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REVIEW PAPER

Systematic Review of Best Practice Guidance for Schools to Respond to Self-Harm

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Abstract

Self-harm rates among adolescents continue to increase globally, placing an increased demand on schools to respond to and manage young people whoengage in self-harm. Schools in developed countries report being ill-equipped tomanage self-harm, and unsure of how to use the evidence available to guide them.The methods used in this systematic review are based on Cochranemethodology. We conducted a search of peer-reviewed publications from threedatabases; PsycINFO, (OVID) MEDLINE and EMBASE published in English from 1990 until 30 September 2022 and completed a grey literature search via Google. Two authors (LB and SH) extracted data from publications that provides guidance, actionsand/or recommendations to school-based professionals (any school staff includingschool pastoral care) on the management of self-harm. The breadth of recommendations made to schools are discussed. Studies suggest schools need specific advice about role and responsibility to effectively respond to and manage self-harm in school settings. Evidenced based, action-oriented guidelines for schools to respond to self-harm is required.

Keywords Self-harm · Suicide prevention · School · Practice · Guidelines · Youth

Introduction

Self-harm is a growing problem globally and is associated with increased risk of suicide (Hawton & Sinclair, 2003; Robinson et al., 2016; Witt et al., 2021). Self-harm can be defined as self-inflicted injury or self-poisoning, irrespective of motivation or degree of intent to die. (Hawton & Sinclair, 2003). Self-harm is a broad term, which often incorporates non-suicidal self-injury (NSSI) (Nock & Prinstein, 2004). Depending on the operational definition used and geographic location of research, globally, an estimated 16.8% of young people aged between 12 and 18 years had a lifetime prevalence of self-harm (Gillies et al., 2018). A 2022 global meta- analysis identified a global prevalence (19%) of self-harm in 10–19 years (Lucena et al., 2022). In the same review, a high prevalence of self-harm in the last 12 months was observed in Spain, Brasil, United States of America, China and New Zealand (Lucena et al., 2022). A review of the prevalence of youth self-harm in Low-Middle Income countries (LMIC's) in 2017 varied from 15.5 to 31.3% (Aggarwal et al., 2017).

Globally, indigenous populations experience significantly higher rates of self-harm and suicide compared to non-indigenous groups. Rates of self-harm in youth aged

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15–19 is higher in Sami (Eckhoff, 2020), Canada (Webster, 2019, Aboriginial Torres Straight Islander (AIHW, 2024) and Artic regions compared to non First nations Peers (A higher proportion of Indigenous youth (rangatahi Māori) in Aotearoa New Zealand (13%) had attempted suicide in the last 12 months compared to their non-Māori peers (3%) (Fleming et al., Young et al., 2015) 2020). It is important to address self-harm given its adverse impact on young people's mental health, education and employment outcomes and its link to elevated risk of suicide (Chan et al., 2018; Clark et al., 2013; Robinson et al., 2016).

There is an active debate in academic literature about the extent to which NSSI and self-harm are separate or overlapping concepts often based on intent. However the overlap of the behaviours make the argument of intent arbitrary (Aggarwal et al., 2017). and subsequently guidance often focuses on self-harm (Hawton et al., 2012; Swahn et al., 2012). Indigenous communities tend to define self-harm more broadly than Western medical models by including cultural, spiritual, and holistic contexts beyond the description of behaviour (Kingi et al., 2017). Schools find the interchangeable use of these terms confusing, do not feel skilled to deal with self-harm, and commonly request guidance for best addressing these complex behaviours (Bergen et al., 2012; Berger et al., 2015; Carroll et al., 2014; Crowe et al., 2020; Hetrick et al., 2020; Mars et al., 2014; Te Maro et al., 2019).

The prevalence of self-harm increases across the adolescent period (Brager-Larsen et al., 2022; Geulayov et al., 2018; Gillies et al., 2018), therefore adolescence represents an important period for prevention and intervention (Denny et al., 2018; Hawton et al., 2015; Kothgassner et al., 2020). Most adolescents attend school, so schools are viewed as a context to provide accessible support to students and their whānau/ families. An umbrella review in 2023 of risk and protective factors of self-harm identified schools as an important setting to address the risk factors of self-harm and to provide support to strengthen protective factors (McEvoy et al., 2023).

School staff are thought to be well placed to offer preventative and supportive interventions for adolescents who self-harm, as they are accessible, familiar to students and provide regular hours of support (Evans et al., 2019; Singer, 2017). From a public health perspective, schools provide a context where universal prevention can be offered, which may be more cost-effective than expensive interventions for a smaller, highly selected group of youth already engaging in self-harm, particularly given the limited evidence of effectiveness demonstrated in trials of psychological interventions (Witt et al., 2021). Furthermore, young people have identified school as a preferred setting for both prevention as well as intervention offerings, as they can provide timely support from people they know (Evans & Hurrell, 2016; Hetrick et al., 2020; Knowles et al., 2022), when they experience 'in the moment' distress, in addition to offering more long-term solutions (Hetrick et al., 2020). Schools are a place where young people navigate many social interactions and transitions. Schools present an opportunity to offer prevention and to practical learnt to apply skills. A recent review in 2023 (Brennan et al., 2023), highlighted the need to focus interventions on interpersonal interactions and to help young people manage the changing needs of their social world, both for immediate effect and long term changes (Brennan et al., 2023). Schools want young people to succeed, thrive and to learn and develop healthy foundations for the future (World Health Organization, 2021). Equally, schools are challenged by student wellbeing, and balancing reputation management, which influences student wellbeing, and schools relationships with key stakeholders. It is recognised that safe, supportive education environments lead to better health outcomes (Denny et al., 2016; Runions et al., 2021; World Health Organization, 2021). Good health is linked to educational performance and attainment (World Health Organization, 2021). Global reviews suggest there are implementation barriers to schools delivering responses to health needs, with limited resourcing, guidance, and inadequate cooridnation among services and sectors, particulary health and edcuation (World Health Organization, 2021).

However, school professionals feel ill-equipped to manage self-harm (Berger et al., 2015; De Riggi et al., 2017; Te Maro et al., 2019). A lack of guidance, including training, is perceived to be the most significant barrier to effectively addressing self-harm in schools (Berger et al., 2015; Dowling & Doyle, 2017; Evans et al., 2019; Te Maro et al., 2019). While there is some information about what works therapeutically with adolescents who engage in self-harm in clinical settings (Witt et al., 2021), there is minimal guidance across the spectrum of universal, selected and indicated prevention in school settings. Schools want more than evidence about prevention and intervention but want specific guidance, actions and/or recommendations for school staff to effectively manage self-harm in school settings (Evans & Hurrell, 2016; Hasking et al., 2016; Knowles et al., 2022; Meinhardt et al., 2022).

To address this gap, we have conducted a systematic review of literature that provides guidance, actions and/or recommendations to school-based professionals (any school staff including school pastoral care) on the management of self-harm. In this review, we describe this advice, guidance, actions and/or recommendations (henceforth referred to as recommendations) made to school personnel via both peer-reviewed and grey literature on how to best manage self-harm.

Method

The methods used in this systematic review are based on Cochrane methodology (Higgins et al., 2019). This review aimed to identify the breadth, scope and nature of recommendations made in both peer-reviewed publications and grey literature publications about recommendations made to schools respond to self-harm. Our population of interest was school students with a mean age between 5 and 19 years. Our outcomes of interest were recommendations for schools about the management of self-harm. Our inclusion criteria were: Any study design (qualitatiave or quantative);any guidance, policies and procedures; a focus of the study setting is schools; population of school students aged (5–19 years) or school staff (any) at primary, and secondary schools, publications conducted in any country but published in English; publications from 1990 until 31 October 2022.

Our exclusion criteria were any publications not published in English and outside the date range above; intervention studies (e.g. DBT-A in schools,mindfulness in schools); risk and protective factor publications; opinion pieces/editorial/commentary; specific universities populations and settings.

We excluded studies that examined school-based services focusing on generic mental health, youth health risk behaviour (e.g. substance abuse, unprotected sexual practices) (World Health Organisation, 2014), mental health disorders, postvention (i.e., after a suicide death).

Searching

Our review included two key strategies for searching; first, we searched for academic peer-reviewed literature using comprehensive database searches of PsycINFO, (OVID) MEDLINE and EMBASE including articles published in English from 1990 until 30 September 2022. We used search terms reflecting the target population (e.g., children, youth, adolescent), schools (e.g., primary school, secondary school, high school) and self-harm descriptors (e.g., self-harm, self-injury, NSSI, suicide attempt). We applied the search terms using multipurpose (mp.) searching in the title, original title, abstract, subject heading, name of substance and registry word fields. Secondly, we used the United States of America, Australia, New Zealand and United Kingdom Google platforms (google.com, google.com.au, google.co.nz and google.co.uk) to search for grey literature. Grey literature in this review is defined as materials not published commercially or not indexed by major databases e.g. reports, school documents, and blogs (University of Otago, 2024). After an iterative process to determine what search terms were the most appropriate and produced the most relevant results, the search phrase "self-harm and school guidance" were used in the grey literature search. We included the first 20 search results on each Google site to ensure that only relevant literature was included in the review (Hetrick et al., 2017).

Screening for Inclusion, Data Extraction and Management

For peer-reviewed literature, titles and abstracts were screened independently by two researchers (LB, SH) as per the inclusion and exclusion criteria (described above). For relevant articles and where there was uncertainty, full-text articles were retrieved. Where a decision could not be made regarding a full-text article's eligibility, two researchers discussed this until a consensus was reached. Data were extracted by LB and IM after pilot testing a data extraction template. The template included study characteristics, such as study design (e.g. observational Higgins studies, intervention studies, qualitative publications, evidence synthesis); the country the research or grey literature was conducted in, the type of school (mainstream, private, integrated, rural/urban, primary, secondary); and key findings including recommendations made to schools. Categorisation of study design was based on the work by Kolves et al. (2021). Findings extracted from the studies were then synthesised by focussing on what recommendations were made to schools, including who and how to approach self-harm in school settings.

All data extraction about study design as well as data synthesis was checked by three researchers (LB, SH, SF). LB led the narrative synthesis and SH reviewed. Discussion occured for any disagreement. Peer-reviewed literature was appraised for quality using two types of quality appraisal checklists to ensure checklist questions were relevant to the study design. We selected Joanne Briggs Institute (JBI) tools (McArthur et al., 2015; Moola et al., 2020; Munn et al., 2020; Tufanaru et al., 2020), and Critical Appraisal Skills Program (CASP) tools (Critical Appraisal Skills Programme, 2018a, 2018b). JBI tools were used for cross cross-sectional, case series, non-randomised control studies, and evidence synthesis publications (literature reviews and narrative reviews). JBI checklists appraise quality components based on the results, their relevance and trustworthiness. CASP checklists were used for systematic reviews and qualitative studies. CASP checklists focus on the validity of the results related to study design and methodology, and local applicability of the results.

Findings were synthesised. These were categorised by type of recommendations made using the following categories:

- *specific roles and responsibilities* (defined as leadership, all school staff, teachers only, school health professionals, designated lead/person);
- *whole-school approaches* (defined as self-harm policies/ procedures / guidelines, associated policies (e.g. bullying), universal education of self-harm as part of student curriculum, school culture and environment, relationships with students/key stakeholders, having designated positions, having infrastructure to monitor student self-harm and mental health and record monitoring information);
- *professional development* (gatekeeper training, specific training program, training in a self-harm policy or guidelines, generic training in self-harm);
- *resources* (including protocol or procedural examples, letters to parents, conversation scripts, helplines);
- *communication* (including who the communication is to e.g. students, parents, both student and parents, other internal school staff, external agencies);
- *assessment of self-harm (*including suicide risk assessment with a risk rating of low–high, specific named risk assessment tool, psychosocial assessment, generic risk assessment with no risk rating);
- *response to and management of self-harm* (including referral/consultation with external services e.g. mental health services, call emergency services/hospital, apply first aid, meet and talk with the student, provide supports to the family, provide peer support to other students, ensure immediate safe environment of the student, multiagency meetings, implement safety plans, provide brief interventions to student e.g. distraction strategies, debrief school staff).

Results

An initial 4206 records were identified in peer-reviewed literature and 4094 were excluded due to not meeting the inclusion criteria based on title and abstract screening. We retrieved the full text of 112 potentially eligible peer-reviewed articles and two authors screened these for inclusion (LB, SH). A further 80 were excluded after full-text screening; the majority due lack of focus on self-harm. In total, 32 peer-reviewed publications were included. See Fig. 1 for the PRISMA diagram (Moher et al., 2009).

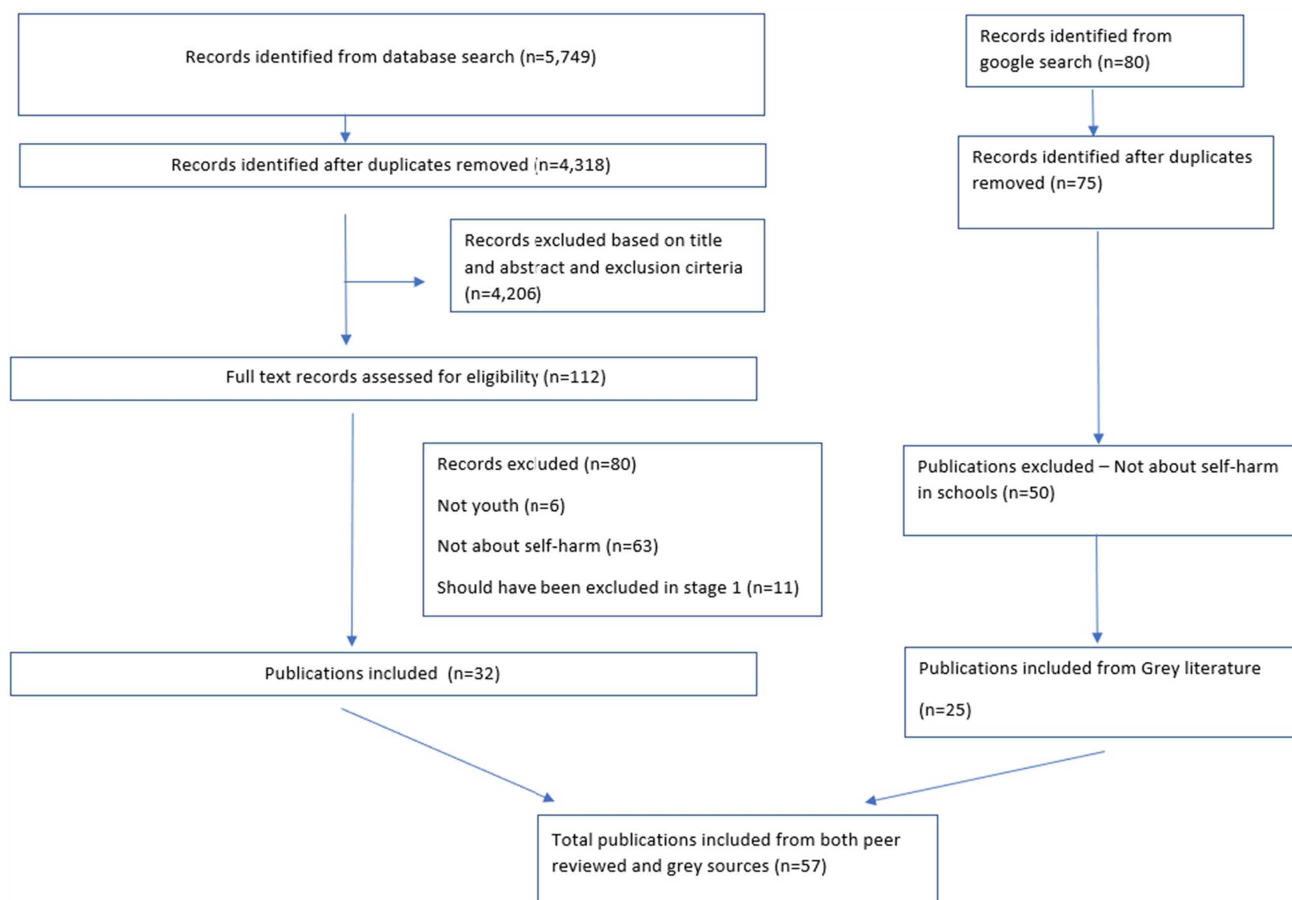

Fig. 1 PRISMA diagram

The grey literature search produced a total of 80 results; duplicates were removed, and 50 studies were excluded because they did not focus on self-harm in schools, resulting in a total of 25 included publications. The grey literature search identified several regionally published practice guidelines for schools, many authored in England. Operational definitions of the study design types are based on the recommendations from Kolves et al. (2021) and have been refined by us for the purpose of this review. The definitions have been applied to the included studies in this review based on the study design type either stated and/or interpreted by us in Fig. 2. These study design types are not the exhaustive list referred to by Kolves et al. (2021).

A summary of study characteristics of the peer-reviewed literature is shown in Table 1 (including country, school type, number of study participants or studies reviewed and study design). Of the 32 peer-reviewed publications, the majority were from the USA ($n=18$) (Bauman et al., 2013; Berger et al., 2015; Capps et al., 2019; Cooper et al., 2011; Davenport & Franci Crepeau-Hobson, 2021; Fernandez, 2013; Haas, 2014; Kodish et al., 2020; Marraccini et al., 2022; Nadeem et al., 2011; O'Neill et al., 2021; Schepp, 1991; Schmidt et al., 2015; Shapiro, 2008; Singer, 2017; Smaby, 1990; Stein et al., 2009; Wester et al., 2018), followed by Australia ($n=4$) (Crowe et al., 2020; Kelada et al., 2017; Matthews et al., 2021; Townsend et al., 2022), Canada ($n=2$), (Bennett et al., 2015; Kenny, 2008), global/international ($n=2$) (De Riggi et al., 2016; Lloyd-Richardson et al., 2020) UK ($n=2$), New Zealand ($n=1$) (Te Maro et al., 2019), Italy ($n=1$) (Gargiulo, 2020) and Ghana ($n=1$) (Baiden et al., 2018). The most common type of study identified was qualitative publications ($n=11$). The majority ($n=31$ publications) focused on secondary schools and one publication included both primary and secondary schools. The number of participants in the included studies ranged from 6 to 1633.

A summary of the grey literature is shown in Table 2 (including country, school type, author, date, grey literature source and URL link). Of the 25 grey literature publications, the majority were from the UK ($n=15$) (Adolescent Self Harm Forum (Oxfordshire), 2016; Anna Freud National Centre for Children and Families, 2020; Association for Child & Adolescent Mental Health, 2022; Cornwall Multiagency Emotional Wellbeing & Mental Health Board, 2017; Devon County Council, 2022; Ealing County, 2014; Harrogate High School, 2017; Hillery, 2008; Norfolk County Council, 2020; Nottinghamshire County Council & Psychology Service, 2017; Staffordshire County Council & Psychology Service, 2022; University of Oxford, 2018; West Berkshire Council, n.d.; Wiltshire Children and Young People's Trust, No Date), followed by Australia ($n=4$) (Beyond Blue Be You In Focus, 2022; Reach Out Schools, 2022; Department of Education of Western Australia, 2021; State of Victoria Department of Education & Training, 2021), New Zealand

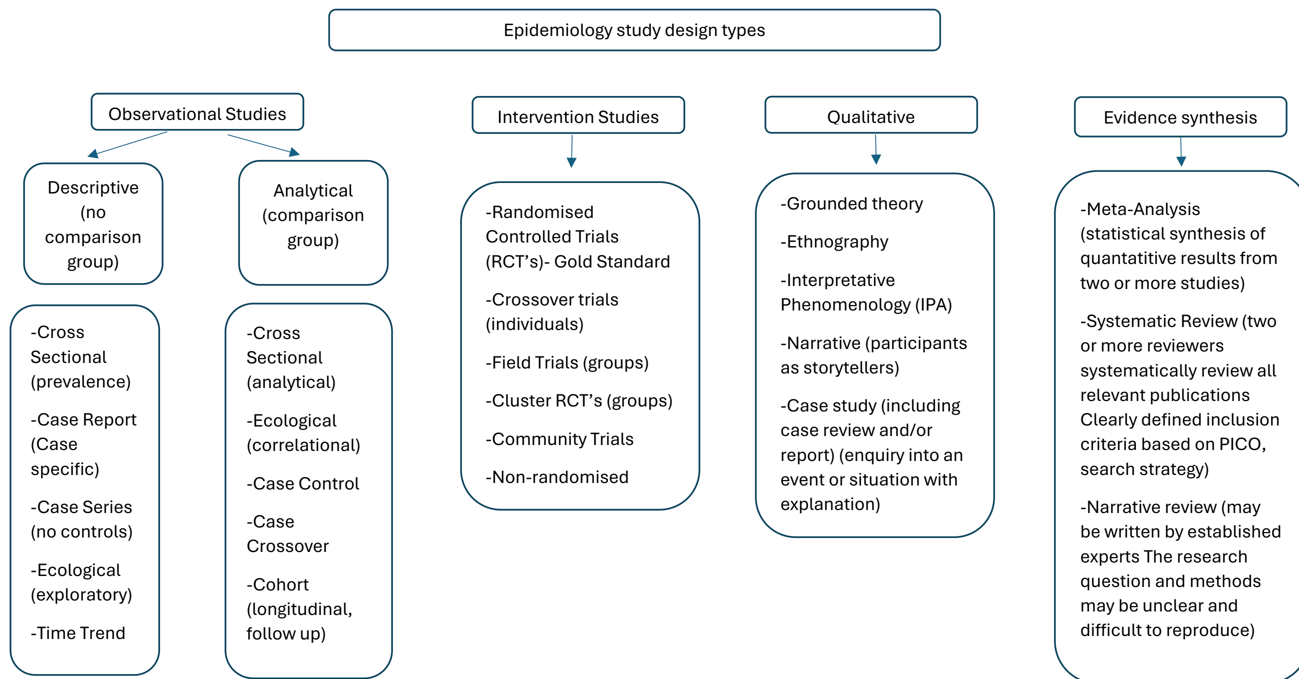

Fig. 2 Epidemiology study design types considered in this systematic review (Kõlves et al., 2021)

Table 1 Overview of peer reviewed publication characteristics and includes details on: country; school type; number of study participants and/or number of studies; study design

Study ID	Authors	Country	School type	Number of participants/studies	Study design
1	Baiden et al. (2018)	Ghana	High school	Participants N = 1633	Observational study—descriptive—cross sectional study
2	Balaguru et al. (2013)	UK	High school	Studies: N = 9	Evidence synthesis—systematic review
3	Bauman et al. (2013)	USA	High school	Participants N = 1491	Observational study—analytic—cross sectional study
4	Bennett et al. (2015)	Canada	High school	Studies N = 28	Evidence synthesis—systematic review
5	Berger et al. (2015)	Australia	High school	Participants N = 48	Qualitative publication
6	Capps et al. (2019)	USA	High school—rural	Participants N = 58 events n = 78	Intervention study—non-randomised
7	Cooper et al. (2011)	USA	High school	N = 0	Evidence synthesis- narrative review
8	Crowe et al. (2020)	Australia	High school	Events N = 77	Observational—descriptive—case series
9	Davenport and Franci Crepeau-Hobson (2021)	USA	High school	Participants N = 72	Observational study—descriptive—cross sectional
10	De Riggi et al. (2016)	Global	High school	N = 0	Evidence synthesis—narrative review
11	Evans et al. (2019)	UK	High school	Schools N = 222 participants N = 153	Observational study—descriptive—cross-sectional
12	Fernandez (2013)	USA	High school	Participants N = 28	Intervention study—non-randomised
13	Gargiulo (2020)	Italy	High school	Schools: N = 2 participants N = 97	Qualitative publication
14	Haas (2014)	USA	High school—rural	Participants N = 10	Qualitative publication
15	Kelada et al. (2017)	Australia	High school	Participants N = 19	Qualitative publication
16	Kenny (2008)	Canada	High school	Participants N = 6	Qualitative publication
17	Kodish et al. (2020)	USA	High school	Participants N = 34	Qualitative publication
18	Lloyd-Richardson et al. (2020)	Global	High school	N = 0	Evidence synthesis—narrative review
19	Marraccini et al. (2022)	USA	High school	Participants N = 19	Qualitative publication
20	Matthews et al. (2021)	Australia	High school	Studies N = 16	Evidence synthesis—systematic review
21	Nadeem et al. (2011)	USA	High school	Schools N = 5 participants N = 45	Qualitative publication
22	O'Neil et al. (2021)	USA	High school	N = 0	Evidence synthesis—narrative review
23	Schepp and Biocca (1991)	USA	High school	Participants N = 169	Observational study—analytical—cross sectional
24	Schmidt et al. (2015)	USA	High school	Events N = 5949 N = 1 school district	Intervention study—non-randomised
25	Shapiro (2008)	USA	High school	N = 0	Evidence synthesis—narrative review
26	Singer et al., (2017)	USA	High school	N = 0	Evidence synthesis—narrative review
27	Smaby et al. (1990)	USA	Primary & high School	N = 0	Evidence synthesis—narrative review
28	Stein et al. (2009)	USA	High school	Participants N = 42 schools: N = 11	Qualitative publication
29	Te Maro et al. (2019)	New Zealand	High school	Participants N = 26	Qualitative publication
30	Townsend et al. (2022)	Australia	High school	Participants N = 17	Qualitative publication
31	Walsh et al. (2022)	Global	High school	Studies N = 12	Evidence synthesis—meta-analysis
32	Wester et al. (2018)	USA	High school	N = 0	Evidence synthesis—narrative review

($n = 3$) (Carville, 2017; Garisch et al., 2020; Unknown, no date) and the USA ($n = 1$) (Bubrick et al., 2010). The most common type of publication identified was a practice guideline ($n = 16$). Twenty-three publications were about secondary schools and two publications included both primary and secondary schools.

Details of the quality appraisal are presented in Table 3. Across peer-reviewed publications, the quality of evidence was low, with 69% of articles having quality components either not considered, and/or not reported or unclear. For example, in intervention studies (non-randomised) and observational studies, only one outcome measurement was used. Qualitative studies often did not consider and/or describe researcher positionality resulting in potential bias in the research question and/or data collection. Not all subtypes of evidence synthesis reviews considered or discussed

Table 2 Overview of Grey Literature with details on: source title; country; school type; author and date; source type and link to the literature

Source ID	Source title	Country	School type	Author and year	Source type	Source link
1	A guide to understanding self-injury for school professionals	New Zealand	Mainstream; Secondary Schools	Unknown no date	Factsheet	Self-injury-schools-highres1pdf (ourhealthhbnz)
2	Preventing and responding to suicide- resource kit for schools	New Zealand	Mainstream; Secondary Schools	Ministry of education new zealand (2019)	Practice guideline	MOE-suicide-prevention-publication-updated-2019pdf (educationgovtnz)
3	Non suicidal self-injury in schools-developing and implementing a protocol	United States of America	Mainstream; Secondary Schools	Bubrick et al. (2010)	Practice guideline	Schools Fact Sheet (cornelledu)
4	Managing SH: practical guidance and toolkit for schools in cornwall and the isles of scilly	United Kingdom	Mainstream; primary and Secondary Schools	Cornwall Multiagency Emotional Wellbeing & Mental Health Board, (2017)	Practice guideline	managing-selfharm-guidance-and-toolkit-for-schoolspdf (healthycornwallorguk)
5	Model guidance: schools responding to incidents of SH	United Kingdom	Mainstream; Secondary Schools	Wiltshire children & young people's trust no date	Practice guideline	A020-13_Model_guidance_for_schools_responding_to_incidents_of_SH_FINAL1pdf (wiltshirehealthyschoolsorg)
6	Responding to SH in the school setting: the experience of guidance counsellors and teachers in Ireland	United Kingdom	Mainstream; Secondary Schools	Dowling & Doyle (2017)	Journal article	Responding to SH in the school setting: the experience of guidance counsellors and teachers in Ireland: British Journal of Guidance & Counselling: Vol 45, No 5 (tandfonlinecom)
7	SH guidelines for school staff	United Kingdom	Mainstream; Secondary Schools	West berkshire county council no date	Practice guideline	https://research.reading.ac.uk/wp-content/uploads/sites/3/2017/04/Self-Harm-guidelines-for-school-staff.pdf
8	SH guidance and policy	United Kingdom	Mainstream; Secondary Schools	Harrogate High School (2017)	Practice guideline	https://www.harrogatehighschool.org.uk/
9	Managing SH: practical guidance for schools	United Kingdom	Mainstream; Secondary Schools	Ealing county (2014)	Practice guideline	EC6221 Managing Self Harm—A4 Guide for Schools 16 pp brochure_v4indd (londongovuk)
10	Young people who SH—a guide for school staff	United Kingdom	Mainstream; Secondary Schools	University of oxford (2018)	Practice guideline	young-people-who-SH-a-guide-for-school-staffpdf (rcpsychacuk)
11	Self-harm	Australia	Mainstream; Secondary Schools	Reach out schools (2022)	Website guidance	SH | Mental health issues | ReachOut Schools
12	Self- harm in the school setting	Australia	Mainstream; Secondary Schools	Beyond blue be you in focus 2022	Webinar handout	SH in the school setting—Be You
13	Break the Silence: SH epidemic 'elephant in room;	New Zealand	Mainstream; Secondary Schools	Olivia carville (2017) New Zealand Herald	Newspaper series	Break the Silence: SH epidemic 'elephant in room'—NZ Herald
14	Self harm guidelines for staff within school and residential settings in Oxfordshire	United Kingdom	Mainstream; Secondary Schools	Adolescent self harm forum (Oxfordshire) (2016)	Practice guideline	SelfHarm 24 pp (oxfordhealthnhsuk)
15	What schools and further education settings can do	United Kingdom	Mainstream; primary and Secondary Schools	Anna Freud National Centre for Children and Families (2020)	Website	What schools and further education settings can do: Mentally Healthy Schools
16	Self injury- a short guide for schools and teachers	United Kingdom	Mainstream; Secondary Schools	Hillery, M	Practice guideline self injury support in north cumbria 2008	scar-tissuenet/images/schoolsipolicypdf

Table 2 (continued)

Source ID	Source title	Country	School type	Author and year	Source type	Source link
17	NICE Guidelines for self harm:a new school of thought	United Kingdom	Mainstream; Secondary Schools	Association for Child & Adolescent Mental Health (2022)	Blog on the practice guideline	PR_03_22_NICE-guidelines-for-SH-a-new-school-of-thoughtpdf (acamhorg)
18	Responding to self harm including suicide attempts in students	Australia	Mainstream; Secondary Schools	State of Victoria Department of Education & Training (2021)	Practice guideline	responding-to-SH-including-suicide-attempts-in-students-a-guide-to-assist-secondary-schoolspdf (educationvicgovau)
19	Responding to non-suicidal self-injury in New Zealand secondary schools: Guidance counsellors' perspectives	New Zealand	Mainstream; Secondary Schools	Garisch et al. (2020)	Journal article	(PDF) Responding to non-suicidal self-injury in New Zealand secondary schools: Guidance counsellors' perspectives (researchgatenet)
20	Self harm guidance for school staff	United Kingdom	Mainstream; Secondary Schools	Devon county council (2022)	Practice guideline	SH guidance for school staff—Support for schools and settings (devongovuk)
21	SH and health harming behaviours guidance	United Kingdom	Mainstream; Secondary Schools	Staffordshire county council & psychology service (2022)	Practice guideline	SH-Guidance-Documentpdf (staffordshiregovuk)
22	Supporting children and students with SH or suicidal thoughts	Australia	Mainstream; Secondary Schools	Department of education South Australia (2022)	Website guidance	Supporting children and students with SH or suicidal thoughts (educationsagovau)
23	Sample Self harm policy-secondary schools	United Kingdom	Mainstream; Secondary Schools	NHS Norfolk, Norfolk county council (2020)	Practice guideline	Sample Self Harm Policy—Secondary Schools (norfolkgovuk)
24	Educational psychology service young people and self harm	United Kingdom	Mainstream; Secondary Schools	Nottinghamshire County Council & Psychology Service (2017)	Practice guideline	young-people-and-SH-guidance-for-schools-10-17pdf (nottinghamshiregovuk)
25	School response and planning guidelines for students with suicidal behaviour and non suicidal self injury	Australia	Mainstream; Secondary Schools	Department of education Western Australia (2021)	Practice guideline	20qo7lv (educationwaeduau)

discourse around the position of the publication. Systematic reviews demonstrated the highest quality results with all components of quality being described in evidence synthesis reviews.

In total, there were 375 findings across the peer-reviewed ($n=173$) and grey literature ($n=202$) publications. Findings from the peer-reviewed publications are presented in Table 4. From the peer-reviewed publications, the most frequent recommendation category was a 'whole-school approach to managing self-harm' featured in 24% ($n=42$) recommendations, which commonly referred to schools needing to have a specific policy, procedure or guideline to explicitly manage self-harm in schools. There was ambiguity about the content of a self-harm policy and/or procedure but frequent recommendations that schools should have a specific policy, procedure, or guideline. The next most frequent category was the 'response to and management of self-harm' featured in 19% of the findings ($n=32$ recommendations) with ambiguity about what the intervention was. However, the most common recommendations within this catergory were to refer to external support agencies (e.g. child and youth mental health services) and provide the student with brief interventions such as distraction strategies. This was followed by specific 'roles and responsibilities' category featuring in 18% of the findings ($n=30$ recommendations). Of these 30 recommendations, predominantly school-based mental health professionals were commonly stated. There was not always a clear school leadership recommendation; despite school leaders having the responsibility for implementing the recommendations. This was closely followed by the 'professional development' category which featured in 16% ($n=28$) recommendations, which predominantly suggested school staff should have gatekeeper training. 'Assessment' was found in 12% ($n=21$ recommendations) of the recommendations, and six of the thirteen risk assessment recommendations suggested risk assessments with risk rating scales of low to high categorisation. This was followed by 'communication' (often to parents) (10% $n=18$

Table 3 Quality appraisal of peer reviewed publications describing quality checklists used, and quality appraisal results relevant to each study design

Intervention study – non-randomised *(JBI Quasi-experimental/ Non randomised Checklist)*	Cause and effect	Participant comparison	Participant comparison received similar treatment	Control Group	Multiple Measurements of Outcome	Follow up complete	Outcomes Measured in the same way	Outcomes measured reliably	Appropriate Statistical Analysis	NA
Capps et al (2019)	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes	
Fernandez (2013)	Yes	Yes	Unable to tell	No	No	Not Applicable	Yes	No	Yes	
Schmidt et al (2014)	No	No	Unable to tell	No	No	Yes	Yes	Yes	Yes	

Observational studies - Descriptive -cross sectional) *(JBI Cross Sectional Checklist)*	Inclusion criteria defined	Study subjects described	Exposure measured reliably	Standard Criteria used measurement	Confounding factors identified	Confounding factors strategies	Outcomes measured reliably	Appropriate Statistical Analysis	NA	NA
Baiden et al (2019)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
Davenport & Crepeau Hobson (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
Evans et al (2019)	Yes	Yes	No	Not Applicable	Unable to tell	Unable to tell	No	No		

Observational Studies – Descriptive – case series *(JBI Case Series Checklist)*	Inclusion criteria defined	Condition measured reliably	Valid identification methods	Consecutive inclusion of participants	Complete inclusion of participants	Participants Demographics reported	Clinical information of participants reported	Outcome reported	Site demographics reported	Appropriate Statistical Analysis
Crowe et al (2020)	Yes	No	No	Yes	Yes	No	Unable to tell	Yes	Yes	Yes

Observational Studies – Analytical - cross-sectional studies *(JBI Cross Sectional Checklist)*	Inclusion criteria defined	Study subjects described	Exposure measured reliably	Standard Criteria used measurement	Confounding factors identified	Confounding factors strategies	Outcomes measured reliably	Appropriate Statistical Analysis	NA	NA
Bauman et al (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
Schepp and Biocca (1991)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		

Key: Appraisal result

Unable to tell (yellow) Yes (green) Not Applicable (black) No (red)

recommendations). There were 1% ($n=2$ recommendations) made in the 'resources' category.

Findings from the grey literature publications are presented in Table 5. In the grey literature publications, 202 findings were extracted. In contrast to the peer-reviewed publications, the most frequently made recommendation category was 'response to and management of self-harm' with 27% ($n=55$) of recommendations made in this category. Of those 55 recommendations, consistent with peer publications, the most commonly found recommendation in the response to and management of self-harm category was to refer to external support agencies, including mental health services ($n=21$, 38%). Thirty-seven recommendations were found in the 'whole -school approach to managing self-harm' category (19%), but again not always with detail about what should be contained in those policies and procedures. This was followed by the specific roles and responsibilities category that featured in 16% of the recommendations ($n=32$ recommendations). Communication (often to parents and to students) featured in 14% of the recommendations ($n=29$ recommendations). The 'resources' category featured in 10% ($n=20$) of recommendations,

Table 4 Findings of peer reviewed publications categorised by finding type

Study	Number of findings	Specified Roles & responsibilities	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
		Category type of finding						
Baiden et al. (2018)	3		1.Schools should have a policy about bullying 2.Schools should have a policy that all victims and perpetrators of bullying are asked about SH[2] 3. Schools should have universal SH and suicide awareness programs in the curriculum	Not mentioned	Not mentioned	Not mentioned	Not mentioned	
Balaguru et al. (2013)	7	1. School leadership teams (SLT) should provide help seeking information to parents and students 2. SLT should educate parents on effective interventions and provide information and resources	3. Schools should have universal SH and suicide awareness programs in the curriculum 4. Schools should have relationships with mental health services and crisis teams	Not mentioned	Not mentioned	5. Communicate to parents by telephone, email, meetings	6.Mental health screening should be done for students identified as high-risk of SH using risk rating scale	7. Schools should have consultation with mental health crisis teams
Bauman et al (2013)	2	Not mentioned	1.Schools to have a bullying policy including restorative justice practices for the perpetrator	Not mentioned	Not mentioned	Not mentioned	2. School pastoral care should risk assess suicidal behaviour in students who are bullied and/or have depression	Not mentioned
Bennett et al (2015)	3	Not mentioned	1. School leadership should use universal programmes such as signs of suicide, good behaviour game across the school curriculum	2. School staff should have gatekeeper training (Sources of Strength)	Not mentioned	Not mentioned	3. Screening should be done using Signs of suicide or teenscreen	
Berger et al (2015)	6	Not mentioned	1. All schools should have school policies for responding to adolescents who self-injure	2. School staff should have education and awareness of NSSI 3. School responder should be trained in how to identify, assess and respond to self-injury	4. School should advise families of mental health services and /or e-mental health resources available	5. Point person or members of school crisis team should communicate to young persons' parents	6. Point person or members of school crisis team should conduct suicide risk assessment	Not mentioned

Table 4 (continued)

Category type of finding								
Study	Number of findings	Specified Roles & responsibilities	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
Capps et al (2019)	15	1.School based clinicians conduct assessment and response to SH 2.School counsellors; clinicians and administrators refer to the PEACE protocol 3.School counsellors meet with students of concern with school-based clinician for assessment and response plan	4.Schools should have standardised SH protocol 5.Schools could implement the PEACE protocol	Not mentioned	Not mentioned	When risk is established: 6. Communicate with young persons' parents; 7. Communicate with school principal 8.Communicate with others involved e.g. coach	9. Risk assessment recommended with severity colours, and associated actions 10. School clinicians should assess for suicide risk with tools, observations and information gathering	11.Develop a safety plan that includes lethal means restriction, 12.Provide a follow-up meeting 13.Refer to mental health services 14.Provide alternative strategies and/or stress management 15.Consult with local crisis team
Cooper et al (2011)	4	1. Teachers should teach mental health coping skills, communication, and connectedness to reduce suicidal behaviour as part of the curriculum	2. Schools should have policies that address bullying	3. All school staff within the school need to be trained to identify and intervene with at-risk adolescents with suicidal behaviour	Not mentioned	Not mentioned	4. Screening should be completed of students	
Crowe et al (2020)	6	Not mentioned	1. Policies need to reflect best practice guidelines by Hasking[2] 2. Schools should have structured responses to help avoid unnecessary escalation to emergency services	3. School staff need training as first responders 4. Teachers need training in identification of risk factors, and suicide, and mental health	Not mentioned	Not mentioned	Not mentioned	5. Ensure mental health services are accessible within schools 6. Escalate to external emergency services when imminent risk is present
Davenport and Franci Crepeau-Hobson (2021)	4	Not mentioned	1.A process is needed for identifying and responding to suicidal behaviour 2. Procedures for re-entry to school are needed	3. Training in risk assessment and identifying suicidal behaviour	Not mentioned	Not mentioned	4. Complete a risk assessment with a standardised tool with risk rating but does not specify the tool	Not mentioned
De Riggi et al. (2016)	7	1. School personnel should identify NSSI in students	2.Create a school-wide response to NSSI including protocols for managing disclosures, response, communication to parents and professionals, external referrals and risk assessment 3. Universal program that address emotional regulation and self-criticism should be offered	4.School mental health professionals need training in NSSI and how to respond	Not mentioned	5. Schools should notify parents when NSSI is disclosed, and school should inform the YP of intent to notify parents	6. Schools MHP's should screen and assess suicide risk in YP who engage in NSSI (NSSI tools specified by authors and includes risk rating	7. School mental health professionals should address online activity related to NSSI, both positive and negative

Table 4 (continued)

Category type of finding								
Study	Number of findings	Specified Roles & responsibilities	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
Evans et al (2019)	2	Not mentioned	1. Coordinated policy and approach is required	2. Training for school staff to respond to disclosures of SH	Not mentioned	Not mentioned	Not mentioned	Not mentioned
Fernandez (2013)	3	Not mentioned	1.Schools should have a ' self-injury handbook' that guides identification, assessment and management of students who self-injure for all school staff 2. The school's handbook should have examples of protocols and response procedures	3.Training in the handbook of self-injury for all school staff	Not mentioned	Not mentioned	Not mentioned	
Gargiulo (2020)	2	Not mentioned	1.Guidelines should be developed for the school setting, that include responses for SH	2.Training for teachers in self-harm should occur	Not mentioned	Not mentioned	Not mentioned	Not mentioned
Haas (2014))	7	1.SLT provide allocated time and resources for school counsellors to specifically respond to SH 2. School counsellors need to be connected to community agencies to ensure wrap around support within rural contexts for SH	3. Schools should provide a policy for school counsellors that includes a protocol for intervention for SH) 4. Schools must have relationships with local support services	5. All school staff should get training about mental health and gatekeeper role and interventions for SH	Not mentioned	6. Schools should inform parents and YP about SH behaviours	Not mentioned	7.Refer to community mental health services
	7	1.SLT should ensure ongoing communication to parents of NSSI students 2. SLT should appoint a team of people to respond to NSSI and implement the school wide response	3. Guidelines and policies for schools and the entire sector are need guide schools about how to support students who are engaging in NSSI (and their families)	4. Supervision for all mental health staff in school is ideal 5.Training for school staff on how to identify and respond to disclosure of NSSI		6. Guidelines should outline disclosure and communication policies and procedures to parents about their child's NSSI	Not mentioned	7. School mental health staff to follow up with student and their family about what support is in place for student engaging in NSSI
Kenny (2008)	4	1. All staff should be available to talk about SH 2. School Counsellors role to educate teachers about SH	3. SH guidelines should be developed	Not mentioned		4.Communication should occur between school staff	Not mentioned	Not mentioned

Table 4 (continued)

Category type of finding								
Study	Number of findings	Specified Roles & responsibilities	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
Kodish et al (2020)	7	1.Schools should involve family in decision making for treatment and management at school	2.Schools should have the infrastructure for monitoring students mental health service use and school climate 3. Schools should have relationships with local support agencies including mental health services	4.Training for educators on gatekeeper information such as suicide risk assessment protocols, critical incident and risk management, and student mental health referral processes	Not mentioned	5.Schools should communicate to family and caregivers about suicide risk for child	6. Schools should have self-report and objective measures and use Measure of Adolescent Potential for Suicide (MAPS; Walsh, Randell & Eggert, 1997)	7. Student and their families should be referred to outpatient care including mental health services
Lloyd-Richardson et al. (2020)	4	1.Nurses should develop, lead and implement the school response	Not mentioned	2. Nurses should have training in NSSI- What is NSSI, the nature and extent of NSSI, importance of emotion regulation, assessment, referral, and intervention; and self-care for nurses (gatekeeper)		3. Authors provided the specific language that should be used by nurses to communicate to students	4. Nurses could complete psychosocial assessment	Not mentioned
Marraccini et al. (2022)	5	1. School psychologists should promote school connectedness	2.Schools need standard protocols for supporting adolescents returning after absence due to SH to assist the return to school	Not mentioned	Not mentioned	Not mentioned	3. School psychologists could conduct suicide risk assessment	4.Schools should create tailor-made safety plans for SH 5. Schools should create re-entry plans based on individual adolescent experiences
Matthews et al (2021)	9	1. Designated lead or team are responsible for safeguarding, ongoing communication and monitoring of SH, receiving up-to-date training, and	1. Schools should have SH policies that include the following areas; SH identification and risk assessment, intervention, roles and responsibilities, and evidence-based psychological education and interventions 2. Schools should educate all students with universal awareness program on SH	3. All school staff need regular training in the prevalence of/trends in/types of SH, the functions of SH, risk-factors, warning signs, myths about SH, SH and mental illness, and the cyclic nature of SH and how to respond to SH	4.Schools should provide factsheets, useful contacts and online support	5. Schools should communicate to parents about student SH	6.Informal risk assessment should be completed by school staff. 7.Formal risk assessment should be completed by mental health professionals	8. Schools should provide SH coping strategies to all students 9. Schools should encourage peers to speak to a staff member, and provide support for peers of students who SH

Table 4 (continued)

Category type of finding								
Study	Number of findings	Specified Roles & responsibilities	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
Nadeem et al (2011)	5	1.Teachers have a gatekeeper role and are frontline in detecting students in crisis or at risk for suicide 2. Mental health professionals should inform school staff when they have addressed SH concerns	Not mentioned	3. Gatekeeper training for all staff including how to respond to those at risk of suicide	Not mentioned	4. Teachers should communicate concerns to external services	Not mentioned	5. Schools should Refer to mental health services for students at risk of self-harm
O'Neill et al. (2021)	7	Not mentioned	1. Schools should have policies and procedures to address SH and suicide	2.Training should occur for school based providers including safety planning and therapeutic risk assessment	Not mentioned	3. Schools should meet with family about SH 4. Schools should include student in safety planning for SH	5.Schools should provide a trauma informed risk assessment	6. Schools should implement family-focused intervention for those with SH (SAFETY-A) 7. Schools should refer for evidence-based trauma-focused treatment when SH is suspected or identified
Schepp and Biocca (1991)	2	Not mentioned	1.Education programmes for students, parents and staff	2.Training for staff about screening and where to refer	Not mentioned	Not mentioned	Not mentioned	Not mentioned
Schmidt et al. (2015)	6	1. School social workers have a role to advocate and address suicide prevention in schools	2. School should have a multipronged suicide prevention approach with gatekeeper training, student training, screening, and interventions	3. Gatekeeper training for school staff including knowledge of risk factors and how to respond to students	Not mentioned	Not mentioned	4.Schools should complete generic mental health screening including SH	5. Peer support program for senior students 6. Adequate follow up should be provided if universal screening is offered to students

Table 4 (continued)

Category type of finding								
Study	Number of findings	Specified Roles & responsibilities	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
Shapiro (2008)	10	1.School nurses should identify and assess SH and develop a plan to address SH 2.School nurses should provide education to the family on SH	3. Universal education on coping strategies and emotions	4.School staff should receive training and education on identification, and triggers of SH	Not mentioned	5.Nurse must notify the parents, and educate, and guide them to where to seek support If further medical intervention is needed, notify parents for chronic concerns, regular check in with parents is needed by counsellor or social worker 6. Communicate calmly with the student who SH and with respectful curiosity and no judgement	6. Complete full assessment including triggers, emotions and thoughts of SH by assessing environmental, biological, behavioural, cognitive and affective factors 7.Nurses need to assess students who present with SH, firstly for intent and immediate action with risk rating scale	8. Nurses need to complete medical intervention when needed 9. Students who SH should re be referred to counselling services 10. Nurses could run emotional regulation strategies for groups of students at risk or engaged in SH
Singer (2017)	7	1.School staff should lead a re-entry to school meeting with family and community providers following a SRA to ensure supports and follow up occurs 2. Community mental health providers are needed to manage suicide risk	3. School staff should monitor ongoing suicidal behaviour and changes to behaviour at school 4. Schools should establish a team of people to address risk of suicide	Not mentioned	Not mentioned	Not mentioned	5.School professionals could use the Suicide Risk Monitoring Tool (Erbacher et al.)	6. School should plan for crisis responses 7. Schools should refer to community mental health supports
Smaby et al (1990)	3	1.School counsellors should lead the response team and collaborate with the community team e.g. church youth leaders, family members, mental health centres, about suicidal behaviour	2. Schools need a school-based community intervention team to respond to SH	3.Training for SLT in suicide prevention, including counsellors, should focus on how to identify risk-factors for suicide and how suicide can be prevented including suicide assessment	Not mentioned	Not mentioned	Not mentioned	

Table 4 (continued)

Category type of finding								
Study	Number of findings	Specified Roles & responsibilities	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
Stein et al. (2009)	10	1.School principals and SLT should be actively involved throughout the suicide prevention process include SA 2. All school staff should have knowledge of how the school responds to students at risk of suicide—this is done through an organised communication chain	3. Schools need a whole of school's suicide and SH protocol and procedure 4. Whole school procedures need to provide staff with practical information that staff members can access and use in real time 5. Centralised data systems across school personnel can facilitate information sharing	6. District suicide prevention training should focus on educating school personnel about the key components of guideline-based suicide prevention services, including information about confidentiality	Not mentioned	7. Communicate the suicide prevention process to all school staff	8. Trained school staff complete a risk assessment of students who SH with risk rating scale	9. Schools should engage the student and their family to facilitate referral 10.Schools should refer students who SH to counselling or treatment
Te Maro et al (2019)	2	Not mentioned	1. Best practice guidelines for all school staff are needed	2. Training school pastoral care staff in how to identify and respond to SH	Not mentioned	Not mentioned	Not mentioned	Not mentioned
Townsend et al (2022)	5	1.SLT's of schools should employ school psychologists for SH 2.School psychologists are important to identify and address SH	3. Schools should provide universal information sessions on SH for all parents	4. Trauma and self-harm training for all school staff 5. Training for parents on identify and responding to SH	Not mentioned	Not mentioned	Not mentioned	Not mentioned
Walsh et al. (2022)	4	1. All school staff could be involved in SH interventions	2.Schools should prioritise universal program such as YAM (Waasserman et al., 2015) and SOS (Aseltine & DeMartino, 2004)	Not mentioned	Not mentioned	Not mentioned	Not mentioned	3. Provide brief interventions in high school with a 12 month follow up 4. Partner and refer to community health providers, adolescent health clinics, or mental health agencies to ensure appropriate aftercare services
Wester et al. (2018)	8	1. All school staff have a role in reducing NSSI in schools 2.School counsellors could provide a multi-tiered approach across students and staff	3. Schools should have a multi-tiered approach to SH 4. Schools should offer universal awareness of NSSI programs in curriculum	5.Staff education about NSSI	Not mentioned	Not mentioned	6. School counsellor should provide assessment of NSSI to determine next action	7. Brief intervention targeting function of behaviour 8.Refer student to external services

[2]SLT, Senior Leadership Team; SH, Self-harm; MHP, Mental Health Professionals; NSSI, Non Suicidal Self Injury; SRA, Suicide Risk Assessment

Table 5 Findings from grey literature publications categorised by finding type

Category type of finding								
Publication title	Number of findings	Named roles & responsibility	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
A guide to understanding self-injury for school professionals (Unknown, nd)	9	1. School staff can facilitate recovery with effective referral for support for the student 2.School staff to monitor themselves to ensure that they respond in a calm, respectful, and helpful way if a student discloses NSSI	3.School should have a NSSI protocol that outlines a standard response 4.Universal awareness of NSSI in student education	Not mentioned	5. Links to support services, helplines	6. Schools should inform parents and involve students 7. Communicate with the student using their language and be non-judgemental	Not mentioned	8.Schools should address any copycat behaviour by asking student to not share NSSI images, stories, details 9. Encourage those engaged in NSSI to seek support from professional services
Preventing and responding to suicide-resource kit for schools (Ministry of Education New Zealand, 2019)	8	1. School leaders and the guidance counsellor need to ensure teachers and students know the range of support systems available through the school and in the community 2. The school counsellor will need to know how to support the student within their family context and work with external agencies	3. Schools need NSSI procedures 4.The school needs to designate people who will respond to NSSI in students	5. School staff should be encouraged to take part in regular training about symptoms of distress, knowing how to identify risk of suicide in students, and school policies and procedures	6. Checklists for emergency responses, assessment template, a recommended book, and website links to NSSI resources and SH policies	Not mentioned	7.School counsellors should assess students at risk of suicide using risk rating	8. Refer to mental health services and other key agencies
Non suicidal self-injury in schools-developing and implementing a protocol (Bubrick et al., 2010)	6	1. SLT should identify a team to respond (typically some combination of guidance counsellors, nurses, school social workers, school psychologists, administrators and/or teachers	2. Develop a self-injury protocol for schools	3. All school staff should be trained in the self-injury protocol; signs and symptoms of SH	Not mentioned	4. Key school staff should communicate to the parents	5. Assessment of student needs and next steps by the designated point person/team as well as from the nurse using risk rating scale	6. School should refer to services and therapists

Table 5 (continued)

Category type of finding								
Publication title	Number of findings	Named roles & responsibility	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
Managing SH:Practical guidance and toolkit for schools in Cornwall and the Isles of Scilly (Cornwall Multiagency Emotional Wellbeing & Mental Health Board, 2017)	12	1. SLT should designate a member of staff to manage and co-ordinate the school's response to SH This is often the designated child protection lead 2. All school staff need to take care of themselves and seek support when they need it	3.Primary schools should have a safeguarding policy that references responses to SH 4. Secondary schools should have a separate and specific SH policy, which contains the protocol of how to deal with SH in school	5.Encourage all school staff to attend training about SH to support their understanding and capacity to respond to SH in appropriate ways	6.Immediate intervention flowchart, policy and protocol templates, checklists, incident form, helplines, website links, information pamphlets for parents, students and staff, letter to parents' template, confidentiality and consent form	7.Communication from staff to students, dos and don'ts list)	8.Risk assessment prompts using higher and risk rating	9. Refer to school nurse or counsellor 10. Refer to Primary Mental Health team and the Educational Psychology Service or specialist CAMHS nurse if concerns are high 11. Ensure the safety of the student and keep in a safe place at school 12. Provide the student with distraction ideas
Model guidance: Schools responding to incidents of SH (Wiltshire Children & YOung People's Trust nd)	8	1. Designated person or child protection lead should inform the parents of SH	2. Schools should have a detailed policy about who will do what for SH	3. All members of school staff should receive training around SH as part of child protection training	4.Flowchart for responses both crisis and routine, incident form template, link to practice guidelines to implement, information sheet for students and families, helplines and websites	Not mentioned	5. Risk assessment prompts using risk rating	6. Implement the "Multi Agency Guidelines for Professionals Working with Children and Young People Who SH" 7. If the risk assessor and/or young person agree a referral to CAMHS is needed, a referral should be sent the same day 8. School should provide parents with both community and web-based resources for understanding and effectively addressing self-injury
Responding to SH in the school setting: the experience of guidance counsellors and teachers in Ireland (Dowling & Doyle, 2017)	1	Not mentioned	Not mentioned	1. All school staff should have training in how to respond to a young person who SHs including how to manage disclosure and when to refer on	Not mentioned	Not mentioned	Not mentioned	Not mentioned

Table 5 (continued)

Category type of finding								
Publication title	Number of findings	Named roles & responsibility	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
SH guidelines for school staff (West Berkshire County Council, nd)	8	Not mentioned	1. School should have a SH policy or protocol for responding to SH 2.Have an anti-bullying policy 3.Use universal education of emotions and social skills for a healthy school environment	4. Staff members with pastoral care roles should have gatekeeper training on SH 5.All staff should have training in the school SH policy and procedure	6.Templates for conversation starters, safety plan, incident forms, SH checklist for school	7. All staff should communicate with students who SH about their concerns	Not mentioned	8. Meet with person who may be engaged in SH and have a supportive conversation, encourage help seeking, alternative coping strategies
SHing Guidance and Policy (Harrogate High School, 2017)	10	1. School Board has the legal responsibility for welfare, may be a nominated governor who leads oversight for provision for students who SH Principal—has responsibility for SH procedure and policy	2. Schools should have a SH policy and checklist	3. Schools should have regular training on identifying and responding to SH 4. All staff should have induction on how to manage SH disclosure	5. Templates for managing participation in PE/Sports, communication template, risk assessment form, management plan, incident forms, SH checklist for school, sample SH policy, conversation starters for staff, information for students, information for parents	6. Parents should be communicated to about the SH and involved in review and monitoring process 7. SH processes should be communicated to students	8. Risk assessment form detailed and to be completed with risk rating	9. Consultation with mental health services by child protection lead of school 10. Groups of students engaging in SH need a multi-agency meeting with schools, mental health services and others

Table 5 (continued)

Category type of finding								
Publication title	Number of findings	Named roles & responsibility	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
Managing SH: practical guidance for schools (Ealing County, 2014)	8	1.Head teacher to implement a school self-harm policy 2. Headteacher to appoint one or more designated key staff to be responsible for all incidents relating to self-harm. 3. Headteacher to ensure that all designated staff receive full and appropriate training regarding self-harm	4. Schools SH policy must contain the protocol of how to deal with SH in school, who to inform and when	Not mentioned	5.Templates for immediate response, ongoing response, managing participation in PE/Sports, communication template, risk assessment form, management plan, incident forms, SH checklist for school, sample SH policy, conversation starters for staff, information for students, information for parents, helplines provided	6. School should communicate to parents, and GP with when/what and who to flow-chart provided	7. School child protection lead to complete assessment 'Ongoing support guidance' with questions provided	8. School should refer the student to their GP
Young people who SH: a guide for school staff (University of Oxford, 2018)	13		1.Self harm guidance should be alongside school safeguarding policies 2. Build a positive school culture which encourages resilience and promotes help-seeking	Not mentioned	3.Helplines, website links, helpful questions and statements, 'how to approach students' resource, school procedure template, strategies that help students, conversation sentence starters	4.Communicate with students in an open, caring empathetic manner 5. Any staff who identify SH should share this with your school's designated safeguarding lead 6. School should communicate with parents/carers about SH	7.Understand the circumstances of SH and what level of concern there should be with risk rating	8. Provide pain relief in immediate situations 9. If an overdose is suspected the student will need to be taken to hospital straight away for tests and possible treatment 10. Schools should follow first aid guidelines for cuts, wounds or burns 11. Make their environment safe at home and ask for the removal of sharps 12. Make a safety plan with the student 13. Contact the local CAMHS team for advice

Table 5 (continued)

Category type of finding								
Publication title	Number of findings	Named roles & responsibility	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
SH (Reach Out Schools, 2022)	5	Not mentioned	1.Schools should encourage universal safe discussion about SH	Not mentioned	2.Links provided to more websites for guidance on SH	Not mentioned	Not mentioned	3. School staff should check-in with the student about any thoughts of suicide 4. School staff provide student with distraction strategies for when the person feels at risk of self harm 5. School staff could encourage the person to seek assistance from a psychologist
Self harm in the school setting (Beyond Blue Be You In Focus, 2022)	3	Not mentioned	1. School staff should take action about SH disclosures by following the schools' policies and procedures	2. School staff should have training in knowledge of warning signs, triggers of SH	Not mentioned	3. School staff should communicate in an open, curious and non-judgemental approach with the student	Not mentioned	Not mentioned
Break the Silence: SH epidemic 'elephant in room' (Carlisle, O, NZ Herald, 2017)	1	Not mentioned	1. Schools should have a self-injury policy	Not mentioned	Not mentioned	Not mentioned	Not mentioned	Not mentioned

Table 5 (continued)

Category type of finding								
Publication title	Number of findings	Named roles & responsibility	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
Self harm guidelines for staff within school and residential settings in Oxfordshire (Adolescent Self Harm Forum Oxfordshire, 2016)	14		1.Schools should have a supportive environment 2.Schools should have a SH policy 3.Schools should have an effective anti-bullying policy	4. Staff should attend training days on SH or obtain relevant literature	5. Net template, distraction activities list, website links, 'resilience risk assessment framework' form; CAMHS consultation forms; letter to parents template, flow chart of procedures template, contact numbers, information sheet for parents and students	6. Communicate to the student with a non-judgemental attitude and reassure them that you understand that SH is helping them to cope now and you want to help them and explain that you need to tell someone 7. Contact parents (unless there are particular reasons why they should not be contacted) and discuss the school's concern	8. Frontline school staff should complete Resilience Risk Assessment framework form	9. Staff should keep calm, give reassurance and follow the first aid guidelines as directed by school policy 10. Staff should consult a medical practitioner (GP or Accident and Emergency Department) following an overdose 11. Consider referral to school counsellor or suggest to the parents a referral to CAMHS single point of access, or an appointment with the GP if there are serious medical issues 12. Consult with child protection services as and when needed 13. Meet with parents and follow up the meeting with a letter of concerns 14. Give a safety plan with crisis numbers to students
What schools and further education settings can do (Anna Freud National Centre for Children, 2020)	8	1. Safeguarding lead should contact parents/carers and other services if necessary	2.Staff should follow schools safeguarding procedures 3. Schools should build positive relationships with students 4. Schools should explore emotions through universal lessons and programmes	Not mentioned	5. Links to resource pack for support of peers, universal classroom lessons	6. Speak to the student and involve them in the plan 7. School should inform parents / caregivers about the student	Not mentioned	8. Consider making a referral to CAMHS and/or GP

Table 5 (continued)

Category type of finding								
Publication title	Number of findings	Named roles & responsibility	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
Self injury- a short guide for schools and teachers (Hillery, 2008)	11	1.Headteacher will appoint a designated teacher to be responsible for self-injury matters, and liaise with them 2. SLT should ensure that self-injury policy is followed by all members of staff 3. School's governing body should decide about whether universal education about self-injury is offered 4. Designated staff member will respond to all students who self-injure	4. Schools should have a self-injury policy that includes how and when a child's parents are informed, and which teachers are informed	5. Designated staff member will have up to date training in self-injury	6. Sample self-injury policy provided as template	7. Designated staff member will liaise with parents of student who self-injure 8. Students must be aware of the policies, and know what to expect if they disclose their self-injury to a teacher) 9. All staff should listen to the student and try not to show them if you are angry, frustrated or upset	Not mentioned	10. Liaise with local health services to access help for students who self-injure 11. Refer the student to school nurse or counsellor
Guidelines for self harm: a new school of thought (Association of Child & Adolescent Mental Health-The Bridge, 2022)	8	1. All education staff should be aware of the guidance for identifying and assessing the needs of students who SH 2. Education staff should consider how the student's SH may affect their close friends and peer groups and provide appropriate support to reduce distress to them and the persons	3. Education settings should have guidance and policies for staff to support students who SH 4. Schools should have a designated lead responsible for ensuring that SH guidance is implemented	Not mentioned	Not mentioned	Not mentioned	Not mentioned	5. Address immediate physical health needs 6. Seek advice from a health or social care professional, 7. Inform young persons of sources of support 8. Ensure safety at home and address any safeguarding issues

Table 5 (continued)

Category type of finding								
Publication title	Number of findings	Named roles & responsibility	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
Responding to self harm including suicide attempts in students (State of Victoria Department of Education & Training, 2021)	9	1. Educators should promote positive help-seeking behaviours, strengthen the awareness and development of safe coping strategies, and enquire sensitively about what is going on for the student	Not mentioned	Not mentioned	2.Templates for self-care for school staff following SH or suicide attempt, responding to emergency, responding to SH not an emergency, safety plan, a step-by-step process for onsite SH	3. All staff should notify the school leadership team of a SH event onsite 4. School leaderships teams or student support services should contact parents or carers unless circumstances indicate that this should not occur	5. An appropriately trained staff member or professional should undertake a SRA	6. Schools should seek advice and professional assistance from CAMHS, and student support services 7. Make a referral for mental health support either within the school or external to the school as appropriate (eg headspace, CAMHS) 8. Ensure there is a debrief for all staff involved in responding to the incident and that they are provided with information about self-care and the supports available to them 9. Ensure the student is in a safe environment, request that the student hand over any instrument that may assist them to SH
Responding to non-suicidal self-injury in New Zealand secondary schools: Guidance counsellors' perspectives (Garisch et al., 2020)	4	Not mentioned	1. Develop a school SH protocol 2. Schools should have relationships with mental health clinicians	3. School staff need specific NSSI training	4. Questions for guiding a discussion among pastoral care and senior leadership teams	Not mentioned	Not mentioned	Not mentioned
Self harm guidance for school staff (Devon County Council, 2022)	3	Not mentioned	Not mentioned	Not mentioned	1.Links to support services, helplines	Not mentioned	2. Schools should complete a SRA using risk rating	3. Create a safety plan with the student

Table 5 (continued)

Category type of finding								
Publication title	Number of findings	Named roles & responsibility	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
SH and health harming behaviours guidance (Staffordshire County Council & Psychology Service, 2022)	9	1. Head teacher to implement a school self-harm policy 2. Headteacher to appoint one or more designated key staff to be responsible for all incidents relating to self-harm 3. Headteacher to ensure that all designated staff receive full and appropriate training regarding self-harm	4. Schools should have a SH policy	Not mentioned	5. Links to support services, helplines, conversation sentence starters	6. Communicate with the student about the concerns about SH	7. Complete a psycho-social risk assessment	8. Devise a safety plan with strategies and templates 9. Schools should consult with health services and educational psychologists
Supporting children and students with SH or suicidal thoughts (Department of Education South Australia, 2022)	6	Not mentioned	Not mentioned	1. Teachers should have training in 'interoception'	2. Links to support services, helplines, Mental Health First Aid guidelines	3. Schools should inform parents of SH of student	Not mentioned	4. Devise a 'site support and safety plan' with student and their family and MHP 5. Update and refer to the 'health support plan' service for students 6. Schools should refer to Social Worker Incident Support Service for SH
Self harm policy in schools (Norfolk County Council, 2020)	17	1. School should have a senior mental health lead who, in conjunction with the senior designated safeguarding lead, will offer advice and support to staff supporting young people who SH 2.Governing body of school should design, implement and review the SH policy regularly 3.Headteachers will ensure that a SH policy is implemented 4.Headteachers should ensure a co-ordinated response is provided to young people who SH, and their families	5.Secondary schools devise and implement a SH policy 6. Schools must ensure that they follow the Norfolk Safeguarding Children Partnership guidance on SH and suicide prevention 7. Schools should teach universal mental health and well-being within curriculum	8.All staff should access SH training, and some groups may need more specific knowledge such as first aiders and safeguarding leads	9. Contact numbers, helplines, how to manage young people online, factsheets for staff, parents and carers	10. Keep calm and communicate with student by acknowledging their distress and use non-judgemental language 11. Advise the pupil that you will need to discuss what happened with the designated safeguarding lead in line with the school's safeguarding policy 12. Advise the young person's parents/carers of the SH and include the student where possible	Not mentioned	13. If you have immediate concerns about the effect of the SH injury including an overdose, call 999 straight away 14. A member of staff will need to talk to the young person and find out about their SH behaviour, including history, frequency, types of method, use, triggers, psychological purpose, disclosure and help-seeking and support 15. Put a safety plan in place with the young person 16. Provide parents/carers with appropriate advice and support about how to support their child with SH 17. Make a referral to CAMHS, with parental consent

Table 5 (continued)

Category type of finding								
Publication title	Number of findings	Named roles & responsibility	Whole school approaches	Professional development	Resources	Communication	Assessment	Response to SH as indicated interventions
Young people and self-harm (Nottinghamshire County Council & Psychology Service, 2017)	7	1. School staff should inform Safeguarding Lead/Team) if concerned that a student is self-harming 2. SLT should regularly review school policy and protocols for SH	3. School has a SH policy or established protocol for supporting students who are at risk of SH	4. Provide SH training for all school staff	5.Resources for helplines/websites; response procedure to follow; do's and don'ts' list for staff; coping strategies for students; information sheets for students, and parents/carers; support plan; how and what questions to ask a student; evaluation checklist for schools)	6. School should communicate with the parents about their concerns about SH	Not mentioned	7. The school should provide education to families and refer parent/carers to sources of support for SH in the community
School response and planning guidelines for students with suicidal behaviour and non suicidal self injury (Department of Education Western Australia, 2021)	12	1. School staff have a role in identifying indicators of concern and supporting students who may be at risk of suicidal behaviour or NSSI 2. The nominated staff member is routinely on the school site and will vary from school to school and may include the deputy principal, student services or other support staff, class teacher or a combination of these 3.School leadership should follow-up and debrief with any students and staff impacted by the disclosure or incident	4.School leaders can adopt a universal whole-school approach to promoting mental health and wellbeing across students 5. Schools should consider potential social media activity and respond by having a social medial policy	6. School staff should have training in cultural competence, trauma informed practice, gatekeeper suicide risk assessment and prevention and mental health awareness	7. Resources are templates for consent forms, emergency contact forms, school response plan, risk management plan, communication to staff, emergency contact numbers postvention operational checklist template	8. Distribute the plan to appropriate staff (including teachers of the student) so they can manage the safety of the student when at school) 9. School staff should communicate to staff about the concerns by documenting and securely storing student information	10. Staff members with appropriate training (Gatekeeper Suicide Prevention) should provide a NSSI assessment with risk rating	11. Ensure student safety at school 12. Schools should offer a return to school meeting with multiagency and the student and their family

[a]Findings are categorised by recommendations made for school under roles and responsibilities; Whole school approaches to managing self-harm; Professional Development; Resources; Communication; Assessment; Response to and management of self-harm

[b]Risk Rating = A rating scale using low, medium and high classifications

[1]Kõlves et al. 2021

[2]Hasking et al. 2016

followed by professional development with 8% ($n=17$) of recommendations, and finally risk assessment in 6% ($n=12$) of recommendations. Of these 12 recommendations for risk assessment, 6 of the 12 recommended risk assessments with risk rating categorisation of low to high.

Overall, 375 findings across both sources of publications (peer-reviewed and grey), were identified as recommendations for schools and were most frequently made in both the 'response to and management of self-harm' 23% ($n=87$), and the 'whole-school approach to managing self-harm' category 21% ($n=79$). Of the 87 recommendations made in the 'whole-school approach' category, the majority 43% ($n=35$) of recommendations were that schools should have a specific self-harm policy and/or guideline for self-harm. Of the 87 recommendations found in the 'response to and management of self-harm' category, the most frequently made recommendation was for schools to refer to external support services e.g. mental health services 39% ($n=34$ recommendations), followed by implementing safety plans, 13% ($n=12$ recommendations). The category with the next most recommendations across peer-reviewed and grey publications was in the 'specific roles and/or responsibilities' category with 16% of the total recommendations ($n=62$ recommendations) featuring. Of those 62 recommendations, the predominant role and responsibility that was described was for school leadership (39%, $n=24$); contributed predominanly by the grey literature. This was closely followed by 'professional development' that had 12% ($n=45$) of the total recommendations across peer-reviewed and grey publications. Of the total 45 recommendations made for professional development, the majority of the recommendations (62% $n=28$ recommendations) were for gatekeeper training in self-harm which included how to manage confidentiality between school and family. Overall, gatekeeper training of school staff is recommended but without a great deal of specificity about what training content is likely to be beneficial and sustainable for schools.

Recommendations in the 'communication' category totalled 13% with 47 recommendations. The vast majority addressed the need for schools to communicate to both parents and students about their self-harm, combined total of 70% ($n=33$) but were not always specific about how or whom to include and when to do this. 'Assessment' featured in 9% of the total recommendations ($n=33$) and of those, just over half 55% ($n=18$) recommended using risk assessments (either named tools or non-specific) with a risk rating categorisation of low- to high. The'resources' category was the least common category with only 6% of the total recommendations ($n=20$ recommendations).

Discussion

Key Findings

This is the first synthesis of peer-reviewed and grey literature publications to understand the current state of evidence in terms of specific recommendations made to school-based professionals on the management of self-harm. The awareness and emergence of self-harm among adolescence as a separate phenomena in suicide prevention literature has developed since the 1990's (Hawton et al., 2012). This systematic review spanned the last 30 years of what publications made recommendations for schools to respond to self-harm. In total, 57 relevant publications were identified with 375 recommendations extracted from these publications. While the grey literature was characterised by local practice guidelines rather than empirical studies, these nevertheless resulted in more specific actions that specific roles within schools could take. Quality assessments conducted using standard quality assessment tools suggested the quality of peer-reviewed publications was low in over 69% of included studies. The key issues were concerning researcher bias and/or positionality not being discussed, and, in some publications, the outcome measurement lacked clarity. Whilst there is literature available to guide schools about how to respond to self-harm in youth, there is a paucity of guidance that is evidence-informed and lack specific on implementable actions schools can take.

The key findings centred predominantly on schools having whole-school approaches, and on specific advice on how schools should respond to and manage self-harm. Although there was ambiguity overall about what specific interventions schools could provide, the most featured recommendations were for indicated type interventions. These included actions such as referral to mental health services, the use of safety plans, and offering students brief interventions such as distraction and coping strategies. It is critical that schools have access to evidence-based interventions for self-harm so that schools can deliver safe and effective interventions and provide high quality advice and intervention to students and families. For example, safety planning is widely used in clinical services and usually comprises a plan a person can use if they notice they are becoming distressed, along with reasons for living, how to keep safe and pre-prepared coping strategies such as social supports and crisis contacts (Ferguson et al., 2022; Nuij et al., 2021; Stanley & Brown, 2012).

We appreciate that globally, recommendations for schools must be feasible and appropriate for the average student support professional or school administrator with limited time, professional expertise, and who may work in varied environments such as rural and remote schools. One

such intervention could include the Collaborative Assessment and Management of Suicidality (CAMS) framework (Jobes, 2006), using the newly developed and more stringent version of the Counseling on Access to Lethal Means (CALM) protocol (Jobes, 2023) as an evidence-based intervention to implement across various settings for self-harm.

Our synthesis suggests a whole-school approach should include universal interventions for the entire school, as well as targeted and tailored interventions for students engaging in self-harm, all within the context of well-developed policies and procedures to guide all school staff about their role in the management of self-harm. Universal programs such as Youth Aware of Mental Health (YAM) (Wasserman et al., 2015) and Signs of Suicide (Aseltine & DeMartino, 2004) within a whole-school approach are important to consider. These programs are worthy of consideration when implementing a whole school, universal approach to prevention, when paired with other targeted approaches and policies identified. Of note, other school policies associated with self-harm included bullying prevention and re-entry to school following self-harm events.

Findings about the need for a whole-school approach are consistent with the emerging evidence base (Goldberg et al., 2019) about this being an appropriate way to address youth mental health more broadly. A whole-school approach encourages a shift from the use of curriculum and classroom programs alone. This includes ensuring school policies, processes, and guidelines, a focus on positive relationships with students and the wider school community including families, and the physical environment. Together these aim to facilitate a change toward a positive school culture and environment (Allison et al., 2021; Quinlan et al., 2020; Runions et al., 2021; White et al., 2017). This places responsibility for positive change on the school community rather than on the individual student. This is consistent with what adolescents tell us they need to have to experience safe and supportive environments (Denny et al., 2016; Knowles et al., 2022) and with evidence showing the protective effects of school connectedness. (Carter et al., 2007). Guidelines that help schools develop responses to self-harm that highlight the need to tailor strategies to the cultural and contextual needs of young people are required to address self-harm, especially for young people who experience marginalisation (Carter et al., 2007; Denny et al., 2016, 2018; Fleming et al., 2024; Quinlan & Hone, 2020; Runions et al., 2021).

While the next most common category of recommendations was about specific roles and responsibilities within the school environment, this is dependent on those staff having good training and confidence. Training in identifying, assessing, and treating self-harm in young people was a recurring recommendation in the findings about professional development and often cited as a gap in practice. This is consistent with evidence highlighting that school staff themselves want gatekeeper training and often feel unequipped (Evans & Hurrell, 2016; Hasking et al., 2016; Te Maro et al., 2019; Wester et al., 2018), and would be an important component of a whole-school approach to the management of self-harm. Of note were findings about the need for this training to include a focus on how to manage confidentiality and privacy between a young person, school staff and a family. Whilst gatekeeper training is recommended, there is also a need to include parents in gatekeeper training and to identify what training will ultimately result in behaviour change in gatekeepers (Torok et al., 2019).

There is often ambiguity about how to interpret privacy laws and, as a result, inconsistent practice (Garisch et al., 2020). Concerns about privacy and confidentiality weigh heavily on a young person's decision to seek help for self-harm, and they are generally reluctant to seek support from formal services, instead turning to friends, family, and increasingly social media (Bellairs-Walsh et al., 2020; Gibson & Trnka, 2020; Rowe et al., 2014). These concerns of young people need to be managed with sensitivity, while also ensuring that they are well supported by the trusted adults in their lives in a way that decreases their distress (Stewart, 2001). School staff need guidance and may benefit from more resources, including templates that include scripts for how to discuss this with young people and how and when to include families. This approach (of providing templates and scripts) was more evident in the grey literature compared with the peer-reviewed publications.

In terms of training, this review did not find sufficient evidence of best practice guidance around the management of social media that young people are increasingly using as a source of support for their self-harm (Thorn et al., 2023). School staff need to understand the social media platforms that young people are using, know how to discuss young people's social media use with them, and how it may be impacting self-harm. Schools also need an understanding of how to manage the risk of imitative self-harm behaviour in those who are engaged in social media forums or groups centred around self-harm (Balt et al., 2023).

Finally, these findings did commonly support the assessment of self-harm; however, when assessment was recommended there was still inference across both peer-reviewed and grey literature publications that a risk assessment can provide a categorisation of the young person's level of risk (low to high) as part of routine practice. Although this approach was evident in the recommendations in this review, it is out of step with the broader scientific literature on risk assessment and prediction that shows that risk assessment for the purpose of risk categorisation is a flawed practice (Carter & Spittal, 2018; Carter et al., 2017; Fortune & Hetrick, 2022; Pokorny, 1983; Rosen, 1954). Rather, schools

should be supporting a thorough psychosocial assessment to understand modifiable and dynamic risk factors and collaboratively develop a management plan that allows the young person and their family to manage modifiable risk factors associated with their self-harm. The focus must be on what support and interventions can be provided that will make a difference to the young person, including an understanding of how distress and crises develop, and where the intervention points are to prevent this escalation ((Fortune & Hetrick, 2022).

Limitations

The scope of this review was limited to studies focussing on school settings and did not include evidence-based practice for self-harm in youth more generally. The ability to synthesise evidence is hampered by poor reporting on outcomes of interest, lack of agreement in operational definitions of self-harm across the literature and limited quality of peer-reviewed publications. The recommendations identified in this review must be cautioned for implementation given the low quality of results and lack of evidence- informed actions.

Implications for Practice and Future Research

This systematic review has highlighted the ambiguity in the specific practice-based recommendations about interventions, policies, and procedures for the management of self-harm and pointed to the need to guide schools about how to address self-harm in their setting. Whilst there is literature available about policies, and procedures in suicide prevention, this often does not specifically include self-harm and tends to focus on what to do after a young person has died by suicide. The development of guidelines for schools' management of self-harm in young people should be a focus for future suicide research and practice. There is a need for empirically developed guidelines that include recommendations for a whole-school approach, and identification of and response to students who self-harm to assist schools in their duty of care (Fernandez, 2013; Hetrick et al., 2020; Kelada et al., 2017; Kenny, 2008; Meinhardt et al., 2022a, 2022b; Robinson et al., 2016). Schools will benefit from knowing how to develop evidence informed guidelines and implementation requirements. Professionals working in schools such as schools psychologists may face challengs in such critical work in schools, without guidelines that highlight the important of tailoring responses to culture and contexts of young people and specific practice strategies. This would be further complicated in schools where there may be no school/educational psychologists or other school professionals who see self-harm as an area their role should respond to. The grey literature appears to provide more specific actions schools could use with named roles and includes templates, resources and procedural guidance. In contrast, peer-reviewed publications predominantly focussed on the association between risk factors and self-harm, and/or the need for specific interventions centred on referring to mental health services. Taken together these two types of knowledge provide a more complete picture about the multifactorial approach that is needed. Ideally, practical guidance should incorporate and be based on the evidence in peer-reviewed publications, but also ensure that best practice recommendations include practical advice about specific actions and specific roles and responsibilities of personnel in schools. It is highly likely that most education professionals do not have the resources to devote to keeping up to date with peer-reviewed publications about self-harm and suicide prevention. Therefore, we need researchers to ensure guidelines and resources are evidence-based and can be implemented in practice. Interventions for young people who self-harm in the school setting remain a research and practice priority. Research is also needed to understand how students and their families experience the actions taken by schools in response to self-harm and what the longer-term outcomes are for these students (Hetrick et al., 2020; Robinson et al., 2016).

Implications and Contributions

The critical need to address self-harm in school settings, requires a more specific and tailored approach; particularly for Indigenous youth and those is school contexts where resources may be limited such as rural schools. Evidence-informed guidelines that contain actions of who, what and how are necessary for schools to support young people. Collaborative research across health and education combined is remains a priority.

Conclusion

This systematic review showed that existing literature frequently recommends that schools have a whole-school approach in both policy and practice, have clear procedures to guide how all staff respond to self-harm in their setting, and deliver interventions across universal and targeted interventions. However, beyond the recommenations of the presence of having policies and procedures, and access to training, there was often little specificity, including about how to develop the recommended practices, who in school settings should do this work, how to practically and safely intervene and respond to self-harm (beyond safety plans, distraction strategies and referring to mental health

services) and what specific training programs or skills staff require. Overall, the lack of specific detail in the guidance for schools suggests that schools may remain hindered in their ability to select and determine what is effective and how best to respond to self-harm in their schools.

This systematic review highlights the need for robust evidence- informed guidelines for responding to self-harm in schools that are evidence-based and are easily accessible to school professionals and context specific. There is a need to have a collaborative approach between the health and education sectors to implement evidence- informed guidelines to address self-harm in schools.

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Data Availabilty Data sharing is not applicable to this article as no new data were created or analyzed in this study.

Declarations

Conflict of interest Associate Professor Sarah Hetrick is currently employed as Principal Advisor Suicide Prevention to the Ministry of Health New Zealand a non financial interest. We wish to disclose that one author- Associate Professor Sarah Elisabeth Hetrick is a principal advisor of the Suicide Prevention Office of New Zealand within the Ministry of Health, New Zealand.

Ethical Approval This study as a systematic review did not require ethical approval.

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