and Don'ts	26 (78.8)
NSSI warning signs	25 (75.8)
Information for school staff	25 (75.8)
Information for parents	24 (72.7)
Protocol examples	22 (66.7)
Information for students	22 (66.7)
Case examples	21 (63.3)
Education around understanding NSSI	20 (60.6)

Table 9

Descriptive characteristics of school leader training sample (N = 40)

Demographic variable	Category	Sample size (%)
Sex	Female	31 (77.5)
	Male	9 (22.5)
School level	Elementary school	7 (17.5)
	High school	31 (77.5)
	Both elementary and high school	2 (5.0)
Years in role	1-5	18 (45.0)
	6-10	14 (35.0)
	11-15	8 (20.0)
How often dealt with NSSI	Very frequently	3 (7.5)
	Frequently	7 (17.5)
	Sometimes	18 (45)
	Rarely	12 (30)
	Never	0 (0)

Table 10

Percentage distribution for reaction/training satisfaction and learning

Evaluation Level	*M (SD)*	Responses (%)				
		Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
Reaction/training satisfaction						
Overall, the training presentation was well done.	1.30 (.52)	72.5	25.0	2.5	0	0
The training was relevant and met my expectations	1.45 (.60)	60.0	35.0	5.0	0	0
The training presented valuable strategies and techniques relevant for principals.	1.43 (.55)	60.0	37.5	2.5	0	0
The training was a valuable professional/personal development experience for me.	1.28 (.55)	77.7	17.5	5.0	0	0
Learning						
I feel knowledgeable about the area of NSSI as a result of this training.	1.83 (.59)	27.5	62.5	10.0	0	0
I believe I would know how to identify NSSI behaviours among students.	2.00 (.60)	17.5	65.0	17.5	0	0
I feel confident that I would know how to respond if a student in my school was engaging in NSSI.	1.88 (.76)	35.0	57.5	7.5	0	0
I would feel comfortable if a student spoke to me about NSSI.	1.95 (.71)	22.5	65.0	7.5	5.0	0

Note. Means and standard deviations (parentheses) presented for all Liker scale response items. Low score (1) indicates strong agreement with the statement, whereas high score (5) indicates strong disagreement.

Table 11

Percentage distribution for perceived change in practice and behaviour

Evaluation level	*M (SD)*	Responses (%)				
		A lot	Moderately	Minimally	Not at all	N/A
Practice and behaviour						
Do you feel that how you deal with NSSI in your school will change as a result of this workshop?	3.36 (.63)	43.6	48.7	7.7	0	0
My understanding of NSSI	3.39 (.72)	52.6	34.2	13.2	0	0
My collaboration with mental health professionals in my school	2.86 (1.06)	29.7	27.0	35.1	2.7	2.7
My interactions with students with NSSI	3.08 (.74)	28.2	53.8	15.4	2.6	0
My approach to parent contact	3.18 (.79)	23.1	59.0	10.3	2.6	5.1
My specific actions or roles in responding to NSSI	3.10 (.74)	23.1	59.0	12.8	2.6	2.6
School protocol for wounds/scars	3.21 (1.02)	44.7	34.2	7.9	10.5	2.6
My approach school wide (e.g., protocol, teacher training)	3.66 (.62)	57.9	34.2	2.6	2.6	5.3

Note. Means and standard deviations (parentheses) presented for all Liker scale response items. Low score (1) indicates high level of perceived behaviour change in statement area, whereas high score (4) indicates low level perceived behaviour change in the statement area.

Appendix A: Interview Questions Study Part 1

In this interview I will be asking you about NSSI and response to NSSI in your school, schools in general and ideally. I will ask you about what, if any training would be helpful.

(i) Your School: First I am going to ask you some questions about NSSI in your school. To get a sense of NSSI in your present school.

1. Tell me about NSSI in your school? (Probes: Prevalence, perceptions, understanding, training of staff & administrators)

2. Tell me about Your School's Response to NSSI? (Probes: Policy/protocol? 1st response, Parent Contact, Different roles of teacher, mental health professional, administrators)

3. Specifically tell me about your role as an Admin, please give examples.

(ii) Schools in General: Now I would like you to comment on NSSI in schools in general, from what you know. Specifically, how it may differ or be similar to your own/present school.

1. Tell me about NSSI in general in schools? (Probes: Prevalence, perceptions, understanding, training of staff & administrators; different or not from your school? how different from your school exactly?)

2. Tell me about how schools generally respond to NSSI (Probes: Policy/protocol? 1st response, Parent Contact, Different roles of teacher, mental health professionals, administrators)

3. Tell me about the general role of a school administrator in responded to NSSI, please give examples.

(iii) Ideal School Response: As we know, frequently what we can do within the current context is not always our ideal for many complex reasons. So next I would like to ask you about how you think school response to should be, ideally? How is this similar or different from your own school or schools in general?

1. Tell me about how you think schools should ideally respond to NSSI in schools. (Probe: How same or different from your school? From schools in general? Why?)

2. Tell me about what the role of the administrator would ideally be. (Probe: How same or different from your school? From schools in general? Why?)

(iv*) Specific Challenges /Facilitators: (N.B. much of this may have been covered above, in which case just clarify/summarize points) Okay, so now I am going to ask you to specify the barriers or challenges to ideal response to NSSI in schools and the facilitators to ideal response both in your school and schools in general.*

1. First, what specifically do you see as the biggest barriers or challenges to responding to NSSI in your school? In schools in general?

2. What specifically do you see as the facilitators to effective response to NSSI in <u>your</u> school? Schools in general? I.e., How could we /or could we (?) overcome the challenges? (Probes: Beyond Resources/Money, more mental health professionals? Beyond having more hospital placements? Within school, achievable. N.B. to interviewer: we are looking for suggestions that could be implemented)

(v) *Other?*

1. Anything we have not spoken about or asked about that we should know as it pertains to NSSI and Schools?

(vi) *Workshop/Additional training?*

1. What, if any, workshop or training do you think would be helpful for you as a school leader? (yes training? What would it entail? No training? Why?)

2. What, if any, workshop/training do you think would be helpful for school administrators/leaders in general? (yes training? What would it entail? No training? Why?)

3. What would be best way to deliver this training (if they said yes for either)?

Appendix B: Recruitment E-mail Study Part 1

Administrators' Perspectives on the Response to Non-Suicidal Self-Injury in Schools

Dear [administrators' name]

The [school board name] has recently approved a project that you are invited to take part in. The project aims to gain an understanding of school administrators/leaders' perspectives on school response to non-suicidal self-injury (NSSI; e.g., self- cutting, scratching, burning, bruising of the skin). Rates of NSSI are highest in adolescence and have been an increasing concern for schools over the past few years. As school leaders your perspective is critical in all efforts to create an effective school response. Therefore, we are interested in learning your thoughts regarding school response to NSSI (i.e., taking an active role when NSSI is discovered at school) and the challenges inherent in this process as well as ideas regarding possible needed training. Part 1 is a short 20 min interview with 15 administrators; Part 2 is a brief 20 min online survey of 50 administrators; and Part 3 is the evaluation of a training for school leaders. At this time, we are asking you as a school administrator if you would be willing to participate in JUST Part 1 of the project.

The research project would be led by myself or Dr. Heath. It will consist of a 20 min interview asking you about school response to self-injury, both currently and ideally as well as challenges involved in response and needed training in this area. We would like to make this process as convenient for you as we can, and therefore the interview will take place either at your school or over the phone.

By participating, you will have the opportunity to attend the final training on school administration and NSSI school response. In addition, all participants will be offered a free workshop for their school staff on Best Practices for Effective School-Wide NSSI Response, which was developed with Self-Injury Outreach and Support (SiOS) founders, Dr. Heath and Dr. Lewis. This workshop has been very highly evaluated by school staff across Canada and typically costs $2000.

Attached please find a summary of the project for your information or to share with other school administrators, as well as the full ethics application which was approved by [school board name] for your information or as needed.

I would be very happy to provide you with additional information about the project. Please feel free to e-mail or call me as per the contact information below.

Best regards,

Sincerely,

Nancy Heath, Ph.D.
James McGill Professor
McGill University, Faculty of Education
nancy.heath@mcgill.ca
(514) 398-3439

Melissa De Riggi, M.A.
Project Coordinator
McGill University, Faculty of Education
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Appendix C: Consent Form Study Part 1

Researchers: Nancy Heath, PhD; Melissa De Riggi, MA
Study Title: School Administrators Perspectives' on Response to Non-Suicidal Self-Injury in Schools

1. WHAT IS THIS FORM?
This consent form will give you the information you will need to understand why this study is being conducted and why you are being invited to participate. It will also describe what you will need to do to participate and any known risks, inconveniences or discomforts that you may have while participating. If you participate, you will be asked to sign this form and you will be given a copy for your records.

2. WHO IS ELIGIBLE TO PARTICIPATE?
High school administrators are eligible to participate.

3. WHAT IS THE PURPOSE OF THIS STUDY?
Non-suicidal self-injury (NSSI) is an increasing problem in school settings. The purpose of this study is to gain a better understanding of the challenges and facilitators that school administrators face in effectively responding to NSSI when it is discovered (e.g., by school staff, other students, self-reported).
in their schools.

4. WHAT WILL I BE ASKED TO DO?
You will be asked to participate in a 20-30-minute interview. This interview will take place will at your school or by phone as you prefer, at your convenience. The session will consist of questions pertaining to understanding (i) your school/your response, (ii) schools in general, (iii) optimal or ideal response, (iv) specific challenges/facilitators, (v) administrators' needs for a training, (vi) other information that we should know.

5. WHAT ARE THE BENEFITS OF PARTICIPATION?
Your participation in Part 1 of this study will provide the necessary information needed to create an online survey for a larger sample of administrators to complete around their views on NSSI school response (Part 2). In Part 3 of the study, you will have the opportunity to receive a free training from leading experts in the field on how to ensure effective NSSI response in your school. In addition, all participants will be offered a free training for their school staff on Best Practices for Effective School-Wide NSSI Response, which was developed with Self-Injury Outreach and Support (SiOS) founders, Dr. Heath and Dr. Lewis. This training has been very highly evaluated by school staff across Canada and typically costs $2000.

6. WHAT ARE THE RISKS OF BEING IN THIS STUDY?
We do not anticipate any risks.

7. HOW WILL MY INFORMATION BE PROTECTED?
We understand that some of the information given may be sensitive. Confidentiality will be respected and the information obtained during the interview will be kept confidential. Specifically, interviews will be conducted only by Dr. Heath or her co-investigator Ms. De Riggi (a senior doctoral student). Research Assistants under the supervision of Dr. Heath will have access to the de-identified, number-coded audio recordings, but not to the code key.

8. WHAT IF I HAVE QUESTIONS?
We will be happy to answer any question you have about this study. If you have further questions about this project, you may contact the project coordinator at schoolnssi.study@outlook.com or me directly at nancy.heath@mcgill.ca

9. CAN I WITHDRAW MY PARTICIPATION?
If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want your information to be used.

10. SUBJECT STATEMENT OF VOLUNTARY CONSENT
Your participation is entirely voluntary. You may refuse to answer any questions. Please feel free to ask any questions you may have about the study, prior to making a decision whether to participate or not.

If you have any questions or concerns regarding your rights or welfare as a participant in this research study, please contact the McGill Ethics Officer at 514-398-6831 or lynda.mcneil@mcgill.ca

Your signature below serves to signify that you agree to participate in this study.

Participant Signature: _____ Print Name:_____

Date:_____

Nancy Heath, Ph.D.
James McGill Professor
McGill University, Faculty of Education
nancy.heath@mcgill.ca
(514) 398-3439

Melissa De Riggi, M.A.
Project Coordinator
McGill University, Faculty of Education
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Appendix D: Recruitment E-mail Study Part 2

Administrators' Perspectives in School Response to Non-Suicidal Self-Injury
INVITATION TO PARTICIPATE IN ONLINE STUDY

Greetings,

This is an invitation to participate in an online study on School Administrators perspectives on responding to non-suicidal self-injury (NSSI) when it is discovered (e.g., by school staff, other students, self-reported).
in schools [Insert REB Reference Number].

This study will examine School Administrators' perspectives about self-injury, perceived challenges and facilitators in responding to NSSI in their schools, and training needs. The online questionnaire will take approximately 15-20 minutes to complete. No identifying information will be requested

The results will be used to create a training specific for School Administrators in effectively responding to NSSI.

For more information about the study or to participate in the study, please click the link below.

[link to be created]

Prior to beginning the online questionnaire, further information about the study will be provided and you will be asked to give your consent. Please forward any questions or concerns to the confidential email address, schoolnssi.study@outlook.com. This email address has been established for the sole purpose of this study and is only accessed by myself and Dr. Nancy Heath. Or directly to Dr. Heath at nancy.heath@mcgill.ca

Thank you,

Nancy Heath, Ph.D.
James McGill Professor
McGill University, Faculty of Education
nancy.heath@mcgill.ca
(514) 398-3439

Melissa De Riggi, M.A.
Project Coordinator
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Appendix E: Consent Form Study Part 2

Researchers: Nancy Heath, PhD; Melissa De Riggi, MA

Study Title: School Administrators Perspectives' on Response to Non-Suicidal Self-Injury in Schools

1. WHAT IS THIS FORM?
This consent form will give you the information you will need to understand why this study is being conducted and why you are being invited to participate. It will also describe what you will need to do to participate and any known risks, inconveniences or discomforts that you may have while participating. If you participate, you will be asked to sign this form and you will be given a copy for your records.

2. WHO IS ELIGIBLE TO PARTICIPATE?
High school administrators are eligible to participate.

3. WHAT IS THE PURPOSE OF THIS STUDY?
Non-suicidal self-injury (NSSI) is an increasing problem in school settings. The purpose of this study is to gain a better understanding of the challenges and facilitators that school administrators face in effectively responding to NSSI when it is discovered (e.g., by school staff, other students, self-reported).
in their schools.

4. WHAT WILL I BE ASKED TO DO?
You will be asked to complete a 15- minute online questionnaire. This questionnaire will consist of questions pertaining to understanding (i) your school/your response, (ii) schools in general, (iii) optimal or ideal response, (iv) specific challenges/facilitators, (v) administrators' needs for a training, (vi) other information that you think we should know.

5. WHAT ARE THE BENEFITS OF PARTICIPATION?
Your participation this current study (Part 2 of the project) will provide the necessary information needed to create a training for school administrators on school NSSI response, based on your needs. In Part 3 of the project, you will have the opportunity to receive this training from leading experts in the field on how to ensure effective NSSI response in your school. In addition, all participants will be offered a free training for their school staff on Best Practices for Effective School-Wide NSSI Response, which was developed with Self-Injury Outreach and Support (SiOS) founders, Dr. Heath and Dr. Lewis. This training has been very highly evaluated by school staff across Canada and typically costs $2000.

6. WHAT ARE THE RISKS OF BEING IN THIS STUDY?
We do not anticipate any risks.

7. HOW WILL MY INFORMATION BE PROTECTED?
Your participation will be kept confidential. All responses will be kept in a password protected file stored within a secure computer accessible only Dr. Nancy Heath and co-investigator Ms. De Riggi. All data will be coded to ensure your confidentiality. Your data will be used in the development of scholarly works. At no point during the dissemination of the results of this study will any of your information be released.

8. WHAT IF I HAVE QUESTIONS?
We will be happy to answer any question you have about this study. If you have further questions about this project, you may contact the project coordinator at schoolnssi.study@outlook.com or me directly at nancy.heath@mcgill.ca

9. CAN I WITHDRAW MY PARTICIPATION?
If you agree to be in the study, but later change your mind, you may drop out at any time and discontinue the online questionnaire. There are no penalties or consequences of any kind if you decide that you do not want your information to be used.

10. SUBJECT STATEMENT OF VOLUNTARY CONSENT
Your participation is entirely voluntary. You may refuse to answer any questions. Please feel free to ask any questions you may have about the study, prior to making a decision whether to participate or not.

If you have any questions or concerns regarding your rights or welfare as a participant in this research study, please contact the McGill Ethics Officer at 514-398-6831 or lynda.mcneil@mcgill.ca

By proceeding to the following page, you have provided consent to participate in the study.

Note : print/save a copy of this consent document to keep for your own reference.

Nancy Heath, Ph.D.
James McGill Professor
McGill University, Faculty of Education
nancy.heath@mcgill.ca
(514) 398-3439

Melissa De Riggi, M.A.
Project Coordinator
McGill University, Faculty of Education
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Appendix F: Professional Development Training Evaluation

About You

What is your position/ role? _____

How many years experience in your role?_____ Gender identification (please circle): M F Other

Your organization/ School Board: _____

How often have you dealt with non-suicidal injury in your position? (Circle appropriate)

1	2	3	4	5
Very Frequently	Frequently	Sometimes	Rarely	Never

Training Satisfaction

The training was relevant and met my expectations (Circle appropriate)

1	2	3	4	5
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

Overall, the the training presentation was well done (Circle appropriate)

1	2	3	4	5
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

The training presented valuable strategies and techniques relevant for administrators (Circle appropriate)

1	2	3	4	5
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

The training was a valuable professional/personal development experience for me (Circle appropriate)

1	2	3	4	5
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

Learning

I feel knowledgeable about the area of NSSI among youth as a result of this training (Circle appropriate)

1	2	3	4	5
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

I believe I would know how to identify NSSI behaviours among students. (Circle appropriate)

1	2	3	4	5
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

I would feel comfortable if a student spoke to me about NSSI. (Circle appropriate)

1	2	3	4	5
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

I feel confident that I would know how to respond if a student in my school was engaging in NSSI.

1	2	3	4	5
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

Practice & Behaviour

Do you feel that how you deal with NSSI in your school will change as a result of this training? (Circle appropriate)

4	3	2	1
A lot	Moderately	Minimally	Not at all

If you feel your practice would change at all, please indicate below all areas that you feel will change as a result of this training; indicating the level of change by area (4 a lot to 1 not at all; N/A if you don't deal with youth directly):

4	3	2	1	N/A
A lot	Moderately	Minimally	Not at all	Not applicable

My understanding of NSSI		My collaboration with the mental health professionals in my school	
My interactions with students with NSSI		My approach to Parent contact:	
My specific actions or role in responding to NSSI		School policy for wounds/scars:	
Other (please specify):		My approach school wide (e.g., protocol, teacher training):	

General Comments

_____
_____
_____
_____
_____
_____

Appendix G: Recruitment E-mail Study Part 3

INVITATION TO PARTICIPATE IN A TRAINING EVALUTAION

Greetings,

This is an invitation to participate in a training created specifically for school administrators on effective management of NSSI when it is discovered (e.g., by school staff, other students, self-reported).
in schools [REB #430-0512]

The training has been developed based on the feedback of school administrators. It will include information on understanding NSSI, best practice in school response to NSSI, description of results of the feedback from Part 1 & 2 of the study regarding the administrators' role and recommendations on effective administrators' response. Materials and resources to support school response will also be provided.

In order to receive feedback on the training, we are asking that you also fill out an evaluation to be used for research. The evaluation will be anonymous, and completing it is voluntary.

Date and time: [to be determined]

If interested, please see the attached consent form for a more detailed description the project. You will then be contacted to confirm your attendance of the training.

If you have any questions, please do not hesitate to contact me. I look forward to your reply.

Thank you,

Nancy Heath, Ph.D.
James McGill Professor
McGill University, Faculty of Education
nancy.heath@mcgill.ca
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Appendix H: Consent Form Study Part 3

Researchers: Nancy Heath, PhD; Melissa De Riggi, MA

Study Title: Effective management of NSSI in schools: A training for school administrators

1. WHAT IS THIS FORM?
This consent form will give you the information you will need to understand why this study is being conducted and why you are being invited to participate. It will also describe what you will need to do to participate and any known risks, inconveniences or discomforts that you may have while participating. If you participate, you will be asked to sign this form and you will be given a copy for your records.

2. WHO IS ELIGIBLE TO PARTICIPATE?
High school administrators are eligible to participate.

3. WHAT IS THE PURPOSE OF THIS STUDY AND WHAT WILL I BE ASKED TO DO?
Non-suicidal self-injury (NSSI) is an increasing problem in school settings. The purpose of this study is to evaluate a training created for school administrators on effective management of NSSI when it is discovered (e.g., by school staff, other students, self-reported) in their schools.

You will be asked to participate in a 45-90-minute training that will be delivered at [location to de determined]. The training has been developed based on the feedback of school administrators themselves. It will include information on understanding NSSI, best practice in school response to NSSI, description of results of the feedback from Part 1 & 2 of the project regarding administrators' role and recommendations on effective administrators' response. Materials and resources to support school response will also be provided.

In order to evaluate the training, we are asking that you also fill out a questionnaire to be used for research. The evaluation will be anonymous, and completing it is voluntary. By completing the evaluation, you consent to have the data used for research.

5. WHAT ARE THE BENEFITS OF PARTICIPATION?
By participating, you will have the opportunity to receive a free training from leading experts in the field on how to ensure effective NSSI response in your school. In addition, all participants will be offered a free training for their school staff on Best Practices for Effective School-Wide NSSI Response, which was developed with Self-Injury Outreach and Support (SiOS) founders, Dr. Heath and Dr. Lewis. This training has been very highly evaluated by school staff across Canada and typically costs $2000.

6. WHAT ARE THE RISKS OF BEING IN THIS STUDY?
We do not anticipate any risks.

7. HOW WILL MY INFORMATION BE PROTECTED?
We understand that some of the information given may be sensitive. Confidentiality will be respected and the information obtained during the interview will be kept confidential. Specifically, interviews will be conducted only by Dr. Heath or her co-investigator Ms. De Riggi (a senior doctoral student), and all identifying information will be immediately deleted from the audio tape. Subsequently, all interviews will only be identified by number. Only Heath and De Riggi will know the names of participants

8. WHAT IF I HAVE QUESTIONS?

We will be happy to answer any question you have about this study. If you have further questions about this project, you may contact the project coordinator at schoolnssi.study@outlook.com or me directly at nancy.heath@mcgill.ca

9. CAN I WITHDRAW MY PARTICIPATION?
If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want your information to be used.

10. SUBJECT STATEMENT OF VOLUNTARY CONSENT
Your participation is entirely voluntary. You may refuse to answer any questions. Please feel free to ask any questions you may have about the study, prior to making a decision whether to participate or not.

If you have any questions or concerns regarding your rights or welfare as a participant in this research study, please contact the McGill Ethics Officer at 514-398-6831 or lynda.mcneil@mcgill.ca

Your signature below serves to signify that you agree to participate in this study.

Participant Signature: _____ Print Name:_____

Date:_____

Nancy Heath, Ph.D.
James McGill Professor
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Melissa De Riggi, M.A.
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