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Professionals' perceptions of people who self-harm

a systematic review comparing attitudes of professionals supporting people with and without learning disabilities who self-harm

Professionals' perceptions of people who self-harm.

A systematic review comparing attitudes of professionals supporting people with and without learning disabilities who self-harm.

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Abstract

Background: National Institute for Health and Care Excellence (NICE, 2013) guidelines state that professionals supporting people who self-harm should demonstrate compassion, respect and dignity, and the organisation they work for should ensure they are adequately trained to provide such support. This systematic review considers the evidence for professionals' attitudes towards people who self-harm, with a comparative focus between professionals supporting people with and without learning disabilities.

Method: Electronic databases were searched to find relevant research since 2000, references were hand-checked for further studies. Narrative synthesis was utilised to identify themes and describe the findings.

Results: Thirty studies (31 articles) were identified; four studies were conducted with professionals supporting people with learning disabilities, the other 27 studies were with professionals supporting people without learning disabilities. Attitudes were found to be largely sympathetic, but there was evidence of punitive and judgemental attitudes and a repeated concern raised across the sectors about inadequate training and support. Professionals supporting people with learning disabilities were found to have some attitudes that mirrored the behavioural and biological theories dominating theory and practice (that self-harm is the result of operant learning or associated with a biological condition or concern). However, they also tended to have a more relational approach, which was more reflective of the NICE (2013) recommendations.

Conclusion: Adequate training for staff supporting people who self-harm remains a priority that is largely not being met. Support and supervision for staff to increase resilience and equip them to sustain compassionate attitudes towards people who self-harm is also a necessity. These require appropriate resourcing. Professionals supporting people with learning disabilities who self-harm were found to have some differing attitudes, including a greater emphasis on relationship; these differences are worth exploring further.

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And thank you Father God, for keeping my brain sharp and my heart soft, against the odds. Waymaker, indeed.

Author's declaration

I declare that the work in this dissertation was carried out in accordance with the requirements of the University's Regulations and Code of Practice for Taught Programmes and that it has not been submitted for any other academic award. Except where indicated by specific reference in the text, this work is my own work. Work done in collaboration with, or with the assistance of others, is indicated as such. I have identified all material in this dissertation which is not my own work through appropriate referencing and acknowledgement. Where I have quoted or otherwise incorporated material which is the work of others, I have included the source in the references. Any views expressed in the dissertation, other than referenced material, are those of the author.

SIGNED:  Beverley Samways

DATE: 10.09.19

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1. Introduction

(This dissertation draws on the candidate's Systematic Review Proposal submitted May 2019.)

This systematic review synthesises the research examining professionals'[1] attitudes and beliefs about self-harm. It seeks to compare attitudes between professionals supporting people who self-harm with and without learning disabilities. This Chapter will introduce self-harm, looking at definitions, prevalence rates and background for people without learning disabilities; the same concerns will be discussed for those with learning disabilities. Research into attitudes will be briefly explored, setting the context for the research. Finally, the chosen approach to this research will be outlined, the aims presented and an outline of the study described.

1.1 People without learning disabilities who self-harm: definitions, prevalence and background.

Self-harm is defined by the National Institute for Health and Care Excellence (NICE) as, *'any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation'* (NICE, 2013:6). Definitions of self-harm are sometimes separated into 'suicidal self-harm' and 'non-suicidal self-harm' (NSSH). Some studies combine self-harm and suicide (James, Stewart and Bowers, 2012; McCann et al., 2007) whilst other use the term 'self-harm' to imply NSSH, but do not state it overtly (Conlon and O'Tuathail, 2012; Koning McNaught and Tuffin, 2018). For the purposes of this study, the term 'self-harm' is taken to mean non-suicidal self-harm; studies examining suicide alongside self-harm, or conflating the two, were excluded from the review.

Self-harm represents a significant challenge for public health in the UK (Evans et al., 2019; HM Government, 2019; Public Health England, 2017). In 2014, 32% female and 11% male 15 years olds reported that they had self-harmed (Public Health England, 2017). Prevalence is increasing in the UK, with self-reported lifetime self-harm increasing from 2.4% in 2000, to 6.4% in 2014 (McManus et al., 2019). In 2018, a prevalence-estimation study in England found that *'for every adolescent suicide, there are approximately 370 adolescents who*

[1] The term 'professionals', in this context, means any paid staff supporting people who self-harm.

present to hospital for self-harm and 3900 adolescents who report self-harm in the community' (Geulayov et al., 2018:168); in short, the majority of self-harm is not reported (McManus et al., 2019). Self-harm, particularly among adolescents, is a risk marker for difficulties later on in life, including antisocial behaviour, mental health problems, substance use and postpartum depression (Borschmann and Kinner, 2019); it also increases an individual's likelihood of suicide (Ness et al., 2016; O'Connor, et al., 2018).

Causation for self-harm is complex and variable, though reasonably well documented (Borschmann and Kinner, 2019). McManus et al. (2019) list the most common reason for self-harm as being *'to relieve unpleasant feelings of anger, tension, anxiety, or depression'* (p.573); whilst Public Health England (2017) introduce it as: *'strongly associated with emotional distress and mental health issues and…accompanied by a complex set of negative feelings such as self-loathing, disgust and shame'* (p.6).

1.2 People with learning disabilities who self-harm: definitions, prevalence and background.

Both in and outside the UK, research and literature has tended to separate self-harm presented by people with and without learning disabilities (Bradley, et al., 2018; Richards and Symons, 2018). 'Self-harm' is the preferred term for people without learning disabilities, whilst 'self-injurious behaviour' has traditionally been the common term for those with learning disabilities (Heslop and Lovell, 2013; Lovell, 2008). Definitions of self-injurious behaviour vary considerably, as does the terminology, the diversity of which *'hints at the state of our knowledge but also reflects a fragmentation of different scholarly disciplines'* (Rojahn, Schroeder and Hock, 2008:1). Murphy and Wilson's (1985) definition is still frequently drawn on, which states that: *'Any behaviour, initiated by the individual, which directly results in physical harm to that individual.'* (p.15). Rojahn, Schroeder and Hock's (2008) comprehensive publication on self-injurious behaviour states that it is a pathological behaviour (i.e. clinically significant), with repeated and largely uniform patterns, which *'cause or have the potential to cause direct or indirect (cumulative) physical damage to the person's own body'* (p.2). They include behaviours such as *'self-biting, head-hitting…self-*

scratching, self-induce vomiting, self-pinching, poking…in orifices, hair pulling…pica and aerophagia' (p.3).

The prevalence of self-harm amongst people with learning disabilities varies from 4%, to 24% (Oliver and Richards, 2015), with more than 30% of children with autistic spectrum disorder presenting with self-injurious behaviour (Soke et al., 2016). Prevalence rates typically increase with age, and self-injurious behaviour is generally very persistent (Oliver and Richards, 2015), with up to 84% persistence over 18 years (Taylor, Oliver and Murphy, 2011).

There are distinctive theories of causation for self-injurious behaviour: emotional distress and mental health problems, considered at the root of self-harm for people without learning disabilities, are much less likely to be considered, or are disregarded, for people with learning disabilities (Dick et al., 2011; Lovell, 2008). Behavioural and biological theories have tended to dominate the literature (Chezan et al., 2017; Oliver and Richards, 2015). Operant learning is the dominant behavioural theory (Symons, Devine and Oliver, 2012). It argues that the reason for self-harm may initially be innocuous, such as a compulsion to communicate something or a display of anger or pain, but then self-harm engenders a particular response (the person's need is met unusually quickly or levels of attention or concern are heightened) that reinforces the behaviour. Thus, self-injury is *'positively or negatively reinforced by sensory, tangible or social stimuli'* (Oliver and Richards, 2015: 1045). Functional Analysis is advocated to identify what is maintaining the self-injury and address it from a functional perspective (Hagopian, Rooker and Zarcone, 2015); thus, behavioural management is the usual approach to self-injury, though research has highlighted that interventions are not always based on a clear understanding of why the person is self-injuring (Symon, Devine and Oliver, 2012). Biological theories argue that self-injury is associated with a genetic condition or diagnosis, a response to pain or part of a movement disorder (Oliver and Richards, 2015). The underlying assumption is that self-injury is not inherently meaningful for the individual (Favazza, 1992; Furniss and Biswas, 2012); this typically leads to pharmacological interventions (Rana, Gormez and Varghese, 2013; Read and Rendell, 2007). There is, however, a growing emphasis on the emotional function for people with learning disabilities who self-harm (Dick et al., 2011; Ghaderi, Dehghan and Abolghasemi, 2017).

The risk of presenting with self-harm typically increases with more significant learning disabilities (Folch et al., 2018; Oliver and Richards, 2015). Future outcomes are concerning: people with learning disabilities who self-harm have a higher likelihood of being in residential facilities which isolate them from family (Minshawi et al., 2015), being excluded from education or social opportunities (Hilary and Dodd, 2009) and having limited or no peer-relationships (Chezan et al., 2017). This paper will use the term 'self-harm' universally to refer to people with and without disabilities who self-harm, following the precedent of papers discussing similar themes (Dick et al., 2011; Lovell, 2008).

1.3 Professionals' attitudes

NICE (2013) guidance on self-harm is the backdrop to this research, setting an expected standard for professionals' attitudes and responses to caring for those who self-harm. The first of eight quality standards emphasises the importance that: *'people who have self-harmed are cared for with compassion and the same respect and dignity as any service user'* (p.10). The reason that it is necessary to state this is clearly outlined: *'staff attitudes are often reported as contributing to poor experiences of care. Punitive or judgemental staff attitudes can be distressing for people who have self-harmed and may lead to further self-harm or avoidance of medical attention'* (NICE, 2013: 10). Staff attitudes have a significant impact upon those who self-harm. The guidelines go on to clearly stipulate that both commissioners and service providers are required to provide appropriate training for all staff who have contact with people who self-harm.

The importance for people who self-harm in receiving a caring, compassionate response, and the detrimental impact upon those who do not, is well documented (NICE, 2013; Rayner et al., 2019; Saunders et al., 2012). Despite this, research continues to highlight that negative attitudes are common across the sectors (Nursing: Karman et al., 2015; Education: Evans et al, 2019; Mental health: Shaw and Sandy, 2016; Prisons: Marzano, Adler and Ciclitira, 2015; Community Care: Fish, 2000). The emergency department is often the first doorway to accessing support services for someone who has self-harmed (Rayner et al., 2019), but services supporting people who self-harm also include schools, prisons, community care services and general healthcare services (Borschmann and Kinner, 2019).

Studies across the sectors concur that '*there remains discord between people's lived experience and the perspectives of people who care for them'* (Baker, 2018: 144). As Fish and Duperouzel (2008) succinctly put it: *'it is therefore clear that clients need to feel that they are being listened to and supported before they can work through the reasons for their self-injury, and subsequently find other coping strategies'* (p.12).

Positive attitudes are largely considered within the literature to be demonstrations of compassion and empathy (Karman et al., 2014; Rayner et al., 2019), alongside understanding and a sense of confidence. Negative attitudes are associated with frustration, anger and hostility (Rayner et al., 2019: 41), described as, '*punitive or judgemental*' (NICE, 2013:10) attitudes, or brought under the umbrella term, '*antipathy*' (Patterson, Whittington and Bogg, 2007:438).

Working with people who self-harm is emotionally challenging, particularly for those who see themselves in a helping or healing role (Marzano, Adler and Ciclitira, 2015; Patterson, Whittington and Bogg, 2007). The sometimes conflicting emotions of feeling responsible to help whilst simultaneously feeling powerless to do so, can lead to professionals distancing themselves (Hodgson, 2016) as a defence mechanism (Marzano, Adler and Ciclitira, 2015) and placing the locus of the problem within the patient, rather than themselves or their skill (Huband and Tantam, 2000). Maintaining compassion towards people who self-harm is not necessarily easy for professionals.

Research examining attitudes frequently draws on Weiner's (1986) attributional theory of motivation and emotion (Dick et al., 2011; Hodgson, 2016; Marzano, Adler and Ciclitira, 2015), which proposes that people's beliefs and assumptions about the cause of something are a key determinant of their emotional and behavioural responses (Reisenzein and Rudolph, 2018). Thus, research into professional attitudes has tended to measure professionals' beliefs and assumptions about self-harm, as well as their attitudes and reactions (Williams et al., 2012).

Research concerning professionals' perceptions and attitudes towards self-harm is relatively well established both in and outside of the UK (Dick et al., 2011; Karman et al., 2015; Timson, Priest and Clark-Carter, 2012), and has become an important research topic across the mental health continuum, as the attitudes of staff have been highlighted as significant

for patient wellbeing and outcomes more generally (Happell and Harrow, 2010; Karman et al., 2015). The research has largely established that professionals' attitudes to self-harm are significant to the maintenance[2] of self-harm (Hastings et al., 2003; Timson, Priest and Clark-Carter, 2012). In light of the tendency for research to examine 'self-injury' and 'self-harm' separately, it would be useful to ascertain if there are any differences in professionals' attitudes towards people with and without learning disabilities.

1.4 Chosen approach

A systematic review is an opportunity to answer a specific question in relation to the current evidence base within the literature. The detailed, transparent nature of systematic reviews aids validity and potential generalisability of findings, as they aim *'to answer a specific question or questions, to reduce bias in the selection and inclusion of studies, to appraise the quality of studies deemed relevant, and to summarize them objectively'* (Hawker, et al., 2002: 1287). Spending time screening and selecting the papers informed the analysis; the heterogenous nature of the studies meant narrative synthesis was the most appropriate approach.

1. 5 Aims of the research

This systematic literature review will seek to summarise research in professional attitudes to self-harm since 2000, which is when the NICE (2013) guidance for self-harm was introduced. It will also explore if professionals supporting people with and without learning disabilities have different attitudes towards self-harm. These differences may have implications for training, practice and policy. The divide in research and thinking around people who self-harm with and without learning disabilities is beginning to close (Lovell, 2008; Heslop and Lovell, 2013). The aim of this research is to examine to whether there is a similar divide in professionals' attitudes towards self-harm.

[2] Maintenance is the term used in the literature to mean the on-going use of self-harm (Oliver and Richards, 2015; Keonig et al., 2017).

1.6 Overview

The structure of this study is as follows. Chapter Two explains the process and methodology of the study, outlining the search strategy and screening methods, quality assessment, data extraction and analysis. Chapter Three presents the findings, sub-grouping them by professional setting and drawing out five major themes across the papers. Chapter Four discusses the findings, in which the attitudes of professionals supporting people with and without learning disabilities are compared; it also highlights limitations and makes recommendations for policy, practice and further research. Chapter Five presents the conclusions of the study.

2. Methodology

2.1 Aims of the study

- To systematically review and summarise the research into attitudes about self-harm, with a comparative focus on professionals supporting people with and without learning disabilities who self-harm.

- To identify and examine any differences that emerge in the research since 2000 between attitudes of professionals supporting people who self-harm with and without learning disabilities.

This research draws on the PRISMA (2009) guidelines to ensure a rigorous methodology. A transparency of methods is essential to ensure validity and repeatability. This Chapter describes how feasibility was checked and search terms decided; it describes the screening process, quality assessment and data extraction.

Ethical approval for this systematic review was sought and granted from the University of Bristol. Please see Appendix 1 for signed research ethical approval.

2.2 Checking feasibility

An initial search was conducted to ensure that the study had not already been done, that appropriate research was available to conduct the review and to explore possible search terms. These databases were searched for similar systematic reviews: Cochrane, Prospero, Campbell and the Centre for Reviews and Dissemination. One appropriate systematic review was found: *Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review* (Saunders et al., 2012), which reviewed perceptions of clinical staff supporting people without learning disabilities who self-harmed. A systematic review of staff supporting people with and without learning disabilities was not found.

An initial search was conducted with three bibliographical databases: EBSCO / ERIC, PsychInfo and IBSS. Experimenting with search combinations revealed that having 'attitudes'

(and the necessary synonym combinations) in the Title ensured a much higher level of relevant articles. It was checked that search terms were producing the articles already known about, plus additional studies; this helped ensure the search term was wide enough to gather relevant articles, but not so wide as to be producing large amounts of irrelevant articles (Petticrew and Roberts, 2006). Feasibility searching was conducted on 19.10.18; 26 articles met the criteria after a first screening, which was expected to reduce after the second screening. Six of the articles related to staff supporting people with learning disabilities and twenty were relating to staff supporting people without learning disabilities.

2.3 Search Strategy

The following bibliographic databases were searched in May 2019: **PsychInfo** (Psychiatry, psychology and social sciences); **IBSS** (International Bibliography of the social sciences), **CINAHL** (Nursing and allied health), **Web of knowledge** (Social sciences, arts and humanities) and **Medline. Google Scholar** was also searched.

Search terms were informed by the feasibility searching.[3] Limit-setting was used, where the database allowed for it, to ensure only peer-reviewed, English language articles were included. Articles published before 2000 were excluded. Three blocks of search terms were developed to capture the various synonyms, combining them with the Boolean operator 'AND' (Robertson et al., 2019). Terms for 'self-harm', 'attitudes' and 'professionals' were collated by examining the reference lists of articles already found and taking advantage of the alternatives suggested by the EBSCOhost database. As an example, the search term used for **PsychInfo** database was:

> (self-injury or self-harm or self-mutilation or self-mutilating or self-injurious).ab. and (attitudes or perceptions or opinions or thoughts or feelings or beliefs or reactions or attributions).ti. and (professionals or staff or teachers or support workers or carers).ab.[4]

[3] Advice regarding databases and search terms was also sought from the subject specific librarian at Bristol university, Angela Joyce, the Cochrane training database and other researchers.
[4] See appendix for full Search Results Table

2.4 Inclusion and Exclusion criteria

Articles were required to meet all the following criteria (Robertson et al., 2019):

2.4.1 Inclusion criteria:

- Peer-reviewed
- Published from 2000-present
- English language full text
- Self-injury or self-harm (or equivalent terms)
- Professionals' (or equivalent terms) attitudes (or equivalent terms) towards self-harm
- Quantitative, qualitative or mixed method studies

Articles were excluded against the following criteria:

2.4.2 Exclusion criteria:

- Not peer-reviewed or status unclear (limits set in search where possible)
- Articles published prior to 2000 (limits set in search where possible)
- Non-English language articles (limits set in search where possible)
- Studies comparing attitudes towards self-harm, whilst not reporting attitudes to self-harm per se; e.g. comparing attitudes towards one form of self-harm with another; or comparing one group of professionals with another
- Studies exploring a discursive aspect of attitudes towards self-harm, e.g. attributional theories or models, or the factors influencing attitudes
- Studies discussing opinions, definitions or knowledge about self-harm only
- Studies discussing both self-harm and suicide or conflating the two
- Studies examining non-professional perceptions and attitudes: students, members of the public, people who self-harm or family members

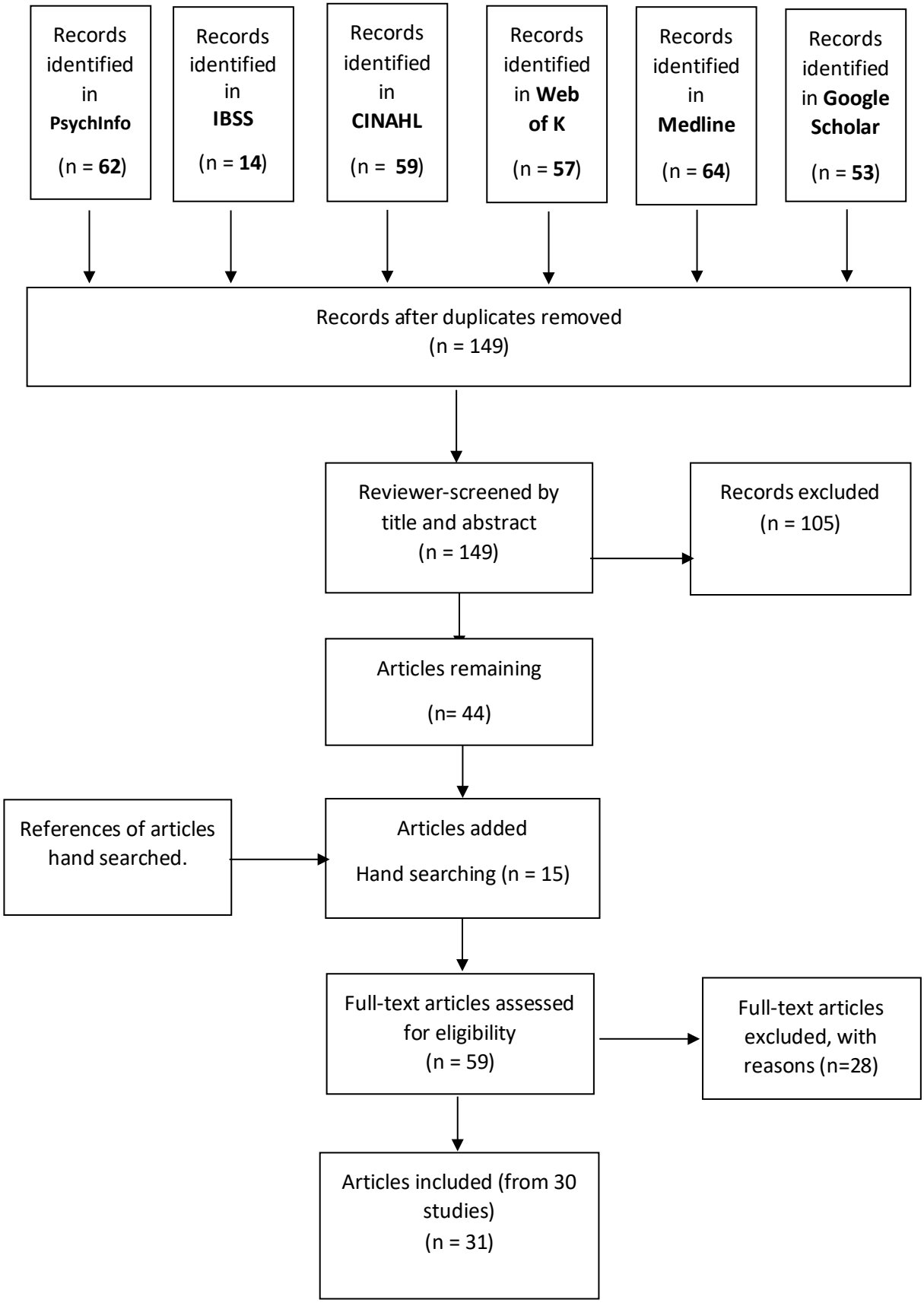
This review is concerned with the attitudes of professionals towards self-harm, when supporting people who self-harm is a substantive part of their role; these are typically considered frontline medical and mental health staff, care staff, prison officers and teachers (Fish, 2000; McHale and Felton, 2010; Short, et al., 2009). Thus, articles involving students or professionals who were unused to supporting people who self-harm were excluded (Fox, 2016; Knowles and Townsend, 2012). This review is specifically concerned with attitudes, so articles only concerned with knowledge were not included (Simm, et al., 2008). Some

articles compared the attitudes of one staff group with another, without stating what those attitudes were; these articles were excluded (Cleaver, 2014; French, 2001; Hastings, et al., 2003; Kumar, et al., 2016; McCarthy and Gijbels, 2010). Other articles discussed a particular facet of attitudes, i.e. factors that inform attitudes, or different models to understand or examine attitudes; these were excluded (Artis and Smith, 2013; Jones, 2003; Leibowitz, 2009; Wheatley and Austin-Payne, 2009).

2.5 Screening and selection

The database search produced 341 articles. Database alerts were set up against the searches until 15.07.19 to capture newly published articles; no relevant articles were produced. Search results were collated in tables and the references exported to Endnote. The articles were screened for duplications and 192 articles removed; this was done through Endnote and double-checked by hand. The 149 remaining articles were compiled in tables and screened by titles and abstracts. Reasons for excluding articles were noted on the spreadsheet, and these decisions were justified against the inclusion and exclusion criteria; 105 articles were excluded. The references of the remaining 44 articles were hand searched, producing an additional 15 relevant articles. The full text articles for the resultant 59 articles were obtained and downloaded as PDF's, and assessed for eligibility against the inclusion and exclusion criteria, resulting in 28 articles excluded. This produced 31 research articles from 30 discrete studies.

Figure 1: Flow Diagram, adapted from PRISMA, 2009[5]



[5] http://www.prisma-statement.org/ [Accessed 22:11:18]

2.6 Quality assessment

Critical appraisal is essential for ensuring the systematic review is reliable, allowing less reliable data to be considered accordingly so it does not skew the data synthesis (Petticrew and Roberts, 2006). The 31 articles included were of a variety of methods, so a relevant quality assessment tool designed for heterogenous studies was sought. Hawker et al.'s (2002) Critical Appraisal tool was utilised, as it enables the appraisal of qualitative and quantitative research (Hodgson, 2016); it lists nine subjects under which each article can be graded:

1. abstract and title

2. introduction and aims

3. method and data

4. sampling

5. data analysis

6. ethics and bias

7. findings/results

8. transferability/generalisability

9. implications and usefulness

This is supported by a protocol, which allows the researcher to assess each article numerically (10 very poor; 40 good), against clear criteria. *'A summary of total scores with sub-scores could be presented, which gives a clear indication of the strengths and weaknesses of each study'* (Hawker, 2002: 1292). Each paper was graded against the protocol and the results compiled in a Table (Robertson, et al., 2019). Overall possible score ranged from 90-360; the range in scores for the 31 articles included was between 210 – 350. Those scoring <270 (75%) were highlighted with an asterisk as being of lower quality. These will be discussed in more detail in the findings; (see Appendix 4 and 5 for Quality Assessment Scores and the Quality Assessment Table for each article).

2.7 Data extraction

A draft extraction table was compiled to facilitate the extraction of descriptive data and study characteristics into a table. Once the 31 articles were selected and read through, the data and themes informed alterations to the extraction form in order that the relevant comparative data could be tabulated; (see Appendix 3 for the full Data Extraction Table[6]).

2.8 Data analysis

The 31 articles included in this review are a mix of systematic reviews, quantitative, qualitative and mixed-method studies, so meta-analysis was not appropriate; this is common for a social science systematic review (Petticrew and Roberts, 2006). Narrative synthesis was chosen as the most appropriate technique to capture the results accurately and answer the research questions. An iterative approach, involving the repeated reading of the articles, informed the identification of five themes (Robertson et al., 2018); as themes developed, a one-page summary of each article was also collated, identifying data under each of the themes for each article. The comparative focus of this review was facilitated by dividing the studies into Group A: professionals supporting people with learning disabilities who self-harm and Group B: professionals supporting people without learning disabilities who self-harm. Chapter 3 discusses the findings and analysis.

[6] It was not possible to include the table in the body of this report due to the high number of studies included.

3. Findings

3.1 Introduction

Thirty-one articles from thirty distinct studies were included in the review. Four studies conducted research within settings which supported people with learning disabilities: this formed Group A. The remaining 26 studies (27 articles) were conducted in settings which supported people predominantly without learning disabilities; these studies formed Group B. Due to the greater number of studies in Group B, it was separated into four sub-groups: education services (4 articles), general healthcare services (13 articles), mental health services (five articles) and prison services (five articles). One study, Crawford et al. (2003), drew participants from emergency departments (ED), inpatient services and CAMHS (child and adolescent mental health service) and was categorised with the mental health services studies, due to the focus on mental health.

The following themes were identified: knowledge of staff members, training and education, characteristics of professionals, attitudes, and recommendations. The themes are discussed for Group A and Group B, with Group B being separated into the four subgroups as discussed. Synthesising the findings into an overall picture and comparisons between Groups A and B is presented and explored in Chapter Four.

The 'attitudes' theme needs expounding, as it has some innate complexities. The NICE (2013) guidelines, as discussed in Chapter 1, indicate that 'positive attitudes' are '*compassion, respect and dignity'* and 'negative attitudes' are *'punitive or judgemental'* (NICE, 2013:10). Very few of the papers in the study define or contextualise 'positive' or 'negative' attitudes, whilst using these terms widely; instead, they imply a reliance upon the NICE (2013) definitions. The studies included would typically include empathy in the concept of 'positive attitudes' (e.g. Berger, Hasking and Reupert, 2014; Conlon and O'Tuathail, 2012; Rayner et al., 2019). 'Negative attitudes' are typically include frustration (e.g. Hadfield et al., 2009; Hodgson, 2016; James and Warner, 2005), anger (e.g. Gough and Hawkins, 2000; MaCarthy and Gijbels, 2010; Pannell, Howells and Day, 2003), hostility (e.g. Dickinson and Hurley, 2012; Heath, Toste and Beettam, 2006; Koning, McNaught and Tuffin, 2018) and antipathy (e.g. Karman et al., 2015; Perboell et al., 2015; Rayner et al., 2019).

There is a conflating of attitudes with attributions across the studies. This is well illustrated by the qualitative studies, as some of the participants' quotes could be coded as both attributional and attitudinal statements. E.g. Marzano, Adler and Ciclitira's (2015) interview with a prison officer states: 'They know they've got us over a barrel. "If you don't do that then I'll, I'll cut myself." That annoys me. Because that's, that's a blackmail' (p. 247). This demonstrates an attributional statement about a prisoner cutting to gain something, as well expressing a frustrated and angry attitude. Attribution and attitudes were often conflated in the researcher's conclusions. Berger, Hasking and Reupert (2014) concluded in their study with teachers that, 'although many identified attention-seeking and manipulation as motivations for NSSI [non-suicidal self-harm], the majority reported feeling sympathy' (p.210). This statement implies that, whilst the teachers made 'judgemental' attributions (which implies negative attitudes), they still felt sympathy (a positive attitude). This is a very common way that researchers in the studies draw together the complex cocktail of negative and positive attributions and attitudes which the research typically uncovers. Staff attributions influence attitudes (Weiner, 1986), and so the combination of the two in the literature is understandable. As Bhola and Ravishankar (2014) conclude, 'an incomplete understanding of the underlying motivations for self-injury among students could impact on the empathetic response' (p.126). For clarity, the sections discussing attitudes will discuss the findings about attribution and attitude sequentially as far as it is possible.

3.2 Group A: Articles exploring the attitudes of professionals supporting people with learning disabilities.

Introduction

Four articles were found that researched professionals' attitudes towards people who self-harm with learning disabilities (Dick et al., 2011; Fish, 2000; James and Warner, 2005; Snow, Langdon and Reynolds, 2007). All four articles were UK-based research with both qualified and unqualified care staff. Two studies utilised Q-methodology (Dick et al., 2011; James and Warner, 2005); Fish (2000) conducted in-depth interviews and Snow, Langdon and Reynolds (2007) conducted a questionnaire study. Dick et al. (2011) conducted their research with community services, Fish (2000)'s research was in a forensic learning disability service,

James and Warner (2005)'s research was based in a medium secure unit. It should be noted that James and Warner's (2005) 40 participants included 'some patients' (p.33); the first phase of participants were professionals from the service, as well as the majority of participants in the second phase and so it was decided to include it in the review. Snow, Langdon and Reynolds' (2007) study was conducted in in-patient services for learning disabilities. Dick et al. (2011) and Fish (2000) scored well in the quality assessment. Snow, Langdon and Reynolds (2007) scored the required (75%) threshold of 270, and James and Warner's (2005)* scored 260 due to no mention of ethical requirements and low scores for the abstract and usefulness; it will be highlighted in the discussion section with an asterisk.

Knowledge of staff members:

None of the articles discussed staff's knowledge regarding self-harm.

Training and Education:

None of the articles discussed training or education except Fish (2000), who mentioned that most staff had received no formal training.

Characteristics of professionals

Snow, Langdon and Reynolds (2007) found that high emotional exhaustion led to higher unstable attributions, i.e. the behaviour was perceived as unpredictable, leading to feelings of helpless in staff. The other articles did not examine characteristics of professionals in relation to attitudes.

Attitudes

Attitudes were largely considered in relation to attributions in these four studies. James and Warner (2005)* reported that staff thought self-harm was commonly a way to cope with internal difficulties, such as powerlessness and abuse or the struggle to process difficult

experiences. It was felt to operate like a safety valve to control emotional distress, feelings of blame associated with previous experiences and as a way of coping that is 'unknowable'; self-harm was seen as connected to low self-esteem and a build-up of interrelated emotional experiences. Self-harm was conversely seen as a way that clients coped with the here and now, including influencing the ward staff: it was considered a way to manage immediate, external circumstances.

Snow, Langdon and Reynolds (2007) found that self-harm was largely attributed to internal factors that originate with the person that are beyond their control (i.e. their personality or their learning disability). Staff also felt self-harm was directed to affect a particular outcome. Higher levels of unstable (unpredictable) attributions for self-harm by staff (that a person self-harms because they need or want attention) were associated with higher levels of emotional exhaustion in the staff.

Dick et al. (2011) found a relatively high level of agreement that self-harm was individual and was an emotionally meaningful act; they concluded that the staff understood the individual and complex meaning for self-harm, and that it was a way to cope with and communicate emotions. However, Dick et al. (2011) also found some evidence that staff felt that self-harm was specific to having learning disabilities; this suggested an underlying attitude that the self-harm was lacking intent or meaning when carried out by someone with learning disabilities. '*There is a split between viewing self-harm as a meaningless response to biological factors and acknowledging that self-harm can be an attempt to communicate distress*' (p.238). Self-harm was also viewed as a response to relational situations (being shouted at or communicating an unmet need), as well as the idea that someone might self-harm to copy other people. This was interpreted in the study as *'an attempt to identify with others and thus build relationships'* (p.238). Dick et al. (2011) concludes that staff beliefs were generally broadening beyond previously dominant biological and behavioural models.

Fish (2000) reported that staff members accounted for self-harm in a wide variety of ways, including, '*that's part of her, part of her personality*' (p.201); that it gave the client something of which to be in control; that it was a way to cope or a way to rebel against feeling controlled or lacking control. Some staff considered some of the behaviour of the client manipulative.

Both Fish (2000) and Dick et al. (2011) discussed as a critical theme the complexity of the relationships between staff and clients. Fish (2000) found positive aspects of the relationship and that it could be rewarding. The relationship was also highlighted as a critical element in staff attitudes by Dick et al. (2011).

Fish (2000) was the only study to consider staff attitudes (rather than attributions). Staff responses fluctuated between guilt, sympathy and resentment, and they were often left feeling inadequate, whilst wanting to help and comfort. Staff tried to cope with the personal aspects of self-harm by trying not to think about it and '*looking past it*' (p.200). Fish (2000) reported a sense of care futility: '*I know she'll do it… it's just a case of delaying it as long as possible*' (p.200). Staff worried about managerial response, and felt self-recrimination, failure and loss of confidence in response to a client self-harming; staff reported that they felt there was a 'blame culture' in which staff were held to account for not being able to stop the self-harm of the client.

All the studies found a mixture of contradictory positive and negative attributions and attitudes, but typically focussed more on the positive attitudes. Dick et al. (2011) concluded that there are some contradictions and complexities within staff's beliefs. James and Warner (2005)* similarly found that self-harm was understood as adaptive and meaningful, whilst the reasons for self-harm were felt to be individual and complex. Dick et al. (2011) also found that staff found self-harm difficult to understand, with high agreement for differing views.

Recommendations:

Dick et al. (2011) recommended training that harnesses the perspectives of people with learning disabilities who self-harm and which promotes skills in psychological formulation. Both Dick et al. (2011) and Fish (2000) discussed the importance of training that provides broad ideas about different causation and promotes the complexity and individuality behind why some people self-harm. Fish (2000) highlighted the importance of organised systems of support, group therapy, debrief and regular supervision. Snow, Langdon and Reynolds (2007) and James and Warner (2005)* did not make any specific recommendations, though the latter concludes, '*formulaic approaches to intervention cannot work*' (p. 125).

3.3 Group B: Articles exploring the attitudes of professionals supporting people without learning disabilities.

Group B is separated into four professional settings: education services, healthcare, prison services and mental health services.

3.3.1 Education services

Four articles (Bhola and Ravishankar, 2017; Berger, Hasking and Reupert, 2014; Heath, Toste and Beettam, 2006; Heath et al., 2011) were found exploring attitudes of staff in mainstream education services towards pupils who self-harmed. All four articles were questionnaire studies, using a mixture of Likert (1932) scales and open-ended questions, and thus requiring both quantitative and qualitative analysis. Bhola and Ravishankar's (2017) study was the exception, only utilising checklists and Likert scales. Berger, Hasking and Reupert (2014) surveyed all school staff, including administrators and pastoral staff; the other surveys were just conducted with teachers.

In the quality assessment, the two Canadian articles did not discuss ethics, scoring 'very poor'. Heath, Toste and Beettam (2006) scored 'poor' for sampling and transferability, as the sample of self-selecting teachers from a cohort with an interest in self-harm resulted in low transferability but scored 270 overall. Heath et al. (2011)* had the same quality concerns whilst scoring low on usefulness, due to stating a clear aim of informing training and education but not making concrete recommendations. This article will be highlighted with an asterisk henceforth.

Knowledge of staff members:

All four studies presented findings of participants' knowledge base. Prevalence of self-harm was largely underestimated, with Berger, Hasking and Reupert (2014) finding that 55%[7] underestimated prevalence, whilst 75% of staff did so in Bhola and Ravishankar's (2017)

[7] Rounded up from 54.8%. Data with decimal points has been rounded to a whole number throughout.

study. Twelve percent of staff correctly estimated prevalence in Heath, Toste and Beettam's (2006) study, compared with 25% in Berger, Hasking and Reupert's (2014) study. The majority of staff were able to identify 11-15 as the most common onset age, percentages ranging from 66% (Heath, Toste and Beettam, 2006) – 89% (Berger, Hasking and Reupert, 2014). Between 2006 and 2011, Heath et al.'s two studies reported that knowledge increased in all areas, including staff feeling knowledgeable, which increased from 20% in the 2006 study to 32% in 2011. Both knowledge and perceived knowledge were positively related to confidence (Bhola and Ravishankar, 2017), although this corresponded to lower levels of sadness in response to self-harm disclosures. Heath et al. (2011)* found that knowledge increased confidence but didn't necessarily lead to more positive attitudes.

Training and Education:

Berger, Hasking and Reupert's (2014) study reported that 80% of staff said they had not received any training or education. The other studies reported that teachers felt they needed more information and training (Bhola and Ravishankar, 2017; Heath, Toste and Beettam, 2006; Heath et al., 2011*). Berger, Hasking and Reupert (2014) found that those who had received some education in self-harm were more confident and had higher self-perceived knowledge; this included mental health workers, who were the most confident group.

Characteristics of professionals:

There was no agreement as to the role that gender played in determining knowledge, confidence or attitudes. Bhola and Ravishankar (2017) found that gender made no difference, whilst Berger, Hasking and Reupert (2014) found that female staff had more knowledge and confidence. Heath, Toste and Beettam's (2006) study found that male teachers had higher perceived knowledge, whilst Heath et al.'s (2011)* study found that male teachers were more likely to agree that self-harm was attention-seeking and manipulative.

Length of professional experience correlated to lower levels of knowledge about self-harm in Berger, Hasking and Reupert's (2014) study. Heath, Toste and Beettam (2006) found that both age and teaching experience positively correlated with *perceived* knowledge, but had no effect on measured knowledge nor attitudes, whilst Heath et al. (2011)* found that teachers with more professional experience were more likely to agree that self-harm was manipulative. There was a tendency for more experienced staff to have greater confidence in their knowledge about self-harm whilst not necessarily having the knowledge needed and being more prone to judgemental attitudes.

However, specific experience of supporting students who self-harm correlated to better knowledge, understanding and attitudes (Berger, Hasking and Reupert, 2014). Bhola and Ravishankar (2017) similarly found that teachers *without* experience of supporting a student with self-harm were more likely to ascribe attention-seeking as the function and more likely to say they were too busy to help. Notably, they also had higher perceived knowledge whilst '*adopting a less helpful stance*' (p.127).

Attitudes

All four studies reported a mixture of positive and negative attitudes in relation to causation and response to self-harm.

In terms of staff attributions, Bhola and Ravishankar (2017) found that self-harm was most commonly attributed to 'getting attention' (78%). Teachers also attributed self-harm to mental illness and depression (77%), substance abuse (<60%) and abuse and eating disorders (50%). Heath, Toste and Beettam, 2006 found that there were some thoughtful explanations given for the reasons for self-harming, however, 22% felt it was 'just trying to get attention'; 12% agreed it was 'often manipulative', and 34% agreed self-harm was a symptom of mental disorder. These attributions increased when the study was repeated in 2011: 30% agreed self-harm was 'just trying to get attention'; 18% agreed self-harm was 'often manipulative' and 46% that it was a symptom of mental disorder. Berger, Hasking and Reupert (2014) similarly reported that *'many identified attention-seeking and manipulation as motivations for NSSI [non-suicidal self-harm]'* (p.210).

In terms of attitudes towards self-harm, in 2006 48% agreed with the statement, '[I] *find the idea of cutting or burning horrifying*' (p.81), and in 2011, 60% agreed (Heath et al., 2006; 2011*). Bhola and Ravishankar (2017) reported that 68% of staff agreed that self-harm made them feel shocked, and 55% that it made them feel scared (p.121); 37% said they were too busy to help someone who self-harmed. Berger, Hasking and Reupert (2014) reported that responses to self-harm were wide ranging, including feeling frustrated, angry and manipulated by the students, but also expressing sympathy, concern and a willingness to help, despite lack of knowledge and confidence. They concluded that '*teachers and other school staff felt empathetic and wanted to help…but [lacked] education and resources*' (p.209). Bhola and Ravishankar (2017) similarly conclude that '*an incomplete understanding of the underlying motivations for self-injury among students could impact on the empathetic response*' (p.126).

Recommendations:

All studies make recommendations for training and education, though they vary in specificity. Berger, Hasking and Reupert (2014) recommend educational programmes for all school staff, specifically advocating that the content should cover active listening and appropriate responding and referral. Bhola and Ravishankar (2017) recommend training to '*expand knowledge about the complex range of reasons why young people self-injure, through sharing of research findings and personal narratives of self-injurers*' (p.126); they also '*highlight the need to avoid rigid assumptions*' (p.127). Heath, Toste and Beettam, 2006 discuss the concern that their sample was well-educated but still routinely requesting training, and the possible implications for less well-trained populations. Heath et al. (2011)* suggest targeting training just with staff already engaged with students who self-harm, which is contrary to NICE (2013) recommendations that *'all staff who come into contact with self-harm should be trained'* (p.11). In addition, Berger, Hasking and Reupert (2014) recommend the provision of group-supervision or debrief.

3.3.2 Healthcare

Thirteen articles were found discussing attitudes of staff towards people who self-harm in general healthcare services; this included Emergency Departments (ED) and paramedic services (Conlon and O'Tuathail, 2012; Friedman et al., 2006; Hadfield et al., 2009; Koning, McNaught and Tuffin, 2018; Perboell et al., 2015; Rayner et al., 2019; Rees, Rapport and Snooks, 2015), a burns and plastic surgery department within a general hospital (Heyward-Chaplin et al., 2018) and general hospital staff (Hodgson, 2016; Karman et al, 2015; McHale and Felton, 2010; Saunders et al., 2012). Gibb, Beutrais and Surgenor (2010) compared staff from a general hospital with staff from a psychiatric hospital. All the studies were from UK or Ireland, except for Gibb, Beutrais and Surgenor, 2010 (New Zealand), Perboell et al., 2015 (Denmark) and Koning, McNaught and Tuffin, 2018 (Australia). There were five questionnaire studies (Conlon and O'Tuathail, 2012; Friedman et al., 2006*; Gibb, Beutrais and Surgenor, 2010; Heyward-Chaplin et al., 2018; Perboell et al., 2015) and two qualitative studies (Hadfield et al., 2009; Koning, McNaught and Tuffin, 2018); six articles were literature reviews (Hodgson, 2016; Karman et al., 2015; McHale and Felton, 2010) or systematic reviews (Rayner et al., 2019; Rees, Rapport and Snooks, 2015; Saunders et al., 2012), with numbers of studies included ranging from five (Rayner et al., 2019) to 73 studies (Saunders et al., 2012).

Quality assessment of the papers overall was good, with only two falling below the 75% threshold. Friedman et al. (2006)* scored 240, due to not mentioning ethics in the article, and scoring 'fair' for most criteria and 'poor' for introduction, aims and usefulness. Koning, McNaught and Tuffin (2018)* scored 250 due to scoring 'poor' for sampling and transferability, and also for findings (the themes did not align well enough with the data presented) and usefulness, due to brief, vague recommendations. These will be referenced with an asterisk.

Knowledge of staff members:

Staff knowledge was not measured by many of the studies, but those that did found it was generally poor (Saunders et al., 2012; Friedman et al., 2006*; Heyward-Chaplin et al., 2018;

McHale and Felton, 2010). The majority of participants had experiential knowledge of supporting patients with self-harm, percentages ranging from 65% of staff in the burns unit (Heyward-Chaplin et al., 2018) to 83% of ED nurses (Conlon and O'Tuathail, 2012). Friedman et al. (2006)* found that ED staff significantly over-estimated the prevalence of patients presenting with self-harm. Only a minority of professionals viewed patients at risk of suicide, which was highlighted as a concern (Friedman et al., 2006)*, or staff acknowledged but underestimated it (Saunders et al., 2012). Heyward-Chaplin et al. (2018) reported that only 12% of the burns unit staff were aware of national guidance in relation to self-harm (81% not aware). Saunders et al.'s (2012) substantial review found that guidelines were not generally available across the 73 studies. McHale and Felton (2010) reported that better knowledge generally correlated to better attitudes in the 19 studies included in their literature review.

Training and Education:

Staff reported training or education about self-harm varied between studies, with the majority of participants feeling they needed more training (Conlon and O'Tuathail, 2012; Friedman et al., 2006*; Gibb, Beutrais and Surgenor, 2010).

Overall, prior training in self-harm was generally confirmed by under 50% of participants (Heyward-Chaplin et al., 2018; Perboell et al., 2015; Rees, Rapport and Snooks, 2015), though numbers ranged from 6% of ED staff (Friedman et al., 2006*) to 68% (Conlon and O'Tuathail, 2012). Koning, McNaught and Tuffin (2018)* reported that education increased staff's feelings of competence and understanding of factors leading to self-harm and Conlon and O'Tuathail, (2012) found it lowered antipathy levels. Perboell et al. (2015) similarly reported that education increased self-efficacy, positive attitudes and empathetic approach. Amongst the literature reviews, there was a consensus that '*a lack of education was the primary rationale for negative attitudes*' (McHale and Felton, 2010: 735), and that effective training increased positive attitudes and reduced antipathy (Hodgson, 2016; Karman et al., 2015). The systematic reviews concurred, reporting that increased training and education about self-harm encouraged more positive attitudes (Rayner et al., 2019; Rees, Rapport and Snooks, 2015; Saunders et al., 2012), as well as improving knowledge and confidence (Rees,

Rapport and Snooks, 2015). Saunders et al. (2012) emphasised that the correlation between training and attitudes was only found with *active* training, rather than simple information-provision, such as leaving out a folder.

The inadequacy of supervision or support for staff supporting patients who self-harm was also highlighted (Hadfield et al., 2009; Hodgson, 2016; Koning, McNaught and Tuffin, 2018*). Koning, McNaught and Tuffin, (2018)*reported that participants felt that the system had failed: they felt ill-prepared and lacking training, with little faith in the mental health system. Rees, Rapport and Snooks (2015) found policies were under-used or lacking. Despite guidelines stating that protocols should be in place and training implemented, it was not.

Characteristics of professionals

Most papers reported that some characteristics of professionals related to attitudes, with only two studies not addressing this (Hadfield et al., 2009; McHale and Felton, 2010).

Perboell et al. (2015) reported that female ED nurses had more positive attitudes, more empathy and higher confidence than male ED nurses. However, the overall picture was that gender differences were not statistically significant (Karman et al., 2015; Rayner et al., 2019; Rees, Rapport and Snooks, 2015; Saunders et al., 2012).

Considerable variation and contradictions were found in relation to the effect of professional experience and age upon attitudes. Some studies reported that more experienced nurses had less antipathy and were more confident (Conlon and O'Tuathail, 2012; Heyward-Chaplin et al., 2018; Hodgson, 2016; Perboell et al., 2015). In contrast, other studies reported that more professional experience correlated to higher levels of anger, antipathy or feelings of inadequacy, although it was not necessarily statistically significant (Friedman et al., 2006*; Koning, McNaught and Tuffin, 2018*; Rayner et al., 2019). Gibb, Beutrais and Surgenor (2010) found no significant correlation with age or experience – but that negative attitudes were correlated with burnout. The literature and systematic reviews reported very mixed results, with professional experience correlating to both negative and positive attitudes or having no effect (Karman et al., 2015; Rees, Rapport and Snooks, 2015). Other studies concluded that, overall, older caregivers had more empathy and

understanding (Conlon and O'Tuathail, 2012; Hodgson, 2016; Rees, Rapport and Snooks, 2015).

Attitudes:

In terms of attributions, healthcare staff commonly attributed self-harm to attention-seeking or manipulation (Conlon and O'Tuathail, 2012; Friedman et al., 2006*; Hadfield et al., 2009; Heyward Chaplin et al., 2018; Karman et al., 2015; Koning, McNaught and Tuffin, 2018*); it tended to be the minority of staff, although Gibb, Beautraies and Surgenor (2010) reported that 51% of staff agreed that '*patients use self-harm as a way to get sympathy and/or attention*' (p.716).

Several papers reported that healthcare staff made judgements as to whether self-harm was 'genuine' or 'not-genuine' from one patient to another (Conlon and O'Tuathail, 2012; Hodgson, 2016; Koning, McNaught and Tuffin, 2018*; Saunders et al, 2012); this led to moral judgements which affected attitudes and responses.

Some staff expressed that self-harm patients wasted time or resources or were less entitled to care than other patients (Karman et al., 2015; Rees, Rapport and Snooks, 2015; Gibb, Beuatrais and Surgenor, 2010). Heyward-Chaplin et al.'s (2018) study of burns unit staff reported that 14% felt treatment for self-harm injuries should be different from injuries with other causes. The evidence that patients may be offered more conservative treatment due to self-harm (i.e. were less likely to be offered surgery or skin grafts) was highlighted as a concern as it contravenes national guidelines.

The studies all typically presented complex and contradictory findings, with attributions that were 'punitive and judgemental' (NICE, 2013) (that self-harm was time-wasting, manipulative and attention-seeking) as well as attributions that demonstrated 'compassion, respect and dignity' (NICE, 2013). Koning, McNaught and Tuffin's (2018)* study captures the spectrum well, reporting that staff attributed self-harm to a multiplicity of reasons, including to release stress or cope, to ask for help, escape but also to gain attention.

There was a sense of 'role conflict' for some staff, particularly ED staff, who sometimes tended to focus on physical needs over psychological needs (Conlon and O'Tuathail, 2012; Hadfield et al., 2009; Hodgson, 2016; Koning, McNaught and Tuffin, 2018*). McHale and Felton (2010) reported that the healthcare staff's cultural and clinical expectations was to

heal and help, rather than be therapeutic. Hadfield et al. (2009)'s interviews with ED doctors found that the separation of mind and body in medicine was felt to disempower them, leaving them feeling ill-equipped and helpless. Trivialising self-harm appeared to help distance them from their helplessness and threats to their professional image.

In terms of attitudinal responses, Heyward-Chaplin et al.'s (2018) results were fairly typical: attitudes were generally found to be non-judgemental and compassionate, but 10% were struggling to be compassionate, not feeling confident or judging patients who self-harm differently. Whilst the majority of participants in the studies demonstrated positive attitudes most of the time, the negative attitudes were typically quite significant (Gibb, Beautrais and Surgenor, 2010; Hadfield et al., 2009; Hodgson, 2016; Karman et al., 2015; Koning, McNaught and Tuffin, 2018*; McHale and Felton, 2010; Perboell et al., 2015) and included a sense of powerlessness, inadequacy, futility, anger, moral judgement and empathy (Conlon and O'Tuathail, 2012; Friedman et al., 2006*). Saunders et al.'s (2012) reported that hostility was particularly present when staff were distinguishing between legitimate and non-legitimate needs of patients who self-harmed.

Attitudes were affected by how the patient behaved (Conlon and O'Tuathail, 2012; Hodgson, 2016; McHale and Felton, 2010; Saunders et al., 2012), with repeat self-harm typically increasing negative attitudes such as irritation and anger amongst staff.

Negative attitudes were exacerbated in settings in which nurses felt untrained or unsupported (Hodgson, 2016; McHale and Felton, 2010; Rayner et al., 2019). Rees, Rapport and Snooks (2015) found that staff in large or intense hospitals typically had more negative attitudes. Karman et al. (2015) found that mental health nurses were more likely than general healthcare nurses to express irritation, frustration, powerlessness and anger, and expressed a greater need for support and supervision. Conversely, Saunders et al. (2012) found frustration was common in ED settings, often alongside a sense of hopelessness. This was a dominant theme: that staff felt overwhelmed, unsupported and consequently inadequate to the task of supporting patients who self-harm (Conlon and O'Tauthail, 2012; Friedman et al., 2006*; Gibb, Beutrais and Surgenor, 2010; Karman et al., 2015; McHale and Felton, 2010). A good summary of the overall picture was provided by Gibb, Beutrais and Surgenor (2010) who found that despite >70 % of staff believing they could be helpful and understanding, they were not confident in their work and believed they were inadequately

trained (this included psychiatric staff). Conlon and O'Tuathail (2012) similarly report a mixture of empathy, powerlessness and futility, whilst Karman et al. (2015) reported feelings of incompetence across the spectrum, associated with lack of training.

Recommendations:

Every article concluded with recommending training, with the exception of Rees, Rapport and Snooks (2015). Some papers simply stated that more training was recommended (Gibb, Beutrais and Surgenor, 2010; Koning, McNaught and Tuffin, 2018*; McHale and Felton, 2010), but most were more specific.

Training was recommended which promotes critical reflection and collaboration, with the use of personal narratives (Hadfield et al., 2009; Karman et al., 2015), as well as teaching effective communication and interpersonal skills to develop therapeutic relationships and alliances (Conlon and O'Tuathail, 2012; Hodgson, 2016; Rayner et al., 2019; Saunders et al., 2012). Training which addresses knowledge and understanding about self-harm was advocated for, as well as teaching better risk assessment, patient management and practical skills (Hodgson, 2016; Rayner et al., 2019). There was an emphasis on the need for *continual* education to gain and reinforce better understanding of the functions of self-harm (Heyward-Chaplin et al., 2018; Hodgson, 2016).

The need for effective clinical supervision was a repeated recommendation (Conlon and O'Tuathail, 2012; Hodgson, 2016, Karman et al., 2015; McHale and Felton, 2010; Rayner et al., 2019; Saunders et al., 2012), with Friedman et al. (2006)* noting that '*unsupported staff risk burnout, which could be reflected in deteriorating attitudes with time*' (p. 276) and Gibb, Beutrais and Surgenor (2010) noting that 91% felt '*it would helpful to have someone to talk to about self-harm patients*' (p.716). More support was highlighted for staff who regularly care for patients who self-harm (Hadfield et al., 2009; Karman et al., 2015). Some studies, which found experienced staff were more empathetic, recommended peer coaching to harness more experienced staff's capacity (Conlon and O'Tuathail, 2012; Perboell et al., 2015). Some studies promoted the wider use of liaison mental health teams for ED's, or closer links to mental health teams (Hodgson, 2016; McHale and Felton, 2010). Concerns about professional lack of access and knowledge to NICE guidelines or local guidelines was

picked up, with recommendations for better dissemination and clarity of guidelines (Heyward-Chaplin et al., 2018; Saunders et al., 2012).

3.3.3 Prison service

Introduction

Four relevant articles were identified from the prison service (Ireland and Quinn, 2007; Marzano, Adler and Ciclitira, 2015; Pannell, Howells and Day, 2003; Short et al., 2009); all were UK based except Pannell, Howells and Day's (2003)* Australian-based study. All studies examined attitudes of prison officers, though Marzano, Adler and Ciclitira's (2015) sample of 30 correctional staff included 15 healthcare staff. Short et al. (2009) and Marzano, Adler and Ciclitira (2015) were qualitative studies using interviews and thematic analysis. Pannell, Howells and Day (2003)* and Ireland and Quinn (2007) used questionnaires.

The quality of Marzano, Adler and Ciclitira's (2015) article and Short et al. (2009) was good. Ireland and Quinn (2007) exceeded the threshold at 280, though it scored 'very poor' in ethics. Pannell, Howells and Day (2003)* scored 250 in the quality assessment, due to not considering ethics and some concerns regarding sampling; it will be flagged with an asterisk.

Knowledge of staff members:

None of the papers discussed participants' knowledge base, although Pannell, Howells and Day (2003)* mentioned that staff only linked self-harm with suicide if it was severe.

Training and Education:

Marzano, Adler and Ciclitira (2015) reported that more than 50% of medical staff were not trained to deal with psychological or mental health issues. Other than that, the training and education of participants was not discussed by the studies.

Characteristics of professionals

Ireland and Quinn (2007) found that female prison staff were more understanding of the reasons for self-harm; male prison staff were more likely to endorse 'negative myths' (see recommendations section). Marzano, Adler and Ciclitira (2015) acknowledged a connection between negative reactions to self-harm and environments where staff are stretched, under-resourced, inadequately trained and yet accountable for prisoners' behaviour. Pannell, Howells and Day's (2003)* study asked participants to read one of four vignettes, in which the severity and repetitiveness of self-harm was varied, before completing a questionnaire. Varying the severity and repetition of self-harm in the vignettes did not affect the perceived cause of self-harm, except when self-harm was perceived as suicidal. Vignettes with self-harm that was low-severity and with low-repetition was more likely to be perceived as a product of prison distress. Short, et al., 2009 did not discuss any professional characteristics.

Attitudes

Self-harm was commonly attributed to prisoners wanting to gain something or seek attention and often used to manipulate officers (Marzano, Adler and Ciclitira, 2015; Pannell, Howells and Day, 2003*; Short et al., 2009). These attributions sometimes led to staff making clear delineations of 'genuine' (overt/in control) and 'non-genuine' (secretive/not in control) self-harm by some officers (Short et al., 2009).

Officers were more likely to ascribe the cause of self-harm to mental illness when prisoners self-harmed repeatedly or at serious levels (Pannell, Howels and Day, 2003*; Marzano, Adler and Ciclitira, 2015; Short et al., 2009). The prison environment and related stresses were not generally considered as contributing to self-harm. (Pannell, Howells and Day, 2003*; Short et al., 2009). However, some officers were able to identify that self-harm was a cry for help or a release of emotion (Pannell, Howells and Day's, 2003*).

Marzano, Adler and Ciclitira (2015) reported that prison officers minimised the emotional impact of supporting prisoners who self-harmed, often maintaining they were neither professionally nor personally affected whilst, for example, reporting they experienced

flashbacks. There was a tendency to cope by switching off and ambivalence about caring, in response to the 'role conflict' between custody and welfare (Short et al., 2009).

Attitudes were found to vary as a function of prisoner's behaviour: the response to 'well-behaved' prisoner was more favourable than to 'disruptive' prisoners (Ireland and Quinn, 2007); prisoners who repeated self-harm, were more likely to be resented and more likely to induce stress in prison officers about blame. Some officers believed that prisoners who self-harm drained and abused resources (Marzano, Adler and Ciclitira, 2015).

The overall conclusions were that staff's responses contravened policies and guidelines which emphasise supportive conversations, proactive care and non-judgemental attitudes. Negative attitudes were linked to resourcing and stress from feeling unguided and unsupported, which potentially led to burnout (Ireland and Quinn, 2007; Marzano, Adler and Ciclitira, 2015; Short et al., 2009). All four studies found evidence for positive and negative attitudes overall, but with significant levels of negative attitudes. Whilst this may appear to echo the pattern of the other papers, the findings in these studies included more extreme negative attitudes. There were examples of officers believing that prisoners self-harmed just to punish them, '*they cut up because they know it causes you paperwork*' (Short et al., 2009: 416), and angry, punitive responses to self-harm, '*if you are going to do it, do it properly*' (Marzano, Adler and Ciclitira, 2015: 249). The frequency and severity of self-harm was emphasised in some of the studies, which sometimes led officers to '*deal with their struggle of caring for prisoners by not caring for them*' (Marzano, Adler and Ciclitira, 2015: 243).

Recommendations:

Ireland and Quinn (2007) recommended training to dissolve the 'myths' that staff believe about self-harm which negatively affected attitudes; the 'myths' listed were that self-harm was something to be ashamed of, ascribing self-harm to attention-seeking or manipulative ends or that self-harm is caused by '*a lack of ability to express negative feelings in other ways*' (p.68). They recommended training which would increase empathy and foster positive attitudes towards self-harm, particularly for male officers. Recommendations were made for training which enhances an understanding of the impact of environment on self-harm and

encourages recognition of the individuality of prisoners (Pannell, Howells and Day, 2003*; Short et al., 2009).

Better support for staff through supervision, support networks and managerial support was highlighted to prevent burnout, pointing out that a policy that requires good staff-prisoner relationships, care and teamwork, must pay more attention to the needs of the staff (Marzano, Adler and Ciclitira, 2015; Short et al., 2009).

3.3.4 Mental Health services

Introduction

Six articles from five studies were found researching professional attitudes to self-harm within the mental health services (Crawford et al., 2003; Dickinson and Hurley, 2012; Gough and Hawkins, 2000; Huband and Tantam, 2000; Sandy and Shaw, 2012; Shaw and Sandy, 2016). Sandy and Shaw (2012) and Shaw and Sandy (2016) are two articles from the same study, the latter having a focus on curricular implications. Henceforth, this study will be referred to as 'Sandy and Shaw, 2012', which represents the article most comprehensively reporting the findings. The second article will be referred to separately when the content differs in a relevant way to this review.

All five studies were UK-based, with three based in a forensic mental health service (Dickinson and Hurley, 2012; Gough and Hawkins, 2000; Sandy and Shaw, 2012). Huband and Tantam (2000) sent a postal questionnaire to county NHS clinical staff and Crawford et al. (2003) involved professionals from ED's, inpatient mental health services and CAMHS services. Participants were clinical staff (Crawford et al., 2003; Gough and Hawkins, 2000; Huband and Tantam, 2000), mental health nurses (Sandy and Shaw, 2012) and registered nurses and nursing aides (Dickinson and Hurley, 2012). Sandy and Shaw (2012) conducted interviews and focus groups; the other four were questionnaire studies.

The quality of most of the articles scored well. Gough and Hawkins (2000)* produced the lowest overall score (210) for quality, due to scoring 'fair' against every criterion, except for ethics and usefulness, which were graded 'poor'. Huband and Tantam (2000)* scored just

under the 75% threshold, with 260. It did not mention ethics, and only scored 'fair' for its briefer than usual introduction and lesser perceived usefulness of findings. They will both be referenced with asterisks.

Knowledge of staff members:

Crawford et al. (2003) found the mean percentage of correctly answered knowledge questions was 60%. There were some significant knowledge gaps: staff did not know that male homosexuality or a history of sexual abuse increased the risk of self-harm; a third of staff were not aware of the increased risk of suicide. Sandy and Shaw (2012) noted that many participants admitted a knowledge deficit and expressed that they needed more knowledge and skills to effectively work with service users who self-harmed. Gough and Hawkins (2000)* noted that staff had worked on average with 15 patients who self-harm.

Training and Education:

The majority of participants said they wanted or needed more training about self-harm (Crawford et al., 2003; Gough and Hawkins, 2000*; Sandy and Shaw, 2012); 88% of participants expressed this in Gough and Hawkins' (2000)* study. Shaw and Sandy (2016) mention that some of the participants refused to undertake training, stating they knew how to care for people who self-harm. Dickinson and Hurley (2012) reported that 35% had undertaken some education in self-harm. Gough and Hawkins (2000)* reported the participants' average training in self-harm was one day, with some receiving none. Huband and Tantam (2000)* did not discuss levels of training received for their participants.

Characteristics of professionals

No significant correlations with gender were found (Huband and Tantam, 2000*; Crawford et al., 2003). The impact of age and experience was once again contradictory across the studies. Huband and Tantam (2000)* found that older staff were more understanding about self-harm, whilst more professionally experienced staff demonstrated more antipathy and

defensive attitudes (Dickinson and Hurley, 2012; Huband and Tantam, 2000*). Conversely, Gough and Hawkins (2000)* found a positive correlation between experience of working with people who self-harm and perceived understanding. Crawford et al. (2003) found that experience had no impact on attitudes but that those with more knowledge tended to be more worried.

Education and training were found to reduce antipathy and increase understanding (Dickinson and Hurley, 2012; Gough and Hawkins, 2000*), although Dickinson and Hurley only found this impactful amongst the registered nurses (RN), not mental health RNs. Huband and Tantam (2000)* found that specific training in self-harm was not found to affect attitudes positively, though counselling / psychotherapy training was: it tended to reduce participants' sense that the patient had conscious control over their self-harm, reducing defensive anxiety which leads to staff placing the locus of control in the patient. Sandy and Shaw (2012) do not discuss any correlating factors in their study.

Attitudes

Attributions included labelling tendencies, such as 'PD's' (personality disorder's), 'attention-seekers' and 'manipulators' (Dickinson and Hurley, 2012; Gough and Hawkins, 2000*; Sandy and Shaw, 2012); repeated self-harm led to more negative attributions. Gough and Hawkins (2000)* reported that some staff felt that people who self-harm should '*reap the consequences*' (p.24). However, most participants felt labels indicated misunderstanding (Sandy and Shaw, 2012) and there was high recognition of self-harm having an underlying cause, that it can be felt to be an effective coping strategy and a way to communicate distress (Gough and Hawkins, 2000*).

Crawford et al. (2003) reported that 98% disagreed that self-harm wastes NHS time; Gough and Hawkins (2000)* conversely found a number of staff held the belief that self-harm wastes staff time and valuable resources. Care futility was very high, with most participants believing some users would continue to self-harm irrespective of interventions (Dickinson and Hurley, 2012; Gough and Hawkins, 2000*). The overriding perception was that any '*effort expended on the care of the individual….is not going to produce any benefit for the client*' (Dickinson and Hurley, 2012: 153). Crawford et al. (2003) reported that 20% agreed

they were worried they would get the blame for self-harm. Dickinson and Hurley (2012) reported very high levels of self-harm in the forensic unit they were researching, which was felt to contribute to stress and burnout, leading to higher antipathy.

Most of the focus of discussion was upon negative attitudes in the studies, but Sandy and Shaw (2012) reported and themed the positive attitudes they found as: acceptance, readiness and engagement; optimism; partnership working; choice of activities and an expressed need for training. Overall it was found that the majority of participants held empathetic attitudes, although they found patients difficult to manage and build relationship with (Crawford et al., 2003; Gough and Hawkins, 2000*; Huband and Tantam, 2000*).

Recommendations:

All the studies recommended training on some level, with varying levels of detail. Shaw and Sandy (2016) recommend that education should bridge the intention-behaviour gap, using activations, role play, case study analysis and practical simulation, promoting training that addressed beliefs, emotions and behaviour. Targeting training towards the groups who have shown the highest antipathy was recommended, whether RN's registered more than 20 years ago, in Dickinson and Hurley's (2012) study, or non-psychiatric nurses from Crawford et al.'s (2003) study.

Clinical supervision or support networks to reduce professionals' experience of being overwhelmed and help them prepare for stressful situations were recommended, to increase confidence and skill (Crawford et al., 2003; Sandy and Shaw, 2012). Crawford et al (2003) recommends improved links between paediatric and psychiatric services and the establishing of multidisciplinary self-harm teams, both for service delivery and to provide training and support for other professionals. Better guidelines and parameters for managing self-harm were advocated for (Dickinson and Hurley, 2012; Gough and Hawkins, 2000*); 83% of participants in Gough and Hawkins' (2000)* study agreed that this was necessary to '*facilitate a consistent, non-judgemental approach to self-harm*' (p.28).

4. Discussion

4.1 Introduction

Self-harm, whether presented by someone with or without a learning disability, is concerning, both as an immediate sign that the individual is distressed and needs support and because self-harm is known to be a risk marker for further mental health problems (Borschmann and Kinner, 2019), as well as increasing the risk of a person completing suicide (O'Connor, et al., 2018; Geulayov et al., 2016). With the rapid increase in levels of self-harm in the UK (McManus et al., 2019), it has never been more apposite that the response and approach to self-harm is as good as it can be. Guidance about the importance of caring, compassionate responses to self-harm is unequivocal, with NICE (2013) clearly correlating punitive and judgemental staff attitudes with further self-harm. Even so, the evidence is that these guidelines are not being followed consistently (Heyward-Chaplin et al., 2018; Rayner et al., 2019; Saunders et al., 2012).

The small number of papers in Group A in comparison to Group B, indicates the paucity of research examining attitudes of staff supporting people with learning disabilities; it is partly impacted by a tendency in the literature to discuss self-harm in amongst wider concerns around challenging behaviour or sterotypy (Chezan et al., 2017; MinShawi et al., 2014); indeed, several studies were excluded on these grounds (Bailey et al., 2006; Male, 2003; Wilderjans et al., 2014). This has been highlighted as a disadvantage when wanting to consider people with learning disabilities who self-harm without conflating it with other concerns (Chezan et al., 2017; Minshawi et al., 2014). However, even accounting for the studies excluded on these grounds, there was simply less research available that meets the criteria for Group A.

4.2 Discussing the findings across the five themes

There were some critical differences between the two groups of studies, which will be examined through the five themes.

4.2.1 Knowledge

Staff knowledge was discussed in most Group B studies; some studies measured specific areas of knowledge, such as the link between suicide and self-harm (Crawford et al., 2003;

Pannells, Howells and Day, 2003*) or mental health problems and self-harm (Saunders et al., 2012), finding in both cases that staff generally underestimated the links. Overall, knowledge of self-harm was found to be generally poor (Saunders et al., 2012; Sandy and Shaw, 2012), as was knowledge of national guidelines (Heyward-Chaplin et al., 2018). Across all settings, increasing staff knowledge was largely found to improve attitudes, with most staff stating that they wanted more knowledge about self-harm (Bhola and Ravishankar, 2017; McHale and Felton, 2010; Saunders et al., 2012; Sandy and Shaw, 2012).

It is notable that this is not addressed in the Group A's studies. This may reflect that 'knowledge' about self-harm when presented by people with learning disabilities is still a matter of debate and discussion, with the biological, behavioural and psychological schools of thought at some variance with each other, or at least being a complex picture to draw together (Minishawi et al., 2014; Symons, Devine and Oliver, 2012). This a key difference in the literature for Group A and B: whilst research about self-harm might conclude that it is complex and multivarious, there is broad agreement about causation and response, unlike in the learning disability literature, where this is still much debate and uncertainty[8].

4.2.2 Training and education

Across most settings in Group B the majority of staff had not received training in self-harm. Education sector staff had the lowest levels of training, with up to 80% untrained (Berger, Hasking and Reupert, 2014). Healthcare staff were more likely to be trained, but levels still tended to fall under 50%. Staff across the studies reported that they wanted training, and there was a well-established efficacy for direct training improving knowledge, confidence and empathy (Karman, et al., 2015; McHale and Felton, 2010; Rees, Rapport and Snooks, 2015).

In Group A papers, only Fish (2000) mentioned training, stating that none of the staff had received any. Training about self-harm in this sector is not straight-forward, due to the tendency to categorise self-harm with 'challenging behaviour' (Chezan et al., 2017; Emerson, 1995; Wilderjans er al., 2014); this tends to stretch to training packages, which often train approaches to self-harm in amongst approaches to other 'challenging

[8] The empirical evidence… clearly indicate the need for models of self-injury that can account for all established observations of influential psychological, environmental and biological variables… we do not have a broad enough empirical base regarding implementation and adherence regarding the successful 'uptake' of effective interventions (Symons, Devine and Oliver, 2012: 423).

behaviours' (Gore and Umizawa, 2011; McDonald and McGill, 2013; West and Kaniok, 2009).

4.2.3 Characteristics of professionals

Group B studies explored whether gender affected attitudes or responses with inconclusive evidence overall. Age and experience were explored in most settings, with mixed results. Length of experience in a role arguably allows staff to accumulate understanding and perspective which might have a positive effect on attitude (Hastings et al., 2003; Cleaver et al., 2014), and it was sometimes found to positively impact understanding and lower antipathy (Berger, Hasking and Reupert, 2014; Conlon and O'Tuathail, 2012; Hodgson, 2016). However, experience in a setting which is high-pressure and unsupported could arguably reduce empathy and increase judgemental attitudes, and thus it was also found that professional experience and increased exposure to self-harm increased antipathy and defensive attitudes (Dickinson and Hurley, 2012; Koning, McNaught and Tuffin, 2018*; Rayner et al., 2019). The mixed results suggest that the setting is the influencing factor (Allen et al., 2013), and indeed, in both prison and healthcare settings, staff who were overstretched or unsupported tended to be more negative (Gibb, Beutrais and Surgenor, 2010; Marzano, Adler and Ciclitira, 2015). Snow, Langdon and Reynolds (2007) was the only paper in Group A to discuss characteristics of professionals, reporting that high burnout (which was associated with supporting a high number of clients who had self-harmed) led to higher unstable (and arguably more negative) attributions.

4.2.4 Attitudes

Attributions and attitudes of staff members had similarities across the studies in Groups A and B. 'Positive' attributions were largely considered responses that demonstrated that the staff member could see past how self-harm made them feel and be able to imagine the difficulties that the person might be experiencing (Huband and Tantam 2000*). Most staff were able to do this at least some of the time, reflecting that self-harm was emotionally meaningful or a form of emotional regulation (Berger, Hasking and Reupert, 2014; Crawford et al., 2003), an expression of distress (Conlon and O'Tuathail, 2012; Dick et al., 2011, Freidman et al., 2006*) or an attempt to cope with a variety of things or escape from something (James and Warner, 2005*; Pannell, Howells and Day, 2003*). 'Negative' attributions were associated with staff demonstrating that they thought about self-harm in

terms of the impact it had upon them, labelling it 'to get attention' or 'manipulative' (e.g. Bhola and Ravishankar, 2017; Marzano, Adler and Ciclitira, 2015; Sandy and Shaw, 2012; Dickinson and Hurley, 2012). There was a minority of staff that talked about judging whether self-harm was 'genuine' (implying self-harm was primarily an expression of distress) or 'not-genuine' (implying self-harm was primarily an attempt to get something, take control or manipulate) (Short et al., 2009; Hodgson, 2016; Saunders et al., 2012); this attitude was reported in all sectors except education. However, the education studies explored whether staff found self-harm horrifying, shocking or scary, finding a significant minority of staff did (Heath, Toste and Beettam, 2006; Bhola and Ravishankar, 2017).

A minority of staff felt that people who self-harmed 'wasted time' (Karman et al., 2015; Gough and Hawkins, 2000*), with education studies not asking this question directly, but reporting that some staff were '*too busy to help*' (Bhola and Ravishankar, 2017: 124). Care futility – which in its extreme form was staff feeling that nothing they did helped or made a difference – was found in all sectors except education (Conlon and O'Tuathail, 2012; Dickinson and Hurley, 2012; Marzano, Adler and Ciclitira, 2015).

A huge array of staff emotional responses were reported, with the implication being not just that there were different responses from different participants, but also possibly mixed emotions within participants (Huband and Tantam, 2000*; Dick et al., 2011; Koning, McNaught and Tuffin, 2018*). Anger, frustration and hopelessness sat alongside sympathy, concern and a profound desire to help (Berger, Hasking and Reupert, 2014; Crawford et al., 2003; Short et al., 2009). The overall picture was one of ambivalence and staff struggling to bear the weight of responsibility for caring for those who self-harmed, particularly those who self-harmed severely and/or repeatedly (Karman et al., 2015; Marzano, Adler and Ciclitira, 2015; McHale and Felton, 2010).

The studies in group A reported similar findings, though from a different stance. There was a greater focus on attributions than attitudes. Staff made some empathetic attributions, showing understanding that self-harm was a response to things such as low self-esteem, coping with internal difficulties, abuse or emotion as well as attributions that were largely about how self-harm affected them - it was to get attention, manipulate or control. (Dick et al., 2011; Fish, 2000). However, there was a much greater emphasis on the relationships between staff and client, with self-harm being viewed as something that occurred within the

context of relationship. This can be understood as rooted in operant learning theories, which argue that self-harm is '*positively or negatively reinforced by sensory, tangible or social stimuli*' (Oliver and Richards, 2015: 1045). This resonates with the NICE (2013) guidelines which state that staff's attitudes and responses can affect if someone self-harms again, which is akin to saying that self-harm is responsive to the context of relationships. This was not really discussed in the studies in Group B.

There was also a focus on whether staff felt that self-harm was a product of a person's learning disability (Dick et al., 2011; James and Warner, 2005*). This was not discussed in Group B, but there was an equivalent attitude. If a person self-harms *because* they have learning disabilities, then a person without learning disabilities might be similarly framed as self-harming *because* they have a mental health illness. These statements effectively place the locus of the self-harm inside the person (Huband and Tantam, 2000*): there is something that is in the person that makes them self-harm, it's how they are or who they are (Fish, 2000). This broader notion, that self-harm was a product of identity one way or another, was also found in some of the prison service studies (Marzano, Adler and Ciclitira, 2015; Pannell, Howells and Day, 2003*).

Overall, the combination of anger and frustration, often expressed through the views that self-harm is attention-seeking and manipulative, alongside sympathy, concern and a desire to help is a familiar cocktail across the studies. Generally, only the weightings vary; some of the weightings towards judgementalism, anger and hopelessness are concerning and usually linked to poor managerial support, poor supervisory practice and poor quality or lack of training (Marzano, Adler and Ciclitira, 2015; Short et al, 2009; Saunders et al., 2012).

4.2.5 Recommendations

Almost all the studies conclude with recommendations for staff training, only varying in specificity. Training which promoted active listening, effective communication, therapeutic alliances and good interpersonal skills was advocated by all sectors in groups A and B (Berger, Hasking and Reupert, 2014; Rayner et al., 2019; Shaw and Sandy, 2016). There was a resonance across the studies that training needs to engage staff in an active way through reflection (Dick et al., 2011; Fish, 2000; Gibb, Beutrais and Surgenor, 2010; Huband and Tantam, 2000*). Such active training, rather than passive information-based training, potentially allows previously overwhelmed staff to challenge internal defence mechanisms

built up against emotionally engaging with patients who self-harm (Obholzer and Roberts, 1994). Building on this idea, it was recommended that training should include case-studies or personal narratives of people who have self-harmed (Bhola and Ravishankar, 2017; Hadfield et al., 2009) or that it was led or co-led by people who self-harm (Dick et al., 2011; Karman et al., 2015).

Supervision, support networks and managerial support was highlighted across all sectors (Fish, 2000; Berger, Hasking and Reupert, 2014; Dickinson and Hurley, 2012; Karman et al., 2015; Marzano, Adler and Ciclitira, 2015). There were some similar alternatives such as peer mentoring in the healthcare sector (Conlon and O'Tuathail, 2012; Perboell et al., 2015) and the use of debrief (Berger, Hasking and Reupert, 2014; Fish, 2000). As has been established for decades now, staff required to routinely be caring, compassionate, emotionally available and resilient in their roles, need a reciprocating approach from managerial and supervisory staff (Kahn, 1993; Lyth, 1998; Obholzer and Roberts, 1994): the positive impact on resilience of good supervisory practice is well-evidenced, whilst this practice is still often lacking (Karman et al., 2015; Wheatley, 2009) .

Lastly, the studies which examined staff knowledge of national or local guidelines tended to find it was very poor, or even that staff did not know about them (Heyward-Chaplin et al., 2018; Saunders et al., 2012). The evidence in the papers was that the NICE (2013) guidelines are being contravened at all levels: training and support was not provided adequately to frontline staff, there was inadequate joined up care between multi-disciplinary teams (Crawford et al., 2003; Hodgson, 2016; McHale and Felton, 2010) and evidence of continued poor attitudes (even if only in the minority of occasions) towards those who present with self-harm.

4.3 Comparing attitudes between professionals supporting people with and without learning disabilities who self-harm

The second interest of this study was to examine if the attitudes of professionals supporting people with and without learning disabilities who self-harm would differ. The historic separation in research and theory was outlined in the introduction, including the biological

and behavioural theories of causation, which dominate learning disability literature. Group A studies might be expected to differ in ways which reflects these theories.

There was some evidence that professionals supporting people with learning disabilities situated self-harm *within* the person: the belief that self-harm occurred because or in relation to the presentation of learning disabilities (Dick et al., 2011; Snow, Langdon and Reynolds, 2007); this mirrors the biological theory. To some extent, these themes were sought out in a way that Group B studies did not even consider. Dick et al. (2011) found a high level of agreement to the question: '*people with learning disabilities self-harm because it makes them feel 'high' afterwards*' (p. 237). Similarly, James and Warner (2005)* asked participants to rate the statement: '*Women with learning disabilities who self-harm are displaying stereotyped behaviour*' (p.127). These are not statements found in the Group B studies, as they are both based on theories advocated in the learning disability literature.

There was also some evidence that professionals in Group A situated self-harm in the immediate circumstance: the person self-harmed to gain something in the moment - attention, escape, a change in sensory input or something physical (Snow, Langdon and Reynolds, 2007; Fish, 2000); this mirrors the behavioural theory.

However, these views were far from dominant. There was also evidence that professional attitudes in Group A were compassionate, respectful and dignified: self-harm was attributed to self-preservation, a way to cope with blame, a series of interrelated emotional experiences and not being able to process difficult experiences (Dick et al., 2011; James and Warner, 2005*); this was an unusual level of thoughtfulness in comparison with the majority of studies in Group B.

The theme of relationships was strong in Group A, with the complexity of relationships discussed as a critical element that interacted with service user's self-harm (Dick et al., 2011; Fish, 2000); most staff believed that self-harm was meaningful within the context of relationships. This was in contrast to the 'role conflict' found in the prison services (Short et al., 2007; Marzano, Adler and Ciclitira, 2015) and, to a lesser extent, in the healthcare and mental health services studies (Conlon and O'Tuathail, 2012; Hadfield et al., 2009; McHale and Felton, 2010), in which professionals found themselves torn between remaining in a

professional role and showing care and compassion, which often led to punitive and defensive responses (Saunders et al., 2012).

The apparent ease in discussing relationships between professionals and service users in the Group A studies, allowed for a reframing of the attributions that were viewed negatively in Group B studies. For instance, James and Warner (2005)* identified the theme '*coping with the here and now*', within which was situated that some staff felt self-harm was an attempt to influence ward staff (p. 124); this may well have been themed under 'attention-seeking' or 'manipulation' by other studies, whereas James and Warner (2005)* conclude instead that it suggests '*the focus, therefore, is on external relationships*' (p.124). Dick et al. (2011) similarly reframe the factors which suggest self-harm could be viewed as manipulative, naming it '*self-harm within the context of relationships*' (p. 238). Evidence that staff felt self-harm was manipulative or attention seeking was largely considered to be a sign of negative attitudes within Group B studies, but Group A saw it as evidence that people were reaching out relationally. This is a radically different reading of potentially similar findings.

Likewise, Dick et al. (2011) found strong agreement for the statement '*people with learning disabilities self-harm because they are copying other people*' (p.238). This was a theme that was discussed in Short et al.'s (2009) prison service study and described as the 'copy-cat' effect (p.414); it was discussed by the staff and the study as an example of manipulative behaviour. However, Dick et al (2011) proposes that this '*can be understood as an attempt to identify with others and thus build relationships*' (p.238).

These examples suggest that the studies in Group A have an underlying assumption that they are in a relational setting and doing relational work. Interestingly, the relational view of Group A studies aligns better with the NICE (2013) guidelines, which state that '*punitive or judgemental staff attitudes…may lead to further self-harm*' (p.10); this implies that the relationship between professionals and those they care for has a direct impact on behaviour. It seems that the learning disability settings are innately more comfortable with this notion.

However, James and Warner (2005)* and Dick et al. (2011)'s studies are consciously responding *to* the biological and behavioural dominant theories, drawing on evidence that counters them and realigns views of self-harm as being a response to emotional distress. In

this sense, comparison of the two groups is inherently problematic, because all the research takes as its starting point current research and theory (which is largely separate and different) and builds on it; thus the starting and end points of the two groups of studies are quite different.

4.4 Strengths and Limitations of the study

This study has a number of strengths and limitations. Firstly, the unequal number of studies was disappointing: four studies in Group A and 27 studies in Group B does not lend itself to balanced comparison. However, the variety of professional settings, locations and methods does mean data was extracted and synthesised from a good range of perspectives.

Secondly, the studies in this review are dominated by survey data, which can be problematic to compare, as phraseology varies considerably. To illustrate this, attributing self-harm to 'attention-seeking' was agreed with generally by a small minority of staff (Conlon and O'Tuathail, 2012; Hadfield et al., 2009; Heyward Chaplin et al., 2018; Karman et al., 2015;). However, when Beautraies and Surgenor (2010) phrase the question '*patients use self-harm as a way to get sympathy and/or attention*' (p.716), 51% of staff agreed or strongly agreed. This much softer phrasing of largely the same idea may have affected the results. Additionally, the predominance of survey studies means the majority of reported professional attitudes are based on self-reported data, which do not necessarily reflect actual perceptions and attitudes of professionals (Rees, Rapport and Snooks, 2015); however, including studies from a variety of methodologies helps mitigate this.

More could have been done to include studies involving professionals supporting people with learning disabilities who self-harm, e.g. including studies prior to 2000, non-peer reviewed studies, or studies that included staff attitudes towards challenging behaviour. However, it was felt that these decisions would have diluted the quality and relevancy of the findings overall.

This study was completed by one reviewer, due to time and logistical constraints; the involvement of a second reviewer at some or all of the stages would have reduced the likelihood of errors (Boland, Cherry and Dickson, 2017).

One of the strengths of this review is the timeframe, as it parallels the timing of the NICE guidelines, which have been in place since 2000 and highlights the urgent need for progress to be made in meeting the recommendations. It also offers an overview of professional attitudes towards self-harm from a multi-disciplinary perspective. The comparison between professionals supporting people with and without learning disabilities brings the separated theories and research base into a different light, demonstrating how these ideas influence practitioners and the experiences of those who need care for self-harm.

5.Conclusion

This systematic review sought to summarise research into professionals' attitudes towards self-harm. The NICE (2013) guidelines are clear about the expected attitudes of staff and about the expectation that organisations ensure adequate training to this end; this review indicates that services are failing at both levels. Twenty-nine of the thirty-one studies spanning the 19 years since the NICE guidelines were published conclude with recommendations for better training of staff to improve professional attitudes. This systematic review echoes the cacophony, calling for the consistent and on-going training of professionals on self-harm (Muehlenkamp, 2013; NICE, 2013). The findings indicate that training is most efficacious when it is active (Saunders et al., 2012), with space for reflection and group discussion (Huband and Tantum, 2000*), ensuring that professionals have clarity about the multiplicity of causes and experiences of self-harm, as well as understanding of local and national guidelines (Heyward-Chaplin et al., 2018).

Professionals across the studies were often able to recognise their own deficits in knowledge, understanding and compassion. Saunders et al.'s (2012) systematic review quotes a doctor from Anderson, Standen and Noon's (2003:509) study: *'They [self-harm patients] cannot…with our current resources…be looked after in the same way… which is not something I'm proud of saying'* (p.207). Ensuring professionals can consistently respond with compassion, dignity and respect requires adequate training, but it also requires environments which are supportive of the staff themselves. Adequate supervision and supportive environments are critical for facilitating resilience in professionals (Kahn, 1993; Lyth, 1998; NICE, 2019). This, as (Hodgson, 2016) points out, requires adequate resourcing.

The second interest of the study was to examine differences between attitudes of professionals supporting people with and without learning disabilities who self-harm. The differences found related to current theory, with professionals supporting people with learning disabilities more likely to attribute self-harm in line with behavioural and biological theories. However, a relational theme was also found in the Group A studies, which reframed some of the more 'manipulative' attributions of self-harm within the context of the relationships between staff and service users. This was something that the studies in Group B struggled with, instead expressing a sense of 'role-conflict' between care and

control. Further research could explore these differences between the sectors, building on the comparative aspect of this review. For instance, a mixed-method survey study with professionals supporting people with and without learning disabilities who self-harm, would help to further highlight areas of thought and practice worth sharing across the disciplines. This study has suggested that the context and resourcing of the environment professionals work in may influence capacity to demonstrate compassion; future research might explore this crucial relationship further, which could help to illuminate why adherence to guidelines for self-harm remains so difficult to achieve across the sectors.

Appendices

Appendix 1: Signed SPS Student Research Ethics Form

University of BRISTOL

School for Policy Studies

SPS RESEARCH ETHICS
APPLICATION FORM: U/G and TAUGHT POSTGRADUATE STUDENTS

This form must be completed for each piece of research carried out by all undergraduate and taught postgraduate students in the School for Policy Studies.

Doctoral (PhD/DSocSci/DedPsy) students should complete the staff and doctoral students form which is submitted to the School Research Ethics Committee.

Students should discuss their proposed research with their supervisors who will then approve and sign this form before forwarding to the relevant dissertation convenor, unit convenor or programme director. Failure to get approval prior to conducting any fieldwork may result in the University taking action for research misconduct – the outcome of such action may be that your degree is not awarded and/or that you are unable to submit your fieldwork findings for assessment.

Depending on the nature of the research you wish to conduct, it may be necessary for you to get additional approvals and checks. This may involve submitting a full application to an NHS National Research Ethics Service (NRES) or submitting your SPS application for review by the SPS Research Ethics Committee (REC). You should discuss this with your supervisor. It is your responsibility to ensure that you have enough time to obtain these approvals prior to conducting any fieldwork.

This signed form or a copy **must** be submitted as an appendix to your dissertation. If appropriate, a copy of approval from the SPS REC or other REC committee should also be in the appendix to your dissertation.

SECTION ONE: GOVERNANCE

1. NHS Research Ethics approval

Who needs to provide Ethics approval for your project?

The School will only consider those projects which do not require ethical approval from elsewhere. As such, you should make sure that your proposed research does not fall within the jurisdiction of the NRES system e.g. does it involve NHS patients, staff or facilities – see http://www.hra-decisiontools.org.uk/ethics/:

If you are not sure where you should apply please discuss it with your supervisor.

Social care research projects which involve NHS patients, people who use services or people who lack capacity as research participants need to be reviewed by a Social Care Research Ethics Committee (see https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/social-care-research/). Similarly research which accesses unanonymised patient records (without informed consent) must be reviewed by a REC and the National Information Governance Board for Health and Social Care (NIGB).

2. Disclosure and Barring Service check

Do you need a Disclosure and Barring Service check?

The Disclosure and Barring Service (DBS) replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA). Criteria for deciding whether you require a DBS check are available from:
https://www.gov.uk/government/organisations/disclosure-and-barring-service/about

You should specifically look at the frequency, nature, and duration of your contact with potentially vulnerable adults and or children. If your contact is a one-off research interaction, or infrequent contact (for example: 3 contacts over a period of time) you are unlikely to require a check.
If you think you need a DBS check then you should consult the University of Bristol web-page:
http://www.bristol.ac.uk/secretary/legal/dbs/

If 'yes' then please discuss with your supervisor and check the university guidance to determine whether you will need to apply for DBS clearance PRIOR to conducting your research

Do you require such clearance?	**Yes**		**No**	**x**
Have you received clearance?	**Yes**		**No**	

SECTION 2: STUDENT, ADVISOR/SUPERVISOR AND PROJECT DETAILS

3. Student's name:

Beverley Samways

4. Programme:

MSc Social Work Research

5. Year of Study:

2nd of 2

6. Project advisor/supervisor:

Pauline Heslop

7. Date dissertation is to be submitted:

10.09.19

8. Project title:

Professionals' perceptions of people who self-harm. A systematic review comparing perceptions between professionals supporting people with and without learning disabilities who self-harm.

If your research only involves secondary analysis of data, please go to question 10.

SECTION THREE: THE RESEARCH

9. For those intending to carry out primary research:

Who are your participants and how are you contacting them?

a)	Describe your research participants. Who will be in your sample? (e.g. general population, lone parents, mature students etc). Identify if your participants come from a vulnerable group (e.g. homeless, victims of crime etc). How many people do you expect to recruit?

b)	Describe your sampling method i.e. how will you find potential participants? how will you select your participants for inclusion in your study? and how will you contact them? Bear in mind that in some cases it is not appropriate for researchers to contact individual potential participants directly (e.g. service users should be informed of any research by the service and not by the researcher).

c)	Are you advertising for participants or posting a notice for volunteers? If **yes**, attach a copy of the advertisement, notice, email or web post.

d)	Are you using a questionnaire, interview or focus group as part of your procedure? If **yes**, attach a copy of the questionnaire(s), topic guide and/or interview questions.

e)	Will you be asking questions that might disturb your participants emotionally or produce stress and anxiety? If **Yes,** what plans do you have to deal with this? For example, what support can be provided to them? If you intend to give participants a list of support services, please provide a copy with your application.

f)	Do you consider any of your participants to be especially vulnerable and/or especially at risk of harm? If yes, what risks do you anticipate and how are you planning to deal with them? For example, a survivor of abuse may be at further risk from the perpetrator if they take an information sheet away with them. Please note that in most circumstances, professionals who are being asked about their professional role and being offered anonymity would not be considered at risk of harm.

Informed consent and researcher safety:

g)	**Information for participants:** what information will you be giving to participants? (e.g. letter of introduction, outline of project's aims, participant information sheet etc). Please attach copies of any such information to this form.

h)	**Informed consent**: what procedures will you follow to ensure all of your participants give informed consent (i.e. that participants know exactly what they are agreeing to and what you will do with the information they provide)? You should consider whether participants have the capacity to give informed consent, provide enough information so that consent is informed, and provide copies of any consent forms with your application. Participants should be asked to put their initials to show they give consent for the specific points on the form. Where written consent is not possible, you should explain your consent process in detail (e.g. will consent be audio recorded?):

i)	**Confidentiality and anonymity**: how are you going to anonymise the data you collect? How will you keep it confidential?

j)	**Researcher safety**: are there any potential risks to you in undertaking this research and how will you deal with them? Where will the fieldwork take place? Who will you notify with details of where and when you are doing the fieldwork? Will you take your mobile phone with you? Please explain your plan for ensuring your safety and explain who will be notified about where you will be and when you are due to return. Note that you should not conduct research in someone's home if you do not know them and are alone. You may need to have a research safety protocol which should be discussed with your supervisor.

10. For those intending to carry out secondary analysis of data:

Please give a brief description of the data:

(1) What secondary datasets you will use?
(2) Where did you get these data from (e.g. ESRC Data Archive)
(3) How did you obtain permission to use these data? (e.g. by signing an end user licence)
(4) Where will you store the secondary datasets?

The study is a systematic review of existing literature.

The datasets will consist of journal articles and any other grey literature pertinent to the subject under review. These will be gathered from bibliographical databases, namely: **PsycINFO** (Psychiatry, psychology and social sciences); **IBSS** (International Bibliography of the Social Sciences), **CINAHL** (Cumulative Index of Nursing and Allied Health Literature), **Web of knowledge** (Social sciences, arts and humanities) and **MEDLINE** (Medical Literature Analysis and Retrieval System Online)**,** through the Bristol University Library online system, which has permission to access them and has signed an end user licence. Data gathered will not be confidential per se, so will be stored in the researcher's Dropbox account.

SECTION FOUR – DATA MANAGEMENT

11. Where is your survey data stored?

If you intend to use an on-line survey (for example Survey Monkey) you need to ensure that the data will not leave the European Economic Area i.e. be transferred or held on computers in the USA. Online Surveys (formally called Bristol Online Surveys) is fully compliant with UK Data Protection requirements – see https://www.onlinesurveys.ac.uk/

12. How will you manage your data?

How will the data you collect be stored? All identifiable electronic data should be stored on the university password protected server. If this is not possible you should ensure that your home computer or laptop is password protected and secure. Password protect any Word or Excel File on your home computer/laptop that contains personal information e.g. participants names, addresses, etc. To do this (a) select "File" > "Info". (b) Select the "Protect Document" option (icon with a lock). (c) Choose "Encrypt with password". (d) Type the password you wish to use, then select "OK". (e) Type the password again, then select "OK". (f) **Don't forget** the password.

Data should be anonymised as soon as possible and identifying files kept securely away from anonymised data. Unanonymised data should never be stored on a memory stick or digital recorder (obviously it may be necessary on your return journey from an interview). Any physical data such as cassette tape, minidisc, or paper files should be locked away in a secure draw or cabinet. Please tell us where this physical data will be stored and whether you have any concerns about security at this location.

13. Will your data be available to others?

What are your plans for the long-term preservation of the data? Will the data be stored in a way that will enable it to be accessed by other researchers? Will the data be destroyed/deleted at any point? If so, how and when will this be done? For example, reformatting tapes or discs, confidential shredding of paper waste etc).

The School may require you to produce your data. If there is no long term data sharing plan, please confirm that you will not destroy your data until after your degree has been awarded.

SECTION FIVE – OTHER DOCUMENTS

14. What documents are you submitting with this form?

Additional Material - please identify which of the following additional materials you have attached to this application and attach in the order listed? (helpful for reviewing lots at same time!) Please collate the form and attachments into one document before submitting to your supervisor/ unit convener

Additional Material	**Number of Documents**
Participants information sheet (s)	
Consent form (s)	
Confidentiality protocol	
Researcher safety protocol	
Recruitment letters/posters/leaflets	
Photo method information sheet	
Photo method consent form	
Risk assessment form	
Support information for participant	
3rd party confidentiality agreement	
Other information	

SECTION SIX: CONFIRMATIONS AND SIGNATURES

A: Student:

I certify that the statements made in this request are accurate and complete, and if I receive approval for this project from my supervisor/unit convener I will conduct my research as stated.	x
I agree **to inform my advisor/supervisor/unit convener in writing of any emergent problems or proposed procedural changes** and that I will not proceed with the research until any proposed changes have been reviewed and approved.	x
I have attached all of the relevant documentation necessary to carry out this research.	x
I am aware that this form and, if necessary, REC approval from the SPS REC or NHS must be included in an appendix in my dissertation.	x

Signature: …… B Samways …… **Date:** …02/05/19……..

B: Student advisor/supervisor: Please tick the first box and one of the subsequent boxes:

I have reviewed this form.	x
I approve the information in this form and do not think higher level approval is necessary.	x
I have sought advice from the SPS REC, this advice has been headed and approval has been given.	
This form should be examined by the SPS REC.	
This project has been submitted for ethical approval from an NHS REC.	

Signature: **Pauline Heslop**……**Date:** 7/5/19

Print Name: Pauline Heslop……

C: The dissertation convenor, unit convener or programme director, on behalf of SPS REC: Please tick the appropriate box:

Approval is granted to this project	x
This form is being referred to the appropriate SPS/NHS REC.	

Signature: …  …… **Date:** …8/5/2019……..

Print Name: ……Demi Patsios……

Appendix 2: Search Results Table

Search terms for databases and results.

Date	Host / platform	Search conducted	Limit to	Results	Filtered	Total
14.05.19	**Psych-Info**	(self-injury or self-harm or self-mutilation or self-mutilating or self-injurious).ab. and (attitudes or perceptions or opinions or thoughts or feelings or beliefs or reactions or attributions).ti. and (professionals or staff or teachers or support workers or carers).ab.	Yr= "2000-Current" and peer reviewed	62	46	16
14.05.19	**IBSS**	(self-injury or self-harm or self-mutilation or self-mutilating or self-injurious) and (attitudes or perceptions or opinions or thoughts or feelings or beliefs or reactions or attributions)).ti. and (professional or staff or support worker or teacher or carer).ab.	limit 1 to yr="2000 - 2019" + Peer Reviewed Journal	14	14	0
14.05.19	**CINAHL**	(self-injury or self-harm or self-mutilation or self-mutilating or self-injurious).ab. and (attitudes or perceptions or opinions or thoughts or feelings or beliefs or reactions or attributions).ti. and (professionals or staff or teachers or support workers or carers).ab.	Year 2000 - 2019 + peer reviewed	59	56	3
14.05.19	**Web of knowledge**	(ti=(self-injury or self-harm or self-mutilation or self-mutilating or self-injurious) combined and ti=(attitudes or perceptions or opinions or thoughts or feelings or beliefs or reactions or attributions)) combined and ts=(professionals or staff or teachers or support workers or carers)	Timespan 2000-2019	57	55	2
14.05.19	**Medline**	(self-injury or self-harm or self-mutilation or self-mutilating or self-injurious).ab. and (attitudes or perceptions or opinions or thoughts or feelings or beliefs or reactions or attributions).ti. and (professionals or staff or teachers or support workers or carers).ab.	limit 1 to yr="2000-Current"	64	63	1
14.05.19	**Hand searching**	Searching references of all the papers which initially met the criteria		32	24	8
Until 15.07.19	**Alerts data**	Set up for each platform		0	0	0
21.06.19	**Google scholar**	All in title: With all of the words: 'attitudes', With at least one of the words: 'professionals OR or OR staff OR or OR teachers OR or OR support OR workers OR or OR carers', with the exact phrase: "self-harm"		44	44	0
21.06.19	**Google scholar**	allintitle: With all of the words: 'attitudes', With at least one of the words: 'professionals OR or OR staff OR or OR teachers OR or OR support OR workers OR or OR carers', with the exact phrase: "self-injury"		9	8	1
		Total papers		341	310	31

Appendix 3: Data Extraction Table

Some columns (Author & year / location; role of participants & no. of participants) have been amalgamated to allow a 'portrait' view.

Author(s) & year of study Location of study	**Aims**	**Method and analysis**	**Role & no. of parti-cipants / studies**	**Key findings**	**Quality Assess-ment**
Berger, Hasking and Reupert, 2014 Australia	Validate a measure of attitudes towards NSSI, examine know-ledge, attitudes and confi-dence and deter-mine if demogra-phics are related	**Quant / Quals method:** (Attitudes towards Deliberate Self-Harm) ADSHQ Q/aire and self-injury knowledge Q/aire including open-ended questions. **Analysis:** Exploratory Factor Analysis + Thematic Analysis	School staff - 501	Majority of staff underestimate prevalence but correctly identify age of onset and reasons for self-harm (SH). 80.4% of staff never educated re SH. Length of professional experience negatively related to knowledge, but experience of supporting student who SH positively correlated to knowledge, understanding and attitudes. Female staff and mental health staff most confident. Attitudes identified: sympathy and concern; frustration at lack of services / support; willingness to help; lack of knowledge / confidence; feeling frustrated / angry / manipulated. Majority felt empathetic and wanted to help (but lacked education and resources). Attitudes towards SH that considered it attention-seeking and manipulative considerable, but not the majority (19.9%) and correlated to lack of experience and education. Recommends educational programmes which cover: active listening; clarifying questions; asking about intentions to self-injure; persuasion to get help and referral to care. Suggests education could double as group-supervision or debrief, and teach a focus on how to monitor student's emotional and social well-being, and observe reactions of peers and 'potential for contagion'.	340

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Bhola and Ravishankar, 2017 India (urban)	To explore the percep-tions of teachers re student SH	**Quant method:** Cross sectional 62-item survey incl. checklists, Likert scales, etc. **Analysis:** Statistical tests, chi-square and ANOVAs.	Teachers - 162	Prevalence underestimated by 75%. No mention of prior education but suggests none. No gender correlations. Teachers viewed SH as a sign of mental illness and depression (77.4%); associated with substance abuse, abuse and eating disorders; varied associations with suicide. Most common reason for SH to 'get attention' (78%). Incomplete understanding of motivation impacted empathy. Less experienced teachers more confident and less helpful. Recommendations for training to expand understanding of reasons for SH, through sharing research and personal narratives. Highlights the need to avoid rigid assumptions and raises concern re inadequate educational counselling services.	310
Conlon and O'Tuathail, 2012 Ireland	Emer-gency Depar-tment (ED) nurses' attitudes re Self-Harm (SH) (and therefore how patients who SH are treated and if they would seek further help)	**Quant/quals: Self Harm Antipathy Scale (**SHAS) scale, 30-qu. validated, likert-scale questionaire to random sample of 100. **Analysis:** SPSS analysis. Content analysis of comments.	Emergen cy Departm ent (ED) nurses - 87 (87%) (100 included out of a possible sample of 168)	Age and experience were correlated with attitudes: both older and more experienced nurses had less antipathy. Respondents felt that they needed training; that ED was often an unsuitable environment; there was evidence of both empathy and judgement amongst respondents. Respondents tended to focus on physical needs over psychological when supporting patients. 83% had nursed a patient with SH in last year; 68% had received SH education. Education lowered antipathy. Age and experience positively correlated with attitudes. Overall slightly positive attitudes identified. However, this includes high level of agreement that SH is morally wrong and manipulative ('not genuine'). Evidence that education helps increase empathy. Patient behaviour affected attitudes. A strong mix of very positive and negative responses. Recommends clinical supervision, retention of older, experienced staff and training that covers effective communication and assertiveness.	310

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Crawford et al, 2003 UK	Investiga ting knowled ge levels, attitudes and training needs amongst a variety of profess-sioinals	Questionnair e (Q/aire)	a variety of profess-sionals involved in the assessme nt and manage ment of children and adolesce nts who self-harm - 126	Mean percentage: 60% knowledge questions correctly answered. Some significant knowledge gaps, particularly male homosexuality and history of sexual abuse increasing risk of SH, and that those who SH are of increased risk of suicide. 42% of participants wanted further training. Gender was not found to correlate with knowledge or attitude. Experience rather than age was examined as a predictor - no relationships found. Participants felt they were reasonably effective in managing SH. There were generally low scores for negativity, e.g. 98% disagreed or strongly disagreed that SH wastes NHS time. 20% agreed they were worried they would get the blame for what would happen to children who SH. Those with more knowledge tended to be more worried. No significant relationships between knowledge and negativity. Participants who felt more effective felt less negative. Many noted they had had very little or no training. Training recommendations vary for group: non-psych nurses should have training focused on improving knowledge (they were the least worried). Psychiatrists were the most anxious and support and supervision recommended. Overall, systematic training for all, with support networks, regular supervision and improved links between paediatric and psychiatric services. Recommends the establishing of multidisciplinary self-harm teams, both for service delivery and to provide training and support for other professionals.	300

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Dickinson and Hurley, 2012 UK	Comparison of relevant attitudinal dimensions of RN's and aides within a secure unit towards y/p who SH. (Also compares results with Patterson et al 2007 study	**Quant/quals:** SHAS scale (validated) 30-question, Likert-scale questionaire **Analysis:** SPSS analysis. Content analysis of comment section.	47 Registered Nurses + 22 Nursing aides - 69 (out of 150 - 46%)	35% trained in SH. All participants working in secure units with extreme examples of SH, which reportedly increases staff stress and burnout. Education reduced antipathy; length of service significantly increased antipathy. Antipathy was comparatively higher than general nursing, with very high levels of care-futility, and low acceptance and understanding. Non mental health nurses had higher antipathy. No difference between registered and non-registered. Female staff more empathetic. Recommendations for training to cover 'core skills' and clearer parameters for how to care for SH.	330
Friedman et al, 2006 UK	ED staff attitudes to SH (self-laceration)	Q/aire (Likert-scale) developed from focus group. **Analysis:** MS Excel and StatsDirect	Emergency Department (ED) staff - 63 (53.8%)	Staff over-estimated numbers of patients presenting with SH. Minority viewed SH as a suicide-risk. 6% had received education; 92% wanted it. More experienced staff felt more angry, inadequate and less likely to see patients as mentally ill. SH seen as serious, associated with distress but also 'seeking attention' and by implication manipulation. Concerns re unsupported staff risking burnout, and concerns about beliefs re SH and suicide and mental health needs. Recommends urgent training and more support for staff.	200* (lowest score)

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Gibb, Beutrais and Surgenor, 2010 UK	Examine: attitudes towards SH; if attitudes vary as a function of character-istics; identify specific difficulties and training needs.	Q/aire re attitudes. (18 qu. re attitudes to SH + Maslach Burnout Inventory + job and characteristics. **Analysis** using exploratory factor analysis	Healthcare staff from general and psychiatric hospital (Dr's and nurses) - 195 (64.4%)	No correlation between age / experience and attitude. However, relationship between burnout and negative attitudes was found. Mixture of positive and negative attitudes - SH difficult to work with, but good empathy and staff felt they were helpful. Staff felt moderately confident they could help, not particularly frustrated and were hopeful. But not confident in their work and believed they were inadequately trained (this included psychiatric staff). Recommends training for all staff, but no details given. Also 90.6% staff felt it 'would be helpful to have someone to talk to about self-harm patients'.	310
Gough and Hawkins, 2000 UK	Staff attitudes to SH in forensic service	Own Q/aire with likert scales and open-ended questions was developed, piloted and then used. **Analysis:** Cluster analysis of quants data. Thematic analysis of quals data.	Clinical staff in a medium secure unit - 77(49.4%)	Average training was 1 day (some had none). Positive correlations between training and experience of supporting SH with perceived understanding. Results very variable - with a number of staff holding negative/punitive attitudes to SH and its management (no demographic links); underlying factors cited were consistent with evidence; division over whether SH should be facilitated or prevented. Recommends: training in understanding, guidelines to facilitate a consistent, non-judgemental approach. 88% felt they needed training.	210*
Hadfield et al, 2009 UK	To investigate ED Dr's treat-ment decisions re SH, with a view to decreas-ing suicide risks.	Quals interviews +IPA. **Analysis:** thematic analysis	Doctors - 5	Both facilitative and unhelpful attitudes found. Trivialising SH helped Dr's distance themselves from feeling helpless and that their professional image was threatened. Three themes: treating the body (feeling helpless to address the emotions, with urgency to stop the person; feeling hopeless and unsupported by psychiatry; reason for SH influenced response of Dr; anger at manipulation); silencing the self (desire to 'cure' is thwarted by SH; avoiding talking to the patient for own 'sanity'; reflecting on experiences of SH empowers Dr); mirroring social and cultural responses (medical culture: autonomy and following protocol protects against empathy). Dr's want to be helpful but feel restricted. Recommends reflective training to promote critical reflection and collaboration; also more support for Dr's.	350

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Heath, Toste and Beettam, 2006 Canada	Investiga ting know-ledge levels of SH, attitudes and how know-ledge and attitudes differ re character -istics	Own survey re attitudes conducted in a 15 min phone call, (Likert scale and open-ended qu.) **Analysis:** evaluated with principle components analysis	Teachers - 50	Overall, attitudes more positive than expected. Some good explanations of the reasons for SH, although also some ideas about 'peer pressure'. 22% 'just trying to get attention'; 12% 'often manipulative' 48% 'horrifying'; 34% symptom of mental disorder. Similar amounts of empathetic / non-empathetic responses. Age and experience correlated to perceived knowledge, but not attitudes. Attitudes did not vary in relation to any demographic, including personal encounter. Lower levels of judgement correlted to lower non-empathetic responses. Recommended training re prevalence and perceived knowledge, but no specific suggestions made.	270
Heath et al, 2011 Canada	Teachers' percep-tions SH: confi-dence, know-ledge, informa-tion and attitude;	Teachers' Knowledge and Beliefs Survey re SI: as above. 21 item measure + open ended questions. **Analysis**: Evaluated with Cronbach's alpha scores	Teachers - 155 (60%)	Knowledge all slightly higher than 2006 paper. Correlations also identical to above paper. Attitudes: 30% 'just trying to get attention' (57% disagreeing); 18% 'often manipulative'; 60% 'horrifying'; 46% symptom of mental disorder. Most teachers willing to be approached re SH, but not confident or knowledgeable. More experience increased likelihood of seeing SH as manipulative. Male teachers more likely to see SH as attention-seeking and manipulative. Recommends: targeting staff members for training who are already engaged with students who SH.	250*
Heyward-Chaplin et al, 2018 UK	Audit of health-care profe-ssionals attitudes to SH in a burns unit, to deter-mine attitudes and also whether treat-ment met national guide-lines.	Audit q/aire developed for study including likert scales; **Analysis:** descriptive analysis and SPSS.	Healthca re professio nals in burns unit - 59	12% only aware of national guidance. 34% trained in SH. More experience correlated with more confidence. Generally non-judgemental and compassionate attitudes; but significant minority struggling to be compassionate, not feeling confident or judging patients who SH differently. 9% agreed it was to gain attention, 14% that treatment should be different, and <25% that it was difficult to understand. Also evidence that patients may be offered more conservative treatment due to SH. Recommends training and continual education regarding the functions of SH, including better dissemination of NICE guidelines.	300

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Hodgson, 2016 UK	Exploring factors affecting nurses' attitudes re SH in order to make recomm-enda-tions for improv-ing practice.	Literature Review	Nurses - 10 Articles	Lack of education identified as key issue in 9/10 papers. Length of experience positively correlated with better attitudes in 4 papers. Attitudes: Personal Values and beliefs (Nurses judged the reason and genuineness of SH, and thus made moral judgements which affected attitudes and response) Context affected attitudes (ED nurses very frustrated); Influence of patient behaviour (manipulative or repeat behaviour challenges positive attitudes). Recommends on-going education and training on SH, addressing knowledge, understanding, attitudes, behaviours, effective risk assessment and management of the patient as well as effective communication and interpersonal skills to develop therapeutic relationships. Supervision and debrief for those dealing with patients who SH. Liaison mental health teams for all ED's, to develop knowledge for all nurses and reduce repeat presentations.	310
Huband and Tantum, 2000 UK	Mental health staff attitudes re SH: partic-ularly what governs profess-sional attitudes and effect of character-istics on these attitudes	Postal survey with vignette, likert scale + demo-graphic info. **Analysis:** Factor and cluster analysis and ANOVA	Clinical psychiatr ic staff - 213 (55.2%)	No evidence that training in SH affects attitudes. Older staff more likely to understand. Prolonged exposure to SH increases defensive attitudes. Overall, majority favoured an empathetic approach, although found patients difficult to manage and build relationship with. Counselling / psychotherapy increased understanding and reduced sense that patient had conscious control over SH - most likely this training reduces defensive anxiety to place locus of control in patient. No explicit recommendations made, although value of therapeutic training highlighted.	260*

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Ireland and Quinn, 2007 UK	Officer attitude to male SH, assessing if attitudes interact with prisoner beha-viour and officer gender	Attitudes to Prisoners (ATP) Likert scale, followed by Attitudes to Prisoners who SH (APSH) survey (developed for paper), 2 vignettes separately graded against Likert scales. **Analysis:** Factor analysis and ANOVA.	Prison officers - 162 (100%)	Knowledge and education not discussed. Female staff more understanding of SH; male staff more likely to endorse negative myths. General response to 'well-behaved' prisoner were more favourable. More positive ATP influenced APSH. Recommends training in empathy and a fostering of positive attitudes towards SH, particularly for male officers.	270
Karman et al, 2015 Netherlan ds	Nurses' attitudes to SH (what attitudes exist? What factors influence attitudes ? How does educa-tion influence attitudes ?)	Literature Review	Nurses from across the disci-plines - 15 Articles	Overall, good evidence that education in self-harm (SH) improved positive attitudes. Mixed correlations re. age and work experience. Both positive and negative attitudes exist amongst nurses. Reported negative attitudes include irritation, frustration and anger. Mental health nurses had trouble showing empathy, more emotionally cut off and anxious, expressing greater need for support. Negative attitudes prolific, but especially at risk in general healthcare, low-qualified or large hospitals. Recommends education across the spectrum that contains reflective and interactive elements. Lack of resources and time affects quality of care and response. Nurses should receive supervision, a structured and coordinated approach to treating SH and support from colleagues and management, particularly for mental health nurses who have more intensive contact with SH.	320

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Koning, McNaught and Tuffin, 2018 Australia	ED staff beliefs about SH - including a broad range of staff working in a metro, tertiary ED - to expand and clarify the literature	**Quals:** semi-structured interviews. **Analysis:** thematic analysis	Medical and ancillary ED staff - 15	Education increased feelings to competence and understanding of factors leading to SH. Participants felt exposure to SH and education changed their beliefs over time. Concludes attitudes mostly positive, although results don't fully support this. Attitudes reported in 5 major themes: causes are multifactorial (to release stress / cope; ask for help; gain attention; social isolation; escape); SH can change over time; ED should only focus on physical; SH occurs on a spectrum; the system has failed. Participants felt ill-prepared and lacking training, with little faith in the mental health system. Recommends education about 'how best to help this group of patients'.	250*
Marzano, Adler and Ciclitira, 2015 UK	Examin-ing prison staff exper-iences of SH in a male prison; how staff deal with SH and coping methods; impact of dealing with SH profess-sionally and person-ally.	**Quals:** semi-structured interviews. **Analysis:** thematic analysis	Correctio nal staff, including health-care staff - 30	<50% of medical staff not trained to deal with psychological or mental health issues. Themes identified: draining and abusing resources; powerlessness, including being openly threatened with SH to gain what the prisoner wants; repeated self-harm (resenting this, stress about blame, pressure to pathologise); minimising emotional impact (saying it wasn't significant whilst also having flashbacks); switching off - coping or burnout? Findings indicate that low resources exacerbate antipathy. Repeated SH increases negative reactions and powerlessness. Ambivalence re. caring - somehow care for the prisoners whilst remaining unemotional. Despite evidence, officers maintained they were not prof. or personally affected. Conclusions - staff's responses contravene guidelines. But negative attitudes linked to resourcing and not inevitable. Recommends better support for staff highlighting that a policy that requires good staff-prisoner relationships, care and teamwork, must pay more attention to the needs of the staff.	330

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
McHale and Felton, 2010 UK	Critically evaluate evidence re attitudes of health-care prof. re SH – interven-tions which affect attitudes percep-tions of people who SH.	Literature Review	19 Articles	Better knowledge and education correlated to better attitudes. Low levels of SH training found across the studies. Factors affecting attitudes grouped in six themes: lack of education and training negatively affects attitudes; cultural and clinical expectations - to heal and help, not to be therapeutic; control and repetition increases negative attitudes; varying positive attitudes reported and attributed reasons; low levels of training re SH; dissatisfaction with care. Conclusions: service users and nurses dissatisfied with levels of care; training essential, although not entirely solving the problem; basic communication and respect identified by service users as essential. Recommends training alongside good support and supervision for healthcare staff supporting people who SH, also closer links with mental health teams.	320
Pannell, Howells and Day, 2003 Australia	Examin-ing prison officers' beliefs re SH: exploring views re the causes of SH and factorial underpin ning; how the severity and repet-ition affects attitudes	4 Vignettes (2 x 2 factors altering severity and repetitivene ss) - followed by a 17 item likert scale re causes and rating SH on 7 possible functions. **Analysis:** SPSS analysis	Correctio nal staff - 76	SH perceived largely as a product of the prisoners' internal world (psychiatric illness, depression and lack of coping), rather than related to environment (distress and personal vulnerability). SH likely to identified as a cry for help, attempt to get attention, a release of emotion. SH only linked to suicide if severe. Severity and repetition did not apparently influence perceptions, except that low severity/repetition was related to distress. SH only linked to suicide if severe. Training which enhances understanding of the impact of environment on SH is recommended.	250*

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Perboell et al, 2015 Denmark	Attitudes re SH towards hospita-lised patients after acetemin-ophen poison-ing.	Cross sectional study - Danish ADSHQ. **Analysis:** SPSS analysis	ED nurses - 122 (48%)	Overall positive results in relation to nursing attitudes towards patients who presented with acetaminophin poisoning. More experienced staff were more empathetic and confident (age not significant). Women had more positive attitudes than men. Education increased positive attitudes and empathetic approach, but only 19% had received training. Recommends training and also peer coaching to harness more experienced staff's capacity.	340
Rayner et al, 2019 UK	Exam-ining the attitudes of ED nurses towards patients who SH, based on current evidence .	Systematic Review with meta-analysis (following PRISMA)	5 Articles	(Examines papers using SHAS and ADSHQ with ED staff). Overall mixed attitudes but demonstrates the presence of high levels of negative attitudes and antipathy (negative attitudes in AQSHQ and some level of antipathy in SHAS); mental health nurses more positive - more exposure increases positive attitudes; increased training and education impacts positively on attitudes. Nursing attitudes not significantly negative, but could be improved by training, particularly if taking in patients' feedback. Concerns raised about levels of negative attitudes in ED staff, and failure to meet recommendations for training. Gender differences not statistically significant (though females scored higher antipathy). More experienced staff showed more antipathy than less experienced staff, though not statistically significant. Education with respect to SH should be the norm for ED staff. Greater exposure to building therapeutic alliances with patients, promoting non-judgemental care. Educational content to include: knowledge building; functions of SH; response to SH; assessment, management and interventions; practical issues; interpersonal processes and communication skills. Ongoing clinical supervision to explore attitudes and beliefs.	330

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Rees, Rapport and Snooks, 2015 UK	Para-medics and ED staff percep-tions and exper-iences of care for people who SH	Systematic Review of the quantative literature re paramedics	16 Articles	All studies reported a lack of training (75-90% not trained); training significantly improved knowledge, confidence and attitudes. A positive correlation between knowledge and effectiveness/confidence; mixed and unclear correlation between years of experience and positive attitudes. Attitudes towards SH varied with 5 studies reporting positive attitudes. Studies reporting negative attitudes presented a complex picture. Attitudes included that SH was time-wasting, demonstrating low empathy and some frustration. Staff in intense or large hospitals more negative. Policies were under-used or lacking. The impact of religion discussed, but inconclusive. Guidelines clearly state protocols and training shuld be given but is not. No clear recommendations but acknowledgements that attitudes are multi-dimensional and influenced by multiple factors.	340
Sandy and Shaw, 2012 UK	Mental health nurses' attitudes to SH in forensic settings	Multi-method: Quals interviews and focus groups - IPA throughout including analysis	Mental Health nurses - 25 for interview , 36 (6x6) for focus groups	Positive attitude themes: acceptance, readiness and engagement; optimism; partnership working; choice of activities; need for training. Negative attitudes: I don't care; rigid-authoritative approaches; labelling and prejudice; blanket approach; insensitive expressions. Overall negative attitudes were the focus and most-discussed, particularly re repeat SH. labelling of SH as manipulative and attention-seeking indicated a serious misuunderstanding. The need for training emphasised and requested by staff. Recommendations for training, not just in knowledge, but also personal and interpersonal skills to increase confidence. Clinical supervision recommended to reduce overwhelm and help prepare them for stressful situations.	320

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Saunders et al, 2012 UK	Clinical staff's attitudes and knowled ge re SH	**Systematic Review**	73 Articles	Staff knowledge of SH was generally poor across all studies. Positive correlation found between active training and attitudes and confidence in all groups. ED staff less sympathetic than other staff. No clear correlations between age / experience / gender and attitudes. Attitudes of general hospital staff, especially doctors, largely negative, particularly towards repeat SH, particularly irritation and anger. Psychiatric staff more positive. This suggests greater expose influences views. Frustration common in ED settings, often alongside hopelessness. Anxiety and insecurity (about litigation / suicide / over-involvement) less consistently reported. Feelings of sympathy reported in approx. 50% of staff. Hostility reported in some studies, particularly when distinguishing between legitimate / non-legitimate needs. Recommends: - formal training be made available to all clinical staff which addresses knowledge, understanding, attitudes, self-awareness, communication and behaviour. - regular supervision and support for staff who care regularly for patients who SH. - agreed guidelines parallel to national guidance.	290

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Shaw and Sandy, 2016 UK	Mental health nurses' attitudes to SH in forensic	Multi-method: Quals interviews and focus groups - **Analysis:** IPA	Mental Health nurses - 25 for interview, 36 (6x6) for focus groups	Lack of training and education repeatedly highlighted in this article. However, some of the participants refused to undertake training, stating they knew how to care for people who SH. (Same research as Sandy, 2012 - but with an emphasis on curriculum dvlp.) Mixed attitudes towards SH, but mainly negative. Most participants believed some users would continue to SH irrespective of interventions. Indicates a deficit in knowledge, skills and attitudes. Anger and frustration expressed, particularly with repeat SH, and labels applied: 'timewasters', 'attention seekers'. However, most participants felt labels indicated misunderstanding. Rigid and controlling attitudes also identified – effective to minimise SH in short-term, but perpetuating SH in long-term. Blanket approaches and insensitive attitudes were highlighted. Positive attitudes included the need for training; increased understanding of SH; unconditional acceptance; working in partnership; optimism and provision of choice of activites. Concludes: with the right support and prolonged exposure to patients who SH, confidence and skill increases; educational interventions should bridge the intention-behaviour gap, using activations, role play, case study analysis and practical simulation. Holistic training should address all 3 components of attitudes: beliefs, emotions and behaviour.	350 (Highest score)

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Short et al, 2009 UK	Exploring prison staff attitudes to female SH – particu-larly with respect to labelling - to inform future training	Quals interviews. **Analysis:** thematic analysis	Correctio nal staff - 13	Four main themes identified: Understanding why women SH: mostly 'outside' stresses, prison environment not recognised as a factor except by healthcare staff; mental illness cited for 'genuine' SH; Labelling of SH: to gain something physical / attention or time; clear delineations of 'genuine' (overt/in control) and 'non-genuine' (secretive/not in control); SH seen as a learned behaviour to manipulate; implication of labelling: resentment, feeling manipulated, feeling controlled; custody vs care: tension between custody and welfare; a sense of 'role conflict'. Staff often felt personally manipulated and blackmailed by self-harm, and simultaneously blamed by management for it. Most felt unguided and unsupported and therefore under pressure. Recommendations: training which encourages recognition of individuality of prisoners and the potential impact of being in prison; support networks and regular supervision to prevent burnout (which impacts attitudes); support from management; training in confidence building.	280
Dick et al, 2011 UK	To explore communi ty staff beliefs re people with LD who SH, giving greater under-standing to inform training and support packages	**Q-methodolog y.** Semi-structured interviews with 4 to identify opinions, followed by 33 staff doing Q-sorts of the statements, with option to add comments. **Analysis:** PQ Method analysis.	Direct care staff (qualified and unqualifi ed) - 30 Q-sorts complete d	Five viewpoints about SH were identified: SH is individual and an emotionally meaningful act (good evidence that the staff understood the individual and complex meaning for SH, and as a need to cope with and communicate emotions); SH is a communication of distress, whether someone has a LD or not and should not be ignored or punished; SH is difficult to understand but may be a way to modify emotional states; SH is specific to having LD – this suggests that SH is lacking intent or meaning when carried out by someone with a LD; SH is meaningful within the context of relationships. Staff beliefs are generally broadening beyond previously dominant biological and behavioural models, but there are some contradictions and complexities within staff's beliefs. Recommends training that harnesses perspectives of people with LD who SH and promotes skills in psychological formulation.	320

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Fish, 2000 UK	Direct care staff expe riences in forensic LD regardin g SH	Quals: in depth interviews. **Analysis:** thematic analysis using QSR NUR*IST	Staff in forensic LD service - 9	Most staff had received no formal training. Staff experiences reported in four themes: Staff/client relationships - both postive/rewarding and negative/manipulative; effect of SH on staff - blame, self-recrimination, failure and loss of confidence, guilt (blame culture organisationally); organisational issues - managers thinking about risk and blame, direct staff thinking about the person; attributions – SH is part of the client's nature; a response to loss of control; a coping mechanism or an act of rebellion. In summary, staff responses fluctuate between guilt, sympathy and resentment, and often left feeling inadequate. Staff were asked about training and support and suggested group therapy / support or some opportunity to debrief, training which enhances knowledge about SH and causation and better support from management. Staff raised concerns about balancing control and risk, i.e. facilition vs. prevention. Highlights the importance of organised systems of support, support groups, regular supervision and education.	300
James and Warner, 2005 UK	To under-stand how women with LD who SH are under-stood	Q-metho-dology. Semi-structured interviews with 5 to identify opinions, followed by 40 staff doing Q-sorts of the statements, with option to add comment. **Analysis:** Factor analysis.	Carers in a secure unit - 40	Six accounts about SH were identified: coping is a unique experience (reasons for SH are individual and complex); coping with the here and now (women SH to influence ward staff and because it works); coping with powerlessness and abuse (SH is a response to not being able to process difficult experiences; it represents self-preservation against these things and locates SH in the women's internal world); controlling emotional distress – SH as a safety valve to take some control over internal distress; coping with blame – SH as a response to previous experiences and the blame associated with them; coping as an unknowable experience – SH is connected to low self-esteem and a build-up of interrelated emotional experiences. SH was understood adaptive and meaningful, with multiple understandings of how it can be used to cope. 'Formulaic approaches to intervention cannot work' p. 125 Questions the appropriateness of definitions that emphasize physical damage above intent or function.	260*

Author(s) & year of study Location of study	Aims	Method and analysis	Role & no. of parti-cipants / studies	Key findings	Quality Assess-ment
Snow et al, 2007 UK	Care staff attribu-tions regard-ing SIB - with concern re. relation-ship between SH and burnout	Maslach Burnout Inventory, demo-graphic info, read 2 vignettes and then 10 min semi-structure interview. (LACS coding system for interviews) **Analysis:** Spearman rho correlations	Care staff (qualified and unqualifi ed nurses) - 41	The more experienced staff tended to make more internal and unstable attributions. High burnout led to higher unstable attributions. No significant relationship between length of time working with adults who SH and emotional exhaustion, depersonalization or personal accomplishment. But there was with the number of clients supported. Majority attributed SIB to internal and specific factors, with some attributing it to gaining attention. Largely considered internal, uncontrollable, unstable (unpredictable) and specific attributes, e.g. factors originate within the individual and are not in control of the individual - also short-term and transitory, i.e. affect a specific outcome (and by implication, not something they or the environment is contributing to).	270

Appendix 4: Quality Assessment Table for the 31 articles included

Article	Quality Assessment Rating (articles scoring <270 (75%) are marked *)
Berger, Hasking and Reupert, 2014	340
Bhola and Ravishankar, 2017	310
Conlon and O'Tuathail, 2012	310
Crawford et al., 2003	300
Dickinson and Hurley, 2012	330
Friedman et al., 2006	240*
Gibb, Beutrais and Surgenor, 2010	310
Gough and Hawkins, 2000	210*
Hadfield et al., 2009	350
Heath, Toste and Beettam, 2006	270
Heath et al., 2011	250*
Heyward-Chaplin et al., 2018	300
Hodgson, 2016	310
Huband and Tantam, 2000	260*
Ireland and Quinn, 2007	270
Karman et al., 2015	320
Koning, McNaught and Tuffin, 2018	250*
Marzano, Adler and Ciclitira, 2015	330
McHale and Felton, 2010	320
Pannell, Howells and Day, 2003	250*
Perboell et al., 2015	340
Rayner et al., 2019	330
Rees, Rapport and Snooks, 2015	340
Sandy and Shaw, 2012	320
Saunders et al., 2012	290
Shaw and Sandy, 2016	350
Short et al., 2009	280
Dick et al., 2011	320
Fish, 2000	300
James and Warner, 2005	260*
Snow, Langdon and Reynolds, 2007	270

Appendix 5: Quality Assessment Tables for each article

(27 Group B papers in alphabetical order by author, followed by 4 Group A papers in alphabetical order by author)

Author:	Berger, E., Hasking, P. and Reupert, A.				
Title:	"We're Working in the Dark Here": Education Needs of Teachers and School Staff Regarding Student Self-Injury				
Date:	2014				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			Full information but not structured with headings
2) Introduction and Aims	40				Thorough background with mostly recent literature and clearly stated aims
3) Method and data	40				Questionnaire and correlation table included; example quotes from thematic analysis given.
4) Sampling	40				Recruited the required sample for validation; broad scope of professionals. Relevant demographic info shared.
5) Data analysis	40				Good descriptors of quals and quants analysis; methods justified and referenced
6) Ethics and bias		30			Cursory confirmation of ethical approval. Some descriptors of confidentiality and consent. No reflexivity despite qualitative content.
7) Findings / results	40				Findings comprehensive and explicit; data described and explained in a linear, logical manner.
8) Transferability / generalizability	40				Good descriptions of where and how recruitment occurred
9) Implications and usefulness	40				Recommends further research; new contribution offered - counselling comes from teachers with poor knowledge as much as those with good knowledge. Recommends training for policy and practice.
Total					**340**

Author:	Bhola, P. and Ravishankar, A.				
Title:	Perceptions of student self-injury: A survey of school and college teachers in an urban city in India				
Date:	2017				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				
2) Introduction and Aims	40				
3) Method and data		30			Survey developed by researchers but not showed in appendix; piloted but not validated.
4) Sampling		30			Doesn't give the number that 152 teachers were recruited from. Also, no description of what 'purposive sampling' meant in this context. However, some descriptors given.
5) Data analysis		30			Analysis described briefly.
6) Ethics and bias		30			Ethical approval gained though no details. Content described and debriefing and support offered afterwards - a rare detail.
7) Findings / results	40				Thorough and well explained
8) Transferability / generalizability		30			This research was conducted quite broadly across India, so descriptors quite weak, but should have good generalisability
9) Implications and usefulness	40				First research of this nature in India, Good recommendations for policy and further studies
Total					**310**

Author:	Conlon, M. and O'Tuathail, C.				
Title:	Measuring emergency department nurses' attitudes towards deliberate self-harm using the Self-Harm Antipathy Scale				
Date:	2012				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			
2) Introduction and Aims	40				Good aims section. Comprehensive, up to date lit review leading into short intro.
3) Method and data	40				Good use of validated questionnaire. Data shared comprehensively described through tables and texts.
4) Sampling		30			No explanation as to why 100 out of 168 were invited. Response rates and details of participants shared well.
5) Data analysis	40				Comprehensive
6) Ethics and bias			20		Ethical approval sought. Anonymity addressed, but not consent per se, nor emotional impact of receiving a SH questionnaire through the post unexpectedly. Nurse researching her own trust / workplace with no reflexivity.
7) Findings / results	40				Good descriptions and data shared relevant to aims
8) Transferability / generalizability		30			Reasonable descriptors - should allow for generalisability.
9) Implications and usefulness	40				Good reflective analysis of data, advocating specific training, and implication for policy and practice. And recommendations for research
Total					**310**

Author:	Crawford, T, Geraghty, W, Street, K and Simonoff, E.				
Title:	Staff knowledge and attitudes towards deliberate self-harm in adolescents				
Date:	2003				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			Title clear. Abstract thorough but not structured with headings.
2) Introduction and Aims		30			Good, whilst brief introduction, introducing the literature. Clearly structured aims.
3) Method and data	40				Questionnaire explained and the full Questionnaire described and shared in the article.
4) Sampling		30			A wide range of professionals, across 3 boroughs. Well explained. Gatekeeper access explained, but not clear what the sample size was of the total possible participants.
5) Data analysis	40				Very clear presentation and analysis of results, with thoughtful examination of predictors.
6) Ethics and bias				10	Not discussed
7) Findings / results	40				Lots of data given and well described.
8) Transferability / generalizability	40				Goes to some length to describe the setting and suggests transferability to a similar setting
9) Implications and usefulness	40				Very clear recommendations for training, policy and future research.
Total					**300**

Author:	Dickinson, T. and Hurley, M.				
Title:	Exploring the antipathy of nursing staff who work within secure healthcare facilities across the United Kingdom to young people who self-harm.				
Date:	2012				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				
2) Introduction and Aims			20		Intro and literature review quite brief. Stated aim doesn't quite line up with title or abstract and shifts again in discussion section.
3) Method and data		30			SHAS appropriate and well described. But not shared in text or appendix. Good data collection descriptors
4) Sampling	40				Sample size clearly calculated and explained and then met by sample
5) Data analysis	40				
6) Ethics and bias	40				E/A obtained. Good consideration and descriptors of confidentiality and consent.
7) Findings / results	40				Lots of data given and described well in text
8) Transferability / generalizability		30			The % sample 'did not achieve the required accuracy in estimation of mean SHASS' p. 152. However, results well-described and still useful
9) Implications and usefulness	40				V. clear, targeted recommendations for training and policy, and clear outline of gaps in knowledge still.
Total					**320**

Author:	Friedman, T., Newton, C., Coggan, C., Hooley, S., Patel, R., Pickard, M. and Mitchell, A. J.				
Title:	Predictors of A&E staff attitudes to self-harm patients who use self-laceration: Influence of previous training and experience				
Date:	2006				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			The abstract is excellent, but the title is unclear and not quite in line with the paper.
2) Introduction and Aims			20		Intro good, but not thorough, as clear by the claim in Discussion that it is the first research to discuss attitudes re self-laceration (when its just the first to adopt this term). But doesn't land at any clear aims and objectives.
3) Method and data		30			Method is well described but doesn't use any of the available questionnaires to influence developing its own. Opportunity missed.
4) Sampling		30			No explanation as to why 117 questionnaires distributed, nor what the bigger pool was. But some descriptors of demographic info re sample.
5) Data analysis		30			Brief descriptors of analysis
6) Ethics and bias				10	
7) Findings / results	40				
8) Transferability / generalizability		30			Response rate low and 'could represent an atypical sample' p.276. Good description of context to aid transferability.
9) Implications and usefulness			20		Recommends training, but no specific content advocated. No reference to future research. Criticism of policy but no recommendations made.
Total					**240**

Author:	Gibb, S. J., Beautrais, A. L. and Surgenor, L. J.				
Title:	Health-care staff attitudes towards self-harm patients				
Date:	2010				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				Very clear and comprehensive
2) Introduction and Aims	40				Brief but adequate background. Clear aims and objectives
3) Method and data		30			Questionnaire described well but how it was put together is not described.
4) Sampling		30			Described clearly, but a little problematic strategy in terms of negotiating shifts and workload - could have been more. Sample size good, but not examined.
5) Data analysis	40				Well described and explained, with lots of data talked through comprehensively and applied to objectives
6) Ethics and bias		30			Adequate ethics. And declaration of interest stated. Confidentiality not particularly described.
7) Findings / results	40				Comprehensively described and applied
8) Transferability / generalizability		30			Comprehensive description of context. But sampling could have been thought about more carefully, particularly factors around consent and motivation. Some recognition about limits to generalisability in the text
9) Implications and usefulness		30			Potentially first research of this nature in NZ. Recommend training. Missed opportunity to suggest types of training or make policy suggestions. No recommendations for future research.
Total					**310**

Author:	Gough, K. and Hawkins, A.				
Title:	Staff attitudes to self-harm and its management in a forensic psychiatric service				
Date:	2010				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			Great title. Abstract sets the scene but doesn't specify much about the study itself.
2) Introduction and Aims		30			Intro quite brief with references all <10 years old. Aim good and driven from practitioners.
3) Method and data		30			Questionnaire developed themselves. Fully described in paper. But *how* it was put together not mentioned or reflected on.
4) Sampling		30			Sample sent to all clinical staff: good breadth of responses and about 50% response rate. Response rate not discussed, but some demographics given.
5) Data analysis					Analysis not described in depth. Quals data listed but not analysed or described in text very well.
6) Ethics and bias				10	No mention
7) Findings / results		30			Findings quite brief on attitudes (stated aim) but go on to discuss management, which does not correspond with aims.
8) Transferability / generalizability		30			Reasonable description of context implied.
9) Implications and usefulness			20		No ideas for further research, raises questions for policy and practice. Reported that staff wanted training, but didn't suggest content.
Total					**210**

Author:	Hadfield, J., Brown, D., Pembroke, L. and Hayward, M.				
Title:	Analysis of accident and emergency doctors' responses to treating people who self-harm				
Date:	2009				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				Thoughtful, insightful abstract
2) Introduction and Aims	40				Comprehensive background exploring various facets landing at a clear, well-described aim.
3) Method and data	40				Method justified and explained.
4) Sampling		30			Small sample of 5, appropriate to the aims of exploring the 'meaning A&E doctors attribute to these experiences'. Recruitment method not described.
5) Data analysis	40				Well described and explained.
6) Ethics and bias	40				Consent and anonymity described. Ethical approval described and impact of participation reflected on and mitigated.
7) Findings / results	40				Logically and thematically presented, with excellent quotes to back up argument and relevant to aims.
8) Transferability / generalizability	40				Context of A&E departments not well described but implied. Excellent reflectivity by researcher and acknowledgement of her own positionality within research
9) Implications and usefulness	40				Further research suggested; specific training / workshop described and support in practice for Dr's to reflect.
Total					**350**

Author:	Heath, N., Toste, J. and Beettam, E.				
Title:	Adolescent Self-injury: teachers knowledge and attitudes				
Date:	2006				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			Title okay. Abstract could be better structured.
2) Introduction and Aims	40				Detailed intro landing at clearly stated (whilst ambitious) aims.
3) Method and data		30			Own survey, given in full in appendix, with explanations as to how it was developed. However, content of survey problematic for extrapolating attitudes in comparison to validated surveys.
4) Sampling		30			Sample well described. Recruited through posters campaign and survey done over the phone. Alternative sampling / delivery not discussed, but acknowledgement that it was likely non-representative as posters were in a graduate training scheme and 60% choosing to study SH. Sample size of 50 not justified
5) Data analysis	40				Analysis well described within the results section, with some justifications given.
6) Ethics and bias				10	Not mentioned
7) Findings / results	40				Data tables good and well described. Good correlations made.
8) Transferability / generalizability			20		Context implied. Some concerns re sampling technique and size affecting generalisability.
9) Implications and usefulness		30			Research recommendations given. Training recommended but not specifics.
Total					**270**

Author:	Heath, N. L., Toste, J. R., Sornberger, M. J. and Wagner, C.				
Title:	"I Am Not Well-Equipped": High School Teachers' Perceptions of Self-Injury				
Date:	2011				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			Good title. Clear if brief, unstructured abstract.
2) Introduction and Aims	40				Really comprehensive discussion of the issues with very clear aims
3) Method and data		30			Survey described and referenced in fullness (Heath, 2006). However, limitations of evidence-base of survey style and potential extrapolation discussed. Survey is problematic.
4) Sampling			20		Self-selected participants from graduate-level classes. Paper acknowledges impact for being representative. Sample size - 155 - not justified or contextualised within possible sample, described only briefly
5) Data analysis	40				Data analysis described throughout results. Reasonable justification given.
6) Ethics and bias			20		Consent taken. But anonymity and ethics not described.
7) Findings / results		30			Findings are well described and comprehensive, but not always backed up by findings or followed through in recommendations - some inconsistencies.
8) Transferability / generalizability			20		Self-selected participants from graduate-level classes. Paper acknowledges impact for being representative. However, sample size bigger, and context implied.
9) Implications and usefulness			20		Recommends training and discussed this but confused as to what this should be.
Total					**250**

Author:	Heyward-Chaplin, J., Shepherd, L., Arya, R. and O'Boyle, C. P.				
Title:	Audit of healthcare professionals' attitudes towards patients who self-harm and adherence to national guidance in a UK burns and plastic surgery department'				
Date:	2018				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				Clear title. Well-structured abstract.
2) Introduction and Aims		30			Few references, with some very old references. Reasonable intro and clear aims.
3) Method and data	40				Distributed own questionnaire via email, the 10 attitude-related items listed in the paper.
4) Sampling		30			Demographics of participants described. 59 respondents, but no percentage that this was from.
5) Data analysis		30			Analysis described briefly, but then expounded throughout results section. Analysis style not justified.
6) Ethics and bias			20		Informed consent mentioned
7) Findings / results	40				Well presented, discussed and applied back to aims
8) Transferability / generalizability		30			Some descriptions of context.
9) Implications and usefulness	40				Does contribute something new, as no apparent equivalent research; specific recommendations made both for research and policy.
Total					**300**

Author:	Hodgson, K.				
Title:	Nurses' attitudes towards patients hospitalised for self-harm				
Date:	2016				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			Succinct, accurate time; clear abstract but not structured.
2) Introduction and Aims	40				Concise but full background leading to clear aims of literature review.
3) Method and data	40				Search method outlined and quality assessment described. Data extraction table comprehensive for the purposes of the study.
4) Sampling		30			Inclusion and exclusion criteria clearly stated.
5) Data analysis			20		Thematic analysis mentioned but not explicated.
6) Ethics and bias		30			Ethical approval of the lit review not mentioned, but this would be uncommon anyway. Quality of the papers assessed, presumably including ethics. Ethical issues around the topic in question discussed.
7) Findings / results	40				Findings presented thematically and clearly, drawing on the full scope of papers.
8) Transferability / generalizability	40				Generalisability discussed. Enough context given about methods and contexts of papers to make this appropriate.
9) Implications and usefulness	40				Specific recommendations given for education, training, policy and research. Useful consolidation of literature in this area.
Total					**310**

Author:	Huband, N. and Tantum, D.				
Title:	Attitudes to self-injury within a group of mental health staff.				
Date:	2000				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				
2) Introduction and Aims		30			Quite a brief intro, but reflective of this being early research in this area. Clear aims and research questions.
3) Method and data	40				Method described well and questions of survey listed in appendix.
4) Sampling	40				Clear reasoning around sampling group, sample size and response rate. Demographics described.
5) Data analysis	40				Analysis described and justified.
6) Ethics and bias				10	Not mentioned
7) Findings / results					Results presented clearly in tables and discussed in relation to aims and research questions.
8) Transferability / generalizability		30			Some context described. Recognition that this research would benefit from being repeated with similar sample to achieve generalizability.
9) Implications and usefulness		30			Implications are more discursive, implying possible ideas around training and intervention. Insightful and interesting though.
Total					**260**

Author:	Ireland, J. L. and Quinn, K.				
Title:	Officer attitudes towards adult male prisoners who self-harm: development of an attitudinal measure and investigation of sex differences				
Date:	2007				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				
2) Introduction and Aims	40				Very thorough and relevant intro. Clear aims and some hypotheses.
3) Method and data	40				Method described briefly. But both questionnaire's shared in full and vignettes described. Data collection clear.
4) Sampling		30			Sample size given. Questionnaire given out at a mandatory training. No discussion re sample size, or appropriateness of context, etc. Some demographic details given.
5) Data analysis	40				Good descriptions of analysis and explanations.
6) Ethics and bias				10	Sample was 100% and distributed during mandatory training in a college. No reflection around whether this impacted participation. Anonymity and consent described but no consideration of potential impact of participating in a highly emotive topic of research, nor details of ethical approval.
7) Findings / results	40				Good descriptions, logically talked through, with sufficient data.
8) Transferability / generalizability			20		Concerns around sampling technique would question generalizability.
9) Implications and usefulness		30			Recommendations for research, education, policy and training given, and potentially some useful findings.
Total					**290**

Author:	Karman, P., Kool, N., Poslawsky, I. E. and Van Meijel, B.				
Title:	Nurses' attitudes towards self-harm: a literature review				
Date:	2015				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				Appropriate title. Comprehensive abstract with structured accessible summary
2) Introduction and Aims	40				Comprehensive, thoughtful intro with clear aims and research questions.
3) Method and data	40				Method of lit review expounded, with figure. Data extraction comprehensive and added into paper.
4) Sampling	40				Inclusion / exclusion criteria justified in line with aims.
5) Data analysis			20		Analysis is implied in the presentation of findings, but how themes were pulled together is not explained
6) Ethics and bias		30			Studies reviewed for quality with appropriate tools. Ethics not discussed directly, which is relatively normal for a lit review.
7) Findings / results	40				Findings are presented logically and in direct relation to 3 questions in aims, drawing on the full range of papers in the study.
8) Transferability / generalizability		30			Good synthesis, but with methodological issues (described).
9) Implications and usefulness	40				Claims to be the first review to discuss attitudes of nurses towards NSSI. Gives clearly structured recommendations for education, practice and research.
Total					**320**

Author:	Koning, K. L., McNaught, A. and Tuffin, K.				
Title:	Emergency Department Staff Beliefs About Self-Harm: A Thematic Framework Analysis				
Date:	2018				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			Title appropriate. Abstract could be clearer and more comprehensively structured.
2) Introduction and Aims		30			Comprehensive intro, but not drawing on enough recent literature. Aims are brief and broad without research questions.
3) Method and data	40				Data collection described. Interview schedule shared in paper. Paper draws well on data.
4) Sampling			20		Poster campaign recruited 'interested participants', but not reflection on this technique for appropriateness. Sample of 15, but no details of wider possible response rates or whether the sample was appropriate. No demographic details given.
5) Data analysis	40				Reasonable description of analysis technique and triangulation.
6) Ethics and bias		30			Ethical approval stated. Consent explained. No emotional support offered or mention of anonymity.
7) Findings / results			20		Themes drawn out seem to disregard some of the negative views expressed in quotations added into the paper. E.g. clear evidence that staff saw SH as manipulative and/or non-genuine was not themed. Concludes that most participants felt positively towards patients who SH, but this is not backed up by the evidence presented.
8) Transferability / generalizability			20		Some description of context. Researcher works in the department in which the research is conducted, but does not reflect on the impact of this. Validity concerns impact on generalizability.
9) Implications and usefulness			20		Training / education recommended but with no clear suggestions as to content.
Total					**250**

Author:	Marzano, L., Adler, J. R. and Ciclitira, K.				
Title:	Responding to repetitive, non-suicidal self-harm in an English male prison: Staff experiences, reactions, and concerns				
Date:	2015				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				
2) Introduction and Aims	40				Comprehensive intro. Good highlighting of gaps in literature, and clear explanation of aims and objectives.
3) Method and data	40				Method is appropriate and explained. Data collection and recording clear.
4) Sampling		30			Descriptive characteristics tabled comprehensively. Recruitment described, but sample could have been put in better context and justified more comprehensively.
5) Data analysis	40				Thematic analysis described and triangulation considered.
6) Ethics and bias		30			Ethical approval granted. Informed consent and anonymity discussed, but not impact of participation.
7) Findings / results	40				Themes relate to aims and are backed up by results.
8) Transferability / generalizability		30			Some descriptive context given. Realistic assessment of how results can add to current literature and understanding.
9) Implications and usefulness	40				Recommendations made for research, training, policy and culture.
Total					**330**

Author:	McHale, J. and Felton, A.				
Title:	Self-harm: What's the problem? A literature review of the factors affecting attitudes towards self-harm				
Date:	2010				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				Title is fine. Abstract comprehensive with well-structured accessible summary.
2) Introduction and Aims		30			Very brief intro, but good aims and objectives.
3) Method and data	40				Good description of methods of lit search, collection and data extraction.
4) Sampling	40				Explanation and justification of inclusion and exclusion criteria could be better, but details of sample clearly described.
5) Data analysis	40				Themes drawn out in relation to aims, and process behind this explained clearly
6) Ethics and bias			20		No mention of this, whilst not being unusual for lit reviews, but also no evidence of quality assessment being conducted.
7) Findings / results	40				Findings presented logically and in line with aims and objectives.
8) Transferability / generalizability	40				Context of papers clear. Discussion draws out some good principles with broader application.
9) Implications and usefulness		30			Recommendations made for training and policy.
Total					**320**

Author:	Pannell, J., Howells, K. and Day, A.				
Title:	Prison officer's beliefs regarding self-harm in prisoners: an empirical investigation				
Date:	2003				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			Good title, and clear, though unstructured abstract.
2) Introduction and Aims	40				Comprehensive discussion of background leading to clear aims and objectives.
3) Method and data			20		Method described well. Details of questionnaire given in the paper. But questionnaire unvalidated, and not clear how it was put together.
4) Sampling		30			Good descriptions of sample, but not clear how or why the sample was achieved.
5) Data analysis	40				Analysis clear and justified.
6) Ethics and bias				10	Not mentioned
7) Findings / results		30			Quite brief. Relevant to aims. Not quite comprehensive enough.
8) Transferability / generalizability			20		Reasonable descriptions of context. Concerns re sample and method impact on potential generalizability
9) Implications and usefulness		30			Recommendations for training and policy.
Total					**250**

Author:	Perboell, P. W., Hammer, N. M., Oestergaard, B. and Konradsen, H.				
Title:	Danish emergency nurses' attitudes towards self-harm - a cross-sectional study				
Date:	2015				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				Good title. Clear, structured abstract
2) Introduction and Aims		30			Good intro, leading to good aims, but no research questions
3) Method and data	40				Validated questionnaire adapted to Danish context, with clear explanation of method and data collection.
4) Sampling	40				Sampling is clear, including percentages and justified in terms of the aims of the study. Good demographic data.
5) Data analysis	40				Analysis explained and justified.
6) Ethics and bias	40				Consent and anonymity dealt with. Access through gatekeepers, including hospital administration, implying ethical approval, and a separate statement of ethical standards.
7) Findings / results	40				Findings relate to aims, expressed in tables and described in text.
8) Transferability / generalizability		30			Good sampling increases generalizability of findings. However, good engagement with possible limitations for this.
9) Implications and usefulness	40				Further research and education discussed as well as policy changes like peer-coaching.
Total					**340**

Author:	Rayner, G., Blackburn, J., Edward, K.-L., Stephenson, J. and Ousey, K.				
Title:	Emergency department nurse's attitudes towards patients who self-harm: A meta-analysis				
Date:	2019				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			Good title. Comprehensive but unstructured abstract.
2) Introduction and Aims	40				Very thorough intro with gaps identified resulting in clear aims and objectives.
3) Method and data	40				Databases and search method outlined, including search string, and table.
4) Sampling	40				Inclusion /exclusion criteria stated and well-justified.
5) Data analysis	40				Meta-analysis explained and justified.
6) Ethics and bias			20		No mention of ethics or quality assessment; however it is a literature review
7) Findings / results	40				Results are presented logically and clearly and in line with aims.
8) Transferability / generalizability	40				Good generalizability as the scope of the review is very specific.
9) Implications and usefulness	40				Very specific recommendations for education content for ED staff, skills training, clinical supervision and further research.
Total					**330**

Author:	Rees, N., Rapport, F. and Snooks, H.				
Title:	Perceptions of paramedics and emergency staff about the care they provide to people who self-harm: Constructivist metasynthesis of the qualitative literature				
Date:	2015				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				Clear title and structured abstract
2) Introduction and Aims		30			Succinct, but relevant resulting in clear aims but no objectives or research questions.
3) Method and data	40				Clearing tabling of method. Search strategy explained, if briefly and data extraction shown.
4) Sampling	40				Exclusion/ inclusion criteria explicated
5) Data analysis	40				Reasons for analysis explained. Analysis thorough, covering various factors. Logical and comprehensive.
6) Ethics and bias		30			Quality assessment completed and papers weighted thus. No mention of ethics, which is normal for systematic reviews
7) Findings / results	40				Good theming of data to explain findings. Tables described in text and results relevant and back up by data.
8) Transferability / generalizability	40				The clear focus, and comprehensive searching of this paper, aid generalizability. Clear contexts shared and thought about in the papers included.
9) Implications and usefulness	40				Recommendations made for policy, training and research.
Total					**340**

Author:	Sandy, P. T.				
Title:	Exploration of psychiatric nurses' attitudes towards service users who self-harm in secure environments				
Date:	2011				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			Good. But abstract could be better structured.
2) Introduction and Aims		30			Thorough intro and background with good reference to literature. Aim very simple but appropriate. No objectives or research questions.
3) Method and data	40				IPA explained and justified. Clear descriptions of data collection and recording.
4) Sampling	40				Very clear explanation of sampling, and all staff in 15 clinical areas invited, with participation from 80 potential reduced to 61 through purposive sampling. Appropriate and broad sample found.
5) Data analysis	40				Analysis described well, including issues of rigour and triangulation.
6) Ethics and bias		30			Ethical approval stated. Consent and anonymity described But no support offered.
7) Findings / results	40				Themes follow a logical flow, according to aims, and backed up by the data.
8) Transferability / generalizability	40				Some good observations made in limitations, but that these come from participants from a whole trust and have a good sample size for IPA, with well-evidenced findings, makes generalizability more viable.
9) Implications and usefulness		30			Education and training recommended, as well as policy decisions re clinical supervision.
Total					**320**

Author:	Saunders, K. E., Hawton, K., Fortune, S. and Farrell, S.				
Title:	Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review				
Date:	2012				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				Fully met criteria
2) Introduction and Aims			20		Disappointingly brief intro and background.
3) Method and data	40				Very clear and thorough, with full search strategy in appendix, and data extraction in full.
4) Sampling			20		Some descriptions of types of papers sampled, but no inclusion / exclusion criteria.
5) Data analysis			20		No explanation as to how this happens, although the analysis itself (descriptive) is very good.
6) Ethics and bias		30			Quality assessment process fully explained in appendix.
7) Findings / results	40				Findings are well explained and structured, drawing from the papers well.
8) Transferability / generalizability	40				The large number of papers and well-constructed results and application make this paper have high generalizability and transferability.
9) Implications and usefulness	40				Clearly evidenced suggestions for training, policy re support of staff, and further research areas implied.
Total					**290**

Author:	Shaw, D. G. and Sandy, P. T.				
Title:	Mental health nurses' attitudes toward self-harm: Curricular implications				
Date:	2016				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				Fully met criteria
2) Introduction and Aims	40				Thorough intro and clear aims.
3) Method and data	40				IPA explained and justified. Clear descriptions of data collection and recording.
4) Sampling	40				Very clear explanation of sampling, and all staff in 15 clinical areas invited, with participation from 80 potential reduced to 61 through purposive sampling. Appropriate and broad sample found.
5) Data analysis		30			Analysis described in brief; more thorough in Sandy et al, 2012 paper, which is referenced.
6) Ethics and bias	40				Comprehensive.
7) Findings / results	40				Findings draw on data to meet particular aims for developing curricular implications.
8) Transferability / generalizability	40				Thorough description of setting, and specific focus with a reasonable sample number.
9) Implications and usefulness	40				Thorough discussion of curricular implications and educational focus, as well as policy as per aims. Further research also suggested.
Total					**350**

Author:	Short, V., Coopper, J., Shaw, J., Kenning, C., Abel, K and Chew-Graham, C.				
Title:	Custody vs care: attitudes of prison staff to self-harm in women prisoners - a qualitative study				
Date:	2009				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title			20		Title draws on one aspect of the findings, which is not really illustrative of the whole piece. Abstract informative but not well structured.
2) Introduction and Aims		30			Intro thorough, but aims don't quite fit with the title, and could be clearer.
3) Method and data	40				Methods described clearly, including how collected and recorded. Appropriate to aims.
4) Sampling			20		Sampling explained, but not recorded from how many potential staff 15 participants were gained, nor why this was considered the right number. Snowball and purposive sampling led to researchers approaching participants directly following a team meeting. This might have been more appropriate through a gate keeper, to ensure voluntary participation.
5) Data analysis	40				Analysis described, including some thought to rigour.
6) Ethics and bias		30			Ethical approval granted. Consent taken. No discussion of anonymity or support.
7) Findings / results	40				Well structured, relevant to aims, drawing on evidence appropriately.
8) Transferability / generalizability		30			Context described. But concerns re sampling affect generalizability.
9) Implications and usefulness		30			Findings are significant within the context and specific, appropriate recommendations made for policy and training.
Total					**280**

Author:	Dick, K., Gleeson, K., Johnstone, L. and Weston, C.				
Title:	Staff beliefs about why people with learning disabilities self-harm: a Q-methodology study				
Date:	2011				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title	40				Good title and summary with structured accessible summary
2) Introduction and Aims	40				Good intro and lead into both context and method of study. Aims are clear.
3) Method and data	40				Q-methodology explained and applied well. Q-sorts fully listed in appendix.
4) Sampling	40				Strategic sampling in accordance with Q-methodology requirements. Appropriate number justified.
5) Data analysis	40				Analysis well explained and applied.
6) Ethics and bias				10	Not mentioned
7) Findings / results	40				Results relate back clearly to data and well-structured in accordance with aims.
8) Transferability / generalizability		30			Good reflection of researcher's own position and positionality of data findings in paper. Accurately states that the findings contribute to our understanding, whilst not being generalisable.
9) Implications and usefulness	40				Makes clear recommendations for research, training and policy
Total					**320**

Author:	Fish, R.M.				
Title:	Working with people who harm themselves in a forensic learning disability service: Experiences of direct care staff'				
Date:	2000				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			Good title and abstract but could be better structured.
2) Introduction and Aims		30			Good intro, but aim is woolly and unclear, but practitioner-led.
3) Method and data	40				Described and justified. Data well presented.
4) Sampling		30			Explained and justified to some extent.
5) Data analysis		30			Good descriptions but no triangulation, probably due to scope and resources of study.
6) Ethics and bias	40				Exemplary
7) Findings / results	40				Well themed, based on evidence, lots of data quotes, relevant to broad aims
8) Transferability / generalizability		30			Context described, and transferability possible to other residential facilities.
9) Implications and usefulness		30			Training and policy recommendations made in great detail based on findings.
Total					**300**

Author:	James, M. and Waner, S.				
Title:	Coping with their lives - women, learning disabilities, self-harm and the secure unit: a Q-methodological study				
Date:	2005				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title			20		Title doesn't quite clarify the study. 'Summary' is informative but could be better structured.
2) Introduction and Aims		30			Very thorough intro and considered aims.
3) Method and data	40				Q-methodology described and justified. Clear descriptions for data collection and recording.
4) Sampling		30			Clear justification of sample size, but it's not clear how the participants were chosen, as wording is woolly (e.g. 'targeted', 'drawn'.)
5) Data analysis	40				Well explained according to Q-methodology principles, and how themes arrived at.
6) Ethics and bias				10	No mention.
7) Findings / results	40				Presented logically and in line with aims, drawing on evidence appropriately.
8) Transferability / generalizability		30			Little description of context. Findings are discursive, offering some theoretical transferability
9) Implications and usefulness			20		Some policy suggestions implied in a discussion more largely aimed at supporting women who SH.
Total					**260**

Author:	Snow, E., Langdon, P. E., Reynolds, S., Snow, E., Langdon, P. E. and Reynolds, S.				
Title:	Care staff attributions toward self-injurious behaviour exhibited by adults with intellectual disabilities				
Date:	2007				
Grading	**Good**	**Fair**	**Poor**	**Very Poor**	**Comment**
1) Abstract and Title		30			Good title and abstract but could be better structured.
2) Introduction and Aims	40				Very thorough intro and background. Clear aims, with some hypotheses and objectives.
3) Method and data	40				Method explained and justified, with full disclosure of questionnaires and vignettes for clarity and repeatability.
4) Sampling			20		Sample described in brief, but not clear how many staff the 41 was taken from. Nor how they were recruited.
5) Data analysis	40				Analysis described and justified for the different aspects of the data.
6) Ethics and bias			20		Ethical approval granted, but no details given about anything else.
7) Findings / results	40				Generally well presented and backed up with the evidence
8) Transferability / generalizability			20		Some broad context given. Results are quite discursive in nature, which might have some transferability into similar settings.
9) Implications and usefulness			20		Research and training suggestions implied but not explicated.
Total					**270**

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