responding to distress, including self-harm

A guide for Australian primary schools

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National Youth Mental Health Foundation

Acknowledgement of Country

headspace National acknowledges Aboriginal and Torres Strait Islander peoples as Australia's First People and Traditional Custodians. We value their cultures, identities and continuing connection to Country, waters, kin, and community. We pay our respects to Elders past and present and are committed to making a positive contribution to the wellbeing of Aboriginal and Torres Strait Islander people, by providing services that are welcoming, safe, culturally appropriate, and inclusive.

Recognition of lived experience

We recognise the immediate and ongoing impacts that distress, self-harm and suicidal behaviours can have on an individual, their family and the school community. We recognise that supporting a child who has engaged in self-harm is not a linear process and relapse of mental health related concerns may occur. We recognise that educators may be repeatedly exposed to distress through supporting others and hearing their lived experiences.

Self-care statement

The topic of distress, self-harm, and suicidal behaviours may bring up a range of emotions, particularly if you have lived or living experience. It is important to take care of yourself as you engage with this resource. Please take time to reflect on any impacts on your wellbeing and be aware of wellbeing supports and how they can be accessed. In addition to local supports, Lifeline is a free, confidential and 24/7 support service: **13 11 14**.

Acknowledgement of contributions

This resource has been developed by the headspace National Schools and Communities team and reflects a collaborative effort across headspace National. We would like to acknowledge the significant contributions of the following individuals: Ruth Jones, Steven Leicester, Natalie Novatsis and Martine Oglethorpe.

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Disclaimer

This publication has been prepared for use by staff working in primary schools, including teachers, school leaders and wellbeing staff to build awareness of distress and self-harm, increase confidence in recognising distress and guide a school's response to distress, including self-harm. This publication is not a clinical practice manual or guideline for clinical intervention. Before using this publication, you should read it in full and consider how it relates to your school's policies, processes and context.

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purpose

This resource is for staff working in primary schools, including teachers, school leaders and wellbeing staff. The term 'educators' is used throughout to refer to all school staff.

This resource aims to:

- build awareness of distress and self-harm
- increase confidence in recognising signs that indicate a child may be in distress
- prepare educators with information on how to respond to distress in children
- guide a school's response when responding to distress, including self-harm.

This resource should be read in conjunction with, and work alongside, local/school emergency management policies.

If states/territories already have established guidance for responding to self-harm in primary schools, educators should refer to these.

why this resource is needed

Increasing emotional distress

Australian data provide clear and consistent evidence that around one in four young people experience a mental health disorder each year. The number of children entering adolescence who are experiencing heightened levels of emotional distress and mental health concerns is increasing, with self-harm increasing sharply from early adolescence and peaking in mid-to-late adolescence[1].

Estimating the prevalence of self-harm among primary school-aged children is difficult, due to significant under-reporting that is often driven by shame, fear, and stigma among both children and parents[6,20]. While data for primary school-aged children is limited, emerging evidence indicates that primary school-aged children are engaging in self-harm behaviours, with a notable increase in hospital presentations related to self-harm in recent years[2,22].

This highlights the importance of building mental health literacy, coping skills, and help-seeking behaviours from the early years. Establishing this foundation strengthens early intervention, reduces stigma, and helps protect children as they move into the higher-risk adolescent years.

Building educator confidence in recognising and responding to distress

With limited research relating to children and distress, including how to appropriately respond to self-harm in primary school settings, there is a need for clear, developmentally appropriate guidance for schools so that educators can be confident in recognising distress and knowing how to respond. The way in which adults respond to distress can significantly influence a child's longer-term wellbeing, shaping their sense of safety, trust and willingness to seek support.

Educator confidence is strengthened when responses to distress are supported by clear, shared systems. A whole-school approach provides consistent expectations, language and processes. This makes wellbeing a shared responsibility, reducing reliance on individual judgement and helping to ensure safer, more coordinated support for children.

Adopting a whole-school approach to mental health and wellbeing

Adopting a whole-school approach to mental health is an evidence-based universal intervention for creating a positive, inclusive and supportive school climate[9,21]. This can be a protective factor for children and strengthens the ability of a school to prevent and respond to distress, including self-harm.

A whole-school approach involves everyone within the school community collaboratively working together to create a safe and supportive environment for children and staff. This involves school leaders, wellbeing staff, educators, parents/carers, children and other relevant community members or organisations (e.g. OHSC), as they all play a role in supporting the wellbeing of children.

emotional safety and educator wellbeing

Supporting children who are experiencing significant emotional distress and who are, or may be, engaging in self-harm can be stressful and leave educators feeling emotionally fatigued.

Witnessing self-harm may result in experiencing vicarious trauma for some people. The term 'vicarious trauma' refers to the emotional and psychological stress that results from being exposed to the trauma of others. It is often used interchangeably with 'secondary trauma'. It is important to acknowledge that direct or indirect exposure to emotionally confronting experiences, such as heightened distress and self-harm, can impact us all.

Educators should take time to consider their response to incidents of self-harm and how to maintain their wellbeing. Enacting self-care strategies and accessing support networks is critical during this time. Modelling self-care and help-seeking is just as important as demonstrating effective leadership following incidents of this nature.

It can be useful to:

- reflect on your experiences and connect with colleagues
- seek support through personal supports
- seek professional support such as through employee assistance programs or a Medicare-rebated Mental Health Treatment Plan through a general practitioner.

considerations specific to primary schools

Age and developmental stage

Primary schools support children across a wide range of ages, language abilities, cognitive capacity, cultural diversities and developmental stages, which requires flexible and developmentally informed responses to distress, including self-harm.

Expressions of distress can vary significantly between early and upper primary years and may also fluctuate rapidly within short periods of time. Younger children are more likely to express distress through physical or behavioural responses (e.g. head banging, hair pulling, emotional outbursts), while older children and adolescents may demonstrate more deliberate self-injurious behaviours (e.g. skin picking, cutting, burning). Developmental capacity influences not only how distress is expressed, but also the child's ability to understand and articulate their experiences, the function the behaviour serves, and their capacity to regulate and recover following periods of distress. Responses must therefore extend beyond the behaviour itself and be tailored to the child's developmental stage, including their level of insight, emotional regulation and available coping strategies.

Family involvement

Responding to distress, including self-harm, in primary school-aged children must involve family. It is important to recognise that it will often be confronting and distressing for a family member to become aware that their child is engaging in self-harm. While many families will be supportive, some may experience embarrassment and shame or view self-harm as a taboo topic. These views may be influenced by cultural, religious or other background factors.

The wellbeing of children is best supported when schools and parents/carers communicate openly, using non-judgemental language, and work collaboratively to support the child. Ongoing engagement with families helps ensure that responses are coordinated across home and school, reinforces protective relationships, and supports families to respond confidently and appropriately to their child's needs.

Family

Family may include parents, caregivers, siblings, partners, Elders, kin, mentors and other community members who play a significant emotional, cultural, faith-based or other role in a person's life. However, in primary school settings, educators must contact the parent/carer nominated by the family, in line with school policies and processes.

Modelling and social learning

Primary school-aged children learn behaviour and how to regulate and manage emotions largely through observation and imitation. The actions, language, and emotional responses of adults, peers, and siblings can significantly influence how children understand and express distress. Calm, compassionate, and regulated adult behaviour is especially important, as children often mirror adult responses during moments of emotional difficulty. Schools should remain mindful of peer influence and the potential for behaviours to be reinforced or normalised through observation. This can have positive or negative effects depending on the modelling and social learning to which the child is exposed.

Attachment and safe relationships

Strong, trusting relationships are an important protective factor for children. While parents and carers remain a child's primary attachment figures, a secure and responsive relationship with a trusted staff member at school can play a critical protective role. Children may seek reassurance, regulation, and safety from familiar adults within the school environment, particularly during periods of distress. Schools should recognise the significance of these relationships and ensure that key staff are equipped with the knowledge and skills to support children engaging in self-harm behaviours. A warm, empathetic approach is essential to help children feel safe and understood, and to support their willingness to express their thoughts and emotions.

introduction to distress, including self-harm

Self-harm and suicide-related terminology

The information in this section is intended to increase understanding of key terms and enhance confidence and understanding of the signs that may indicate a child is engaging in self-harm.

Unhelpful or harmful coping behaviours

Ways of dealing with distress that may provide some temporary or immediate relief but can have negative outcomes either in the short or long term.

Non-suicidal self-harm / non-suicidal self-injury

The act of a person deliberately hurting their body, and the absence of suicidal intent has been explicitly established[11].

Self-harm

The act of a person deliberately hurting their body, and where the intent to die is either absent or not able to be determined[16]. Intent is the defining factor differentiating a suicide attempt from self-harm[8].

Social transmission

When other children are aware of and influenced by others' self-harm behaviours, either through directly witnessing the behaviour, seeing photos or wounds after the event, or being encouraged to engage in the behaviour to increase a sense of belonging or show empathy.

Suicide

The act of intentionally causing one's own death[24].

Suicidal behaviour

Refers to all non-fatal suicidal thoughts and behaviours, including suicidal ideation, suicide plan, and suicide attempt[17]. This also includes suicide-related communications, both verbal and non-verbal, and expressing suicidal intent[3].

Suicidal ideation / suicidal thoughts

Thoughts about engaging in behaviour intended to end one's life. These thoughts can include active intent and planning, as well as longer term themes related to not wanting to live[17,23]. Individuals may move between this passive and active ideation in the context of increased distress and stressors. Suicidal ideation/ thoughts can also be historical (i.e. a person has experienced them in the past) or current.

Suicide attempt

An act carried out by an individual where the intended outcome is death, and they survive. Intent to end one's life is the defining factor differentiating a suicide attempt from self-harm[8].

Vicarious trauma

Often used interchangeably with 'secondary trauma' and refers to the emotional and psychological stress that results from being exposed to the trauma of others.

Self-harm and other signs of distress

A range of observable behaviours can indicate a child may be experiencing distress or using unhelpful or harmful coping behaviours. These behaviours can arise when they are experiencing emotions they are unable to understand or manage on their own. In this context, behaviour becomes a form of communication. A comprehensive response requires attention to the broader range of emotional and behavioural signals a child may present.

What is self-harm?

Self-harm is an umbrella term used to refer to instances of a person deliberately harming their body, irrespective of motive or suicidal intent[8]. Self-harm behaviours in primary school-aged children are likely to be expressions of distress.

Research about self-harm in primary school-aged children is limited, however, we know that:

- children can express distress in many ways, including cutting, head banging, self-hitting, severe scratching, hair pulling, interfering with wound healing, restricting food intake, poisoning and running across the road recklessly[22]
- prior to age 12, self-harm is between 1.2 to 3 times more prevalent among boys than girls the same age. From age 13 onwards this is markedly reversed, and girls are between 2 to 4 times more likely to present to an emergency department for self-harm[4,7,23].

Another critical difference between primary and secondary school-aged children is that adults, particularly educators, often have a narrow view of what constitutes self-harm for younger children[22]. This can contribute to self-harm behaviours being missed or misunderstood, including behaviours that some adults may not consider to be self-harm when in fact, they are, such as self-hitting, picking a wound and risk-taking behaviour.

In some cases, children and adolescents can utilise self-harm as a tool to manage suicidal thoughts/ideation, and this may be especially true for children experiencing ongoing mental health concerns or significant distress.

It is therefore important:

- not to dismiss or downplay self-harm behaviours in primary school-aged children
- to proactively focus on prevention and protective factors
- to provide adults, including educators, health professionals and parents/carers, with relevant and helpful information about self-harm and suicidal behaviours in order to understand how to respond to children in a safe and supportive way.

Self-harm should not be described as "attention seeking" as this assumes the child is in control of their behaviours, is making a conscious choice and is trying to be noticed; this is not the case. Instead, self-harm behaviours should be seen as "connection seeking", attempts to communicate or express distress, or attempts to self-regulate.

Note

It is important to recognise that some forms of self-injurious behaviour occur without intent to cause pain, injury, or harm. These behaviours, often repetitive in nature (e.g. head banging), are typically responses to heightened distress or responses to sensory experiences, rather than deliberate acts of self-harm. The response by educators remains the same.

Responding to distress, including self-harm
Introduction to distress, including self-harm

Other signs of distress

Importantly, self-harm is only one indicator of potential distress. There may be other observable indicators that a child is distressed, including:

- challenges with emotional regulation, including difficulty calming down
- externalising behaviours (e.g. being 'disruptive' or 'argumentative', etc)
- a sudden escalation in emotions and associated behaviours (e.g. anger, signs of aggression)
- showing or reporting signs of anxiety, such as frequent physical complaints (e.g. tummy aches or headaches), lack of concentration or being preoccupied
- isolating themselves or withdrawing
- a noticeable change in the ability of a child to verbally express themselves (e.g. unable to describe how they are feeling or why they did something, when they would typically be capable of doing so)
- Some children may reduce their communication and appear to "shut down" their overall expression.

This presentation can be a form of distress, reflecting emotional overwhelm or limited capacity to process and express internal experiences, and may be more common in neurodivergent children.

Impact of distress on a child

Signs of distress, including self-harm, may include unhelpful or harmful behaviours. Experiencing distress can impact on a child's ability to concentrate, to feel good about themselves, maintain connections with family and peers, and to make safe decisions.

Responding to children in distress through a trauma-informed lens, can help educators to see the profound impact that experiences can have on a child and their thoughts, feelings and body. A trauma-informed approach recognises the potential impact of traumatic experiences and prioritises safety, trust, choice and empowerment for the child when providing support. While it is not the role of educators to unpack those experiences for a child, keeping those understandings in mind can help shape effective and caring response towards the child.

Connection between self-harm and suicide

The intent of the action is what differentiates self-harm from a suicide attempt. A person can engage in self-harm where there is no suicidal intent, also known as non-suicidal self-harm, or non-suicidal self-injury[5]. Alternatively, a person can engage in self-harm where the intended outcome is death, which is referred to as a suicide attempt.

While self-harm and suicide are sometimes directly linked, such as in the case of a suicide attempt, most people who engage in self-harm do so without intending to end their life[12].

Primary school-aged children will have varying understanding of death depending on their age. Younger children around ages 4 to 6 do not yet understand death as permanent and irreversible and therefore are unlikely to understand the concept of suicide. By around age 7, children usually understand that death is permanent and universal, and by the upper primary levels, around ages 10-12, children's understanding of death is almost like an adult's and they therefore can comprehend suicide as a concept[15,19].

For many younger children, self-harming behaviour may function as a form of communication rather than an expression of suicidal intent. Children may engage in behaviours to signal distress, unmet needs, confusion, or emotional pain when they lack the language, cognitive capacity, or emotional skills to articulate their experiences verbally. In some cases, children may not recognise that their behaviour is harmful or may not associate it with long-term consequences. Instead, the behaviour can be understood as an attempt to cope with overwhelming feelings or to elicit care, safety, or connection from trusted adults. Interpreting such behaviours through a developmental and relational lens supports responses that prioritise understanding, emotional containment, and the child's underlying needs, rather than focusing solely on the behaviour itself.

Social transmission

Social transmission refers to information about self-harm behaviour being shared between people. It may occur when children are aware of, and influenced by, others' self-harm behaviours.

Children can become exposed to self-harming behaviour through peers, siblings, social media and/or the internet through:

- directly witnessing the behaviour
- hearing about the behaviour
- seeing wounds in person or in photos or videos.

For example, a child may be:

- encouraged by peers to join in the behaviour to increase their sense of belonging to a group or to demonstrate empathy for a distressed friend
- exposed to online content relating to self-harm. This may occur when they are seeking support or information and come across unfavourable content, as this environment is largely unregulated[13, 14, 18].

Exposure to self-harm in adolescents may lead to a greater predisposition to engage in self-harm behaviours[10]. This could therefore be a factor for self-harm behaviours in younger children. Exposure is not, however, a necessary factor or the only risk factor.

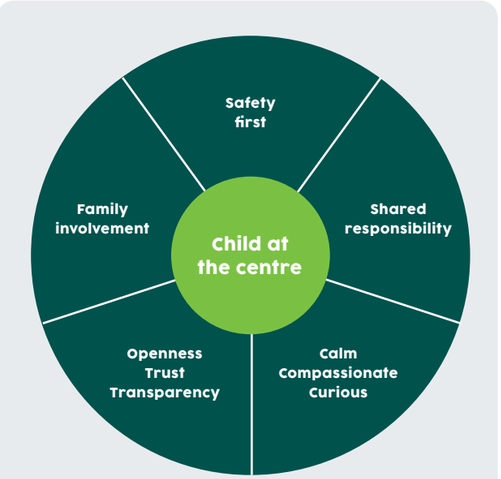
Even if the methods of self-harm are similar between peer groups, that does not mean the motives are the same. If a child is engaging in self-harm behaviours, it is important to look at each child individually, and support them to find other ways of coping with their distress and feel a sense of belonging.

Resource

For information and resources for educators on online safety and digital wellbeing, see: **eSafety Commissioner**

principles for responding to distress, including self-harm

Effective responses to children experiencing distress or engaging in self-harm behaviour must be grounded in safety, compassion and developmental understanding. The following principles can be applied by schools to support them to respond in ways that reduce harm, promote trust, and support the child, while placing them at the centre of all decision making.



1. Child at the centre

Responses are individualised and child-centred, tailored to the specific needs, circumstances, and voice of the child rather than applying a group-based approach.

2. Safety first

All responses prioritise the immediate physical and psychological safety of the child.

3. Shared responsibility

Responsibility for supporting a child is shared and does not rest with only one individual. Relevant adults and professionals who provide care to the child are included when responding to distress and self-harm.

4. Calm, compassionate and curious adult response

Adults respond calmly, compassionately, and without judgement, using a non-punitive and curious approach to help regulate distress, validate the child's experience and support their wellbeing, rather than assigning blame or making assumptions.

5. Openness, trust and transparency

Sensitively and as developmentally appropriate, children are informed of requirements to share information about self-harming behaviours with their parents/carers and relevant school staff.

6. Family involvement

Parents/carers are engaged as key partners, recognising their central role in supporting the child.

roles and responsibilities

Supporting the mental health and wellbeing of children and responding to distress in primary schools requires a coordinated, whole-school approach. Clear policies and processes, shared understanding, consistent practice, and collaboration with families are essential to ensure children are supported.

Whole-school approach, with clear policies, processes and accountability

School leaders are responsible for:

- building and maintaining inclusive and positive environments
- fostering a whole-school culture that promotes and encourages positive messaging around mental health literacy and help seeking.

This culture should be promoted within the school, to children and staff, and among the wider school community, including through communications to parents/carers.

Underpinning a whole-school approach are clear and concise written policies and documented processes for responding to distress and self-harm, including clear escalation pathways.

Be You can support your school in developing a whole-school approach to mental health and wellbeing, including free professional development, tools and resources.
beyou.edu.au

While not every primary school will have a dedicated wellbeing leader or team, there must be a clearly identified staff member responsible for wellbeing, regardless of school size or structure. This could be a teacher or member of the school leadership team.

The **wellbeing leader or team**:

- has oversight of wellbeing processes
- supports staff in responding to concerns
- coordinates communication with families and external services where required.

Schools should refer to their jurisdiction's Child Safe Standards or National Principles for Child Safe Organisations for guidance on developing policies and procedures that support the safety and wellbeing of all children.

Educators play a key role in:

- supporting the mental health and wellbeing of children
- promoting awareness about mental health and wellbeing
- promoting positive help-seeking behaviours
- building awareness of coping strategies.

Taking a trauma-informed and holistic approach to teaching and learning encourages educators to consider the needs and experiences of individual children. This helps to create a safe, supportive and empowering environment for all children, to support wellbeing and learning.

Staff awareness

All educators must be familiar with the school's policies and processes relating to wellbeing and responding to distress, including self-harm. They must understand their responsibilities if they observe or suspect a child is distressed or engaging in self-harm behaviours. This includes knowing:

- how to recognise signs of distress
- who to report concerns to, and when
- how to apply early-intervention approaches such as the NIP it in the bud framework
- what is not within their scope of practice.

Shared understanding of professional boundaries

Educators must understand the limitations of their role. Unless engaged as a school-based mental health professional (who have clearly defined roles and responsibilities relating to self-harm), it is **not their role** to:

- diagnose mental health difficulties
- determine the reason or intent of distress or self-harm
- undertake a risk assessment.

These are the role of a mental health professional, who can work with the child to understand underlying challenges and work with them to ensure safety and improve wellbeing. Outside of school, this could be: an external mental health professional, a GP, paediatrician or other relevant doctor.

It is also not the role of educators to tell parents/carers how to manage their child's mental health. Rather, they should work collaboratively with the family and mental health professional, where appropriate, to support the child.

School processes should clearly outline escalation pathways so that staff are aware of who the wellbeing contact is within the school, and how children and their families can be connected to further support if needed.

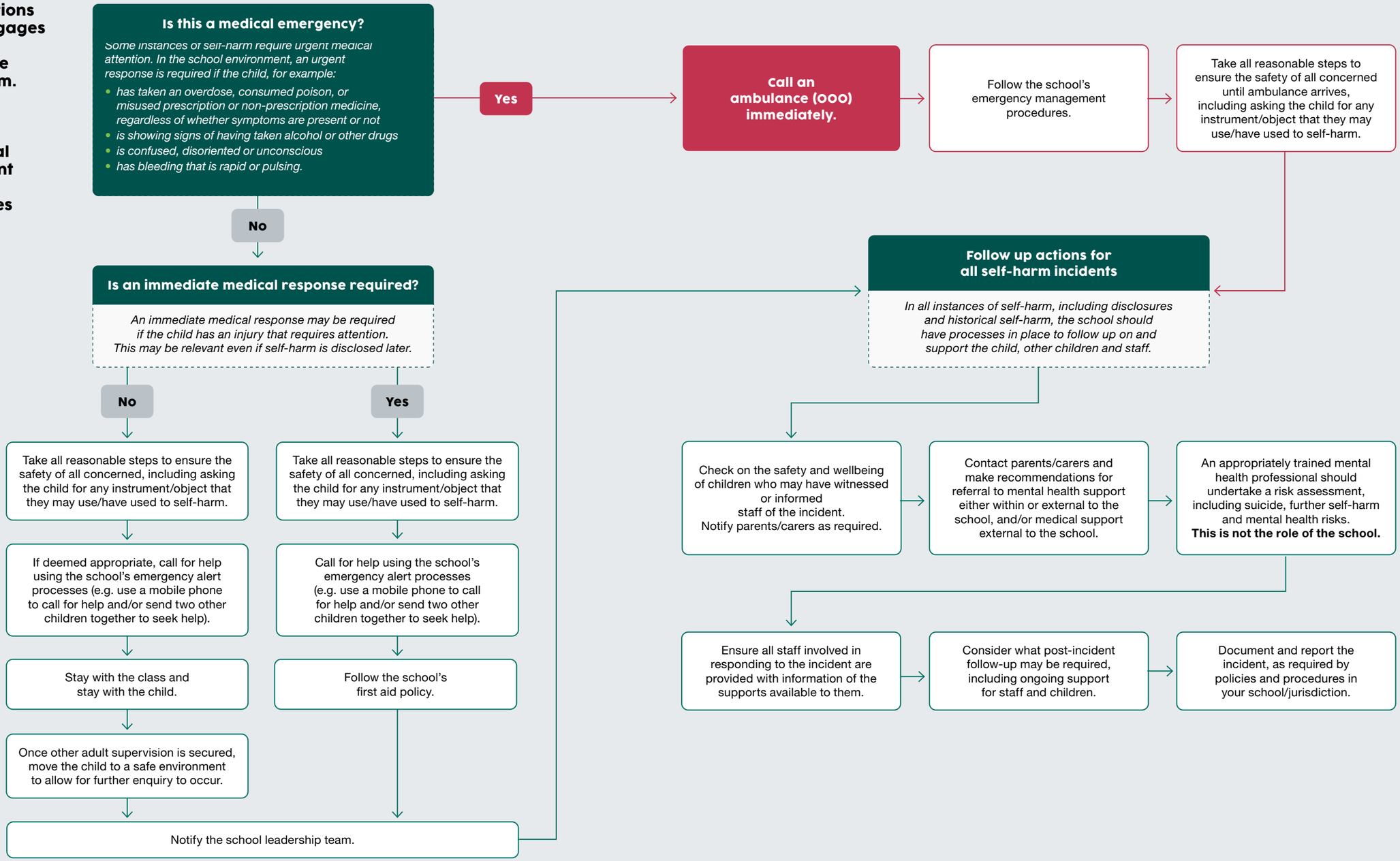
Partnership with families and the school community

All members of the school community play a role in fostering positive mental health and wellbeing; this is a shared responsibility across the school community, including staff, families, children, and relevant external partners (e.g. OSHC providers).

This can be achieved through whole-school approaches to building and maintaining inclusive and positive environments for children, and promoting and encouraging positive messaging around mental health literacy and help-seeking pathways. This helps to build a culture that can facilitate optimal wellbeing outcomes for children, as they are best supported when understanding and messaging are consistent across home and school.

responding to self-harm

This section outlines actions to take when a child engages in self-harm behaviour or if there is a disclosure or suspicion of self-harm. Educators should also consider these actions in the context of their own school, such as local emergency management policies and processes, roles and responsibilities within the school and referral pathways.



communication with children, families and staff

Privacy, information sharing and consent

Information sharing within the school

When managing information about a self-harm incident, it is important that staff carefully consider who needs to know about the incident, and share information only with those people. It may not be appropriate for all staff members to know but perhaps only those who have direct contact with the child. Ensuring conversations are held in private is important to avoid others overhearing information, including other children and staff.

Protecting a child's privacy and dignity should be paramount and be balanced with the need to keep the child safe and provide them with support.

Ongoing communication between staff involved helps ensure that all adults interacting with the child are aware of any safety considerations, follow-up plans, or adjustments needed to support the child and the broader school community.

Information sharing external to the school

In some cases, it may be beneficial to the child's safety and wellbeing to share information external to the school, such as with external health services and/or other schools, so the child can be appropriately supported.

When a child is starting at a new school, not all staff at the school need to know that the child has engaged in self-harming behaviours. For example, to support a child transitioning to secondary school, it may be most appropriate for the wellbeing leader to know, but not necessarily the teachers and year level leaders/coordinators. The frequency, duration and intensity of self-harm behaviours may also help to determine what information is shared and with whom.

Communication and information sharing

A conversation with the parent/carer is important to ensure clarity and transparency about what information will be shared, with whom, and why this is important. Schools should continue to communicate with parents/carers to ensure ongoing clarity around care and support.

communicating with the child

If a staff member witnesses, is made aware of, suspects or receives a disclosure of self-harm they should have a conversation with the child to ensure appropriate support and referral pathways are in place.

Considerations

Who is best placed to have this conversation?

It is okay if the educator who witnesses, is made aware of, suspects or receives a disclosure of self-harm does not feel comfortable having the conversation with a child. If there is another educator in the school who already has a trusted relationship with the child, they may be best placed. The educator's role is to ensure safety, and to follow the school's policies, processes and referral pathways.

Is the child in the right frame of mind to have a conversation?

If the child is distressed or upset, then it may be best to focus on helping the child to feel settled and safe first. Even if the educator thinks it is best to delay the conversation, it is still important to let the child know that they care and want to support the child when they are ready.

What language is appropriate for the child?

Language should be clear and easily accessible for the child. The child's age and stage of development and their level of understanding can help determine the language used with them. Regardless of the child's age and stage of development, it is essential to:

- communicate in a sensitive, calm, curious and non-judgemental way
- ask open-ended questions
- focus on reducing any shame or stigma.

Conversation prompts

Below are some prompts to support educators in having a conversation with a child.

These are a guide only. Educators should tailor these responses according to the situation and use language that feels authentic to them. It is appropriate to ask the child which identified adult (within the school's records) they would like contacted when communication with parents or carers occurs.

Ensure that you can find a private, safe space to have these conversations and be sure to let the child know that you may need to share this information with the Principal and their parent/carer to help keep them safe. Where possible, explain this in a clear and supportive way so the child understands what will happen next and feels involved and informed in the process.

- I have noticed that you haven't been your usual self lately. I'm wondering why that is. How are you feeling right now?
- I've noticed you have some marks on your body. I am concerned about this and I care about your wellbeing. Do you want to tell me about them?
- Big feelings can show up in our bodies. Can you tell me what was happening just before this?
- When they're feeling overwhelmed, some kids try to manage this in ways that can also hurt their body. Is that something that ever happens for you?
- We'll need to let your parents/carers know, so you can be supported. Is there anything you think is important or helpful for them to know.
- Thank you for telling me. You're not in trouble at school, my job is to help keep you safe and supported.
- I'd like to get someone to have a look at your sore. It's important that we make sure you don't get any infections. Your health and wellbeing is important to me.
- Is there someone else in the school who you would feel most comfortable to have a chat to?
- I would like to help you get the support you need.

communicating with parents and carers

Parents/carers must always be informed of their child's self-harming behaviours. This can be an overwhelming conversation for parents/carers so educators should reassure them that the focus is on supporting their child. Educators and parents/carers communicating and working together are essential parts of the support system and help-seeking pathway for a child.

Considerations and how to prepare for the conversation

Who is best placed to have this conversation?

School processes can be used to determine who is responsible for having this conversation; often this rests with school leadership and/or school wellbeing staff.

When and where should the conversation take place?

Parents/carers should be informed as soon as it is safe and appropriate to do so. It may be useful to make an initial phone call and then invite them to the school so that further communication can occur in-person.

What language is appropriate?

The conversation should focus on explaining concerns calmly, objectively and non-judgementally, building trust and encouraging help-seeking. Non-stigmatising language should be used, with a focus on wellbeing and support rather than diagnoses, labels or blame.

How might parents respond?

Some parents/carers may already be aware that their child is engaging in self-harm behaviours and may not have felt comfortable sharing this information or discussing it with the school. For others, this may be the first time they are hearing about their child's self-harming behaviours, which can come as a shock and they may experience disbelief, distress, anxiety or fear.

In these conversations, regardless of whether the parent/carer already knows about their child's self-harming behaviour, educators should validate any distress the parent/carer is experiencing, and reassure them that they want to work together to support the child's safety and wellbeing.

Some parents/carers may find it difficult to understand the concept of self-harm and/or may respond by minimising, dismissing or becoming defensive, which can invalidate the experience for the child. If emotions escalate or productive discussion is not possible, it may be appropriate to use protective interruption strategies. For example, pausing the conversation and reconvening at another time, once the parent/carer has had time to process the information and additional support can be arranged if needed.

If you are concerned about a child's safety

If there are immediate or ongoing concerns about a child's safety, or if a parent or carer is unresponsive or unwilling to engage, educators must prioritise these concerns.

Schools should follow **child protection and safeguarding policies and processes** and escalate concerns as required. A lack of parent/carer response should not delay action where there is a risk to the child.

Responding to distress, including self-harm
Communication with children, families and staff

What are the family's cultural or religious beliefs?

Cultural or religious needs of the child and their family/community may shape a family's understanding of mental health and help-seeking. Some families may experience increased stigma around mental ill-health. Many families also have their own strengths and values that can provide support. Families differ widely even within the same cultural or religious group, and educators should approach families with curiosity rather than assumptions or generalisations.

It may be appropriate to:

- seek guidance from community cultural leaders to support communication
- organise an interpreter and consider a longer meeting time. The child shouldn't be relied upon to interpret for their parent/carer
- ask how distress is understood and spoken about in their family
- invite families to share family strengths, values and existing supports that may inform how the school and family can work together to support the child.

What family circumstances are known that may be relevant?

Educators should consider any circumstances of family conflict or other contributing factors involving family that may be having an impact on the child. Being aware of parenting plans or court orders can help educators understand parental responsibility and living arrangements. This information can guide decisions about who the educator communicates with.

What documentation is useful to have on hand?

Documenting what you have observed can be useful in helping to communicate observations of the child clearly and objectively. If this is the first time the parent/carer is hearing about their child's self-harming behaviour, then being aware of referral pathways and options for parents/carers to seek further support is important so that this information can be communicated during the conversation. In some cases, parents/carers may already be aware their child is engaging in self-harming behaviour and seeking support for this. In this case, it can be useful to invite the child, along with their parent/carer, to talk about strategies that may support the child's wellbeing in the school environment. This may inform a school wellbeing plan for the child (see section, follow up and support for the child).

Conversation prompts

Below are some prompts to support educators in starting a conversation with a parent/carer.

These are a guide only. Educators should tailor these responses according to the situation and use language that feels authentic to them. Conversations should always begin with telling the parent/carer how their child is and if they are safe, reassuring the parent/carer of this.

- We've noticed [child's name] engaging in [self-harm behaviour] and are curious as to whether this could be an expression of distress.
- Hello, I'm calling you as we are concerned that your child has hurt themselves in response to some distress they are feeling. We would like to meet with you to talk about the behaviours we are seeing so we can all support the safety and wellbeing of your child.
- We have been made aware that your child is experiencing some distress and has been hurting themselves. We have provided medical attention, and your child is safe, but it is important we work together with you to respond to their distress and support them.
- Your child is safe, but we are concerned about their wellbeing and would like to talk with you in person about how we can support them. Would you be able to come to the school today to meet with us?
- You know your child best. Are there things that have helped them at home when they are feeling distressed, or concerns you would like us to be aware of as we plan support together?
- When we see these behaviours in children at school, we recommend that families seek professional advice. We recommend visiting a GP in the first instance. They may be able to provide advice and refer you to further support.

communicating with other children

Other children may be aware of a peer's self-harm behaviours and it is important to have a conversation with them to reassure them that the child is getting the help they need, and to provide them with any support they themselves may need following any exposure to another's self-harm (including hearing about self-harm).

These conversations should be conducted individually or in small, group settings with peers that may be impacted or have an awareness of the self-harming. It is not appropriate to address or discuss a child's self-harm in a whole-class setting.

Considerations

Who is best placed to have this conversation?

The conversation should be led by an appropriate staff member, often with support from school wellbeing staff, in line with school processes. If there is an educator in the school who already has a trusted relationship with the child, they may be best placed. The educator's role is to ensure safety, and to follow the school's policies, processes and referral pathways.

What language is appropriate?

It is important to use language that is not shaming or stigmatising, and provide reassurance that the child is being supported in the best way possible to help them stay safe and well. Conversations should focus on the need to keep their peer safe and other members of the school community safe.

What support might other children need?

Other children may have mixed emotional responses about a peer's self-harm behaviours. This may include distress, fear, confusion, anxiety, sadness, anger and concern, or even curiosity. Some children may not know how they feel in response to a peer's self-harm and may not display an overt emotional response. It is important to check in with how other children, who are aware of a peer's self-harm behaviours, are coping and respond as appropriate to any signs of distress.

What follow ups and further communication may be required?

Children should be directed to and followed up by school wellbeing staff, who can make referrals for further support, if needed. It is also necessary to contact their parents/carers to inform them about what their child has witnessed.

Conversation prompts

Below are some prompts to support educators in having a conversation with other children.

These are a guide only. Educators should tailor these responses according to the situation and use language that feels authentic to them.

- It can be confusing or upsetting to find out that your friend has been hurting themselves. It's important that you know they are safe and they are getting support. How are you feeling?
- It can be helpful to chat to someone about what you have seen/heard. Can I help you find some support?

Responding to distress, including self-harm
Communication with children, families and staff

Protective interrupting

Protective interrupting involves redirecting a conversation to prevent a child from discussing potentially distressing issues in front of others (e.g. peers).

A child may sometimes disclose or share information in front of others relating to personal experiences, or something they have heard about from others or online. Children who are vulnerable or at increased risk can be adversely affected by hearing details of another person's story or experience.

In these moments, the priority is ensuring safety and minimising distress. Educators can prepare for this by having strategies in place to redirect the conversation. For example, a staff member may gently interrupt, redirect and then follow up afterwards, or seek support from school wellbeing staff.

Conversation prompts

To redirect the conversation, it can be useful for educators to have some phrases in mind to use in these situations. Some examples are provided below.

- That sounds really stressful, and I want to make sure we talk about it properly. Let's find a quieter place where we can chat privately.
- I'm just going to pause us for a second. Let's step outside so that we can chat about this properly.
- It sounds like you have something serious to share. Let's pause for a moment and see if we can find the best person for you to chat to about this.
- Sometimes we hear about things that can feel confusing or scary. We don't need to hear about all the details now, but why don't we chat more about this after class.

Social media and other online spaces

Content posted to social media or other online spaces (e.g. gaming, messaging apps) can significantly increase the risk of exposure to self-harm incidents among children.

While it can be difficult to ascertain what information has been posted or shared online and how to restore safety, educators are encouraged to listen out for references to self-harm and engage with children regarding what they have seen and heard.

Understanding what has been posted or shared online can provide schools and external services (such as police and mental health professionals) with timely information about levels of risk to enable additional supports or interventions to be offered.

For information about managing social media, staying safe online and reporting or removing inappropriate posts see: eSafety Commissioner.

follow up and support for the child

The purpose of this stage is to restore safety and support the mental health and wellbeing of children, staff, and families.

Supporting a child who has engaged in self-harm is not a linear process. Relapse of mental health-related concerns may occur so expecting immediate or complete cessation of self-harm is often unrealistic. Ongoing support, regular review, and clear communication are essential.

Establishing a support team – a collaborative approach

School processes must be followed to determine who is responsible for:

- managing immediate risk, safety and wellbeing concerns
- follow up and school-based support
- communication with family and external services
- documentation and review.

It may be useful to identify a team who collaborate and meet regularly to ensure the child continues to be supported. In most cases this will include:

- the child
- parents/carers
- the classroom teacher
- school wellbeing staff
- school leadership
- external mental health professionals (if applicable).

To support the child, the perspectives and voices of both the child and their parents/carers must be considered and included during this process.

Areas of focus for the support team

Support person

A support person, or ideally two or more support people, provides support to the child during school hours. This may be a member of staff, the leadership team, school wellbeing staff, or a combination of all of these. It is important the child knows who the person/s is who they can go to for support.

Where possible, it is beneficial to have the child identify who they would nominate as their support person. Having an already established relationship can increase the likelihood that they will access support if they become overwhelmed at school.

Protective and risk factors

To ensure the child is supported, the following should be identified:

- Any ongoing risks of self-harm or emotional distress should be identified, including any challenges presented by the school environment, and ways to mitigate these where possible.
- Strengths and protective factors, including ways to reduce distress, increase school engagement, and support the child can receive in the classroom and playground.

Reasonable adjustments

Educators should consider any reasonable adjustments needed to enable the child to participate in education. Other health professionals, such as a GP or mental health clinician (with consent), may help to inform what types of adjustments may be helpful. With everyone's consent, adjustments may include:

- a gradual re-entry for the child, building up to returning to school full-time, if applicable (noting that some children may have no pause in their school attendance following a self-harm incident)
- processes for leaving class to check into a pre-determined location, if needed (e.g. First Aid for medical assistance, wellbeing space for a reset or a check in).

Responding to self-harm

The team should have a stepped-out plan for what the child, parent/carer, and school will do when responding to self-harm behaviours, both at school and away from school.

Escalation and external support

It can be useful for the family to share the contact details of other people who are providing support to the child. This may include other support figures or services involved in the child's support and wellbeing.

The referral and escalation pathways should also be clearly communicated and agreed upon (where possible) by everyone involved in the care of the child.

Documentation – developing a support plan

Outcomes of collaborative planning should be documented in a support plan for the child so that everyone can work together to keep them safe. This is to be developed with input from the child, parents/carers, educators and relevant information from external support services.

As part of the plan, the support team should agree on how the family and school will continue to work together and communicate, including identifying timing for regular check ins.

See Be You's My Return to School Support Plan: Primary School, which aims to ensure the best possible reintegration, safety, care and support for a child returning after time away from school. Consider the developmental age and stage of the child when developing this support plan.

Ongoing monitoring and support

It is important to continue to build on and encourage the child's strengths and protective factors, and check in with the child to ascertain their mental health and wellbeing. Educators should be alert for any changes in the child's behaviour, thoughts or emotions. If they are concerned, they should enquire sensitively, refer the child to school wellbeing staff for additional support and contact the parent/carer.

An important component of ongoing support is the school and family continuing to communicate so that everyone involved in supporting the child can remain informed, and so the support plan can be updated as needed.

resources

Be You

Be You provides educators with knowledge, tools and resources to create positive, inclusive and responsive learning communities where every child, young person, educator and family is empowered to achieve their best possible mental health and wellbeing.
beyou.edu.au

Professional Learning consists of modules across 5 domains:

- Mentally Health Communities
- Family Partnerships
- Learning Resilience
- Early Support
- Responding Together

beyou.edu.au/courses

Mental Health Continuum describes mental health at different points along the continuum, and this can help educators in knowing when to seek support for a child or young person.
beyou.edu.au/resources/implementation-tools/mental-health-continuum

BETLS Observation Tool can be used by educators to record and reflect on a child's wellbeing. It is an acronym for Behaviour, Emotions, Thoughts, Learning, and Social relationships. This structured approach helps identify triggers, patterns, and changes in behaviour to support a child's mental health.
beyou.edu.au/resources/implementation-tools/betls-observation-tool

My Return to School Support Plan: Primary School aims to ensure the best possible reintegration, safety and support for a child. It outlines situations the child might find difficult and how these can be managed for them to feel safe and supported at school.
beyou.edu.au/resources/wellbeing-toolkits/wellbeing-tools-for-children-and-young-people/my-return-to-school-support-plan

Wellbeing tools for educators including fact sheets, self-care tools and articles, videos and posters.
beyou.edu.au/resources/tools-and-guides/wellbeing-tools-for-you

Online safety

The **eSafety Commissioner** (eSafety) is the Australian Government's independent online safety regulator and exists to safeguard Australians at risk of online harms and to promote safer, more positive online experiences.
esafety.gov.au

Mental health language and early intervention

The **National Communications Charter** is an evidence-informed document to help guide the way mental health and suicide prevention sectors, governments, businesses, communities and individuals communicate about mental health and wellbeing, mental health concerns and suicide.
lifeinmind.org.au/the-charter

NIP it in the bud! is an early intervention framework developed by headspace to help educators identify mental health concerns and provide or seek the appropriate help
headspace.org.au/our-impact/campaigns/nip-it-in-the-bud

SAFEMinds: Schools and Families Enhancing Minds – a professional learning package that helps school communities apply the NIP it in the bud! (Notice, Inquire, Plan) early intervention approach using a range of tip sheets, mapping tools, individual plans and supporting videos.
safeminds.org.au/

Resources for parents/carers

Beyond Blue – Resource library
beyondblue.org.au/mental-health/resource-library

headspace – Understanding self-harm for families
headspace.org.au/explore-topics/supporting-a-young-person/self-harm

Kids Help Line – Self-harm explained
kidshelpline.com.au/parents/issues/self-harm-explained

Community mental health services

Beyond Blue
Beyondblue.org.au

Your local child and adolescent mental health services
raisingchildren.net.au/grown-ups/services-support/services-families-of-teens/mental-health-services-teens-children

eheadspace
1800 650 890
(3-10pm in all states and territories)
headspace.org.au/eheadspace

headspace
headspace.org.au

Kids Helpline
1800 551 800
(24 hours a day 7 days a week)
kidshelpline.com.au

Lifeline
13 11 14
(24 hours a day 7 days a week)
lifeline.org.au

QLife
Qlife.org.au

ReachOut Australia
au.reachout.com

Suicide Call Back Service
1300 659 467
(24 hours a day 7 days a week)
suicidecallbackservice.org.au

notes

Responding to distress, including self-harm

notes

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references

1. Australian Institute of Health and Welfare. (2022). AIHW National Hospital Morbidity Database 2021-2022 (annual). https://www.aihw.gov.au/suicide-self-harm-monitoring/overview/self-harm-hospitalisations.
2. Australian Institute of Health and Welfare. (2025). Intentional self-harm hospitalisations among young people. https://www.aihw.gov.au/suicide-self-harm-monitoring/population-groups/young-people/suicide-self-harm-young-people.
3. Baldwin, G., Butler, H., Hannaway M., & headspace. (2017). Delivering effective suicide postvention in Australian school communities: A report on headspace school support's current practice, learnings and recommendations for action. Melbourne.
4. Borschmann, R., Mundy, L. K., Canterford, L., Moreno-Betancur, M., Moran, P. A., Allen, N. B., Viner, R. M., Degenhardt, L., Kosola, S., Fedyszyn, I. & Patton, G. C. (2020). Self-harm in primary school-aged children: Prospective cohort study. *PLoS ONE, 15*(11). e0242802. https://doi.org/10.1371/journal.pone.0242802.
5. De Leo, D., Goodfellow, B., Silverman, M., Berman, A., Mann, J., Arensman, E., Hawton, K., Phillips, M. R., Vijayakumar, L., Andriessen, K., Chavez-Hernandez, A. M., Heisel, M., & Kolves, K. (2021). International study of definitions of English-language terms for suicidal behaviours: A survey exploring preferred terminology. *BMJ Open, 11*(2), Article e043409. https://doi.org/10.1136/bmjopen-2020-043409.
6. Geoffroy, M. C., Bouchard, S., Per, M., Khoury, B., Chartrand, E., Renaud, J., Turecki, G., Colman, I., & Orri, M. (2022). Prevalence of suicidal ideation and self-harm behaviours in children aged 12 years and younger: A systematic review and meta-analysis. *The Lancet Psychiatry, 9*(9), 703–714. https://doi.org/10.1016/S2215-0366(22)00193-6.
7. Geulayov, G., Casey, D., Bale, L., Brand, F., Townsend, E., Ness, J., Rehman, M., Waters, K., Clements, C., Farooq, B., Kapur, N., & Hawton, K. (2022). Self-harm in children 12 years and younger: Characteristics and outcomes based on the Multicentre Study of Self-harm in England. *Soc Psychiatry Psychiatric Epidemiology, 57*(1), 139-148. https://doi.org/10.1007/s00127-021-02133-6.
8. Hawton, K., Saunders, K. E. A., & O'Connor, R. (2012). Self-harm and suicide in adolescents. *The Lancet, 379*, 2373–82.
9. Hoare, E., Thomas, K., & Ofei-Ferri, S. (2025). Evidence-based practices in school settings for student wellbeing. *Australian Education Research Organisation*. https://www.edresearch.edu.au/research/research-reports/evidence-based-practices-school-settings-student-wellbeing.
10. Jarvi, S., Jackson, B., Swenson, L., & Crawford, H. (2013). The impact of social contagion on non-suicidal self-injury: A review of the literature. *Archives of Suicide Research, 17*(1), 1-19, https://doi.org/10.1080/13811118.2013.748404.
11. Kelada, L., Hasking, P., & Melvin, G. A. (2017). School response to self-injury: Concerns of mental health staff and parents. *School Psychology Quarterly, 32*(2), 173-187, https://doi.org/10.1037/spq0000194.
12. Klonsky, E. D. (2011). Non-suicidal self-injury in United States adults: Prevalence, socio demographics, topography and functions. *Psychological Medicine, 41*(9), 1981-1986, https://doi.org/10.1017/S0033291710002497.
13. La Sala, L., Sabo, A., Michail, M., Thorn, P., Lamblin, M., Browne, V., & Robinson, J. (2025). Online safety when considering self-harm and suicide-related content: Qualitative focus group study with young people, policy makers, and social media industry professionals. *Journal of Medical Internet Research, 27*:e66321, https://doi.org/10.2196/66321.
14. Memon, A. M., Sharma, S. G., Mohite, S. S., & Jain, S. (2018). The role of online social networking on deliberate self-harm and suicidality in adolescents: A systematized review of literature. *Indian Journal of Psychiatry, 60*(4), 384-392, https://doi.org/10.4103/psychiatry.IndianJPsychiatry_414_17.
15. Mishara, B. L. (1999). Conceptions of death and suicide in children ages 6–12 and their implications for suicide prevention. *Suicide and Life-Threatening Behavior*, *29*(2), 105–118.
16. National Institute for Health and Care Excellence. (2022). *Self-harm* [QS34]. https://www.nice.org.uk/guidance/QS34.
17. Nock, M. K., Borges, G., Bromet, E. J , Cha, C. B., Kessler, R. C., & Lee, S. (2008). Suicide and suicidal behavior. *Epidemiologic Reviews, 30*(1), 133-54, https://doi.org/10.1093/epirev/mxn002.
18. Robinson, J., La Sala, L., Kenny, B., Cooper, C., Lamblin, M., Spittal, M., Gao, C., Kunin, M., Nicholas, A., Rezwan, A., Gifford, M., Pirkis, J., & John, A. (2026). How do Australian social media users experience self-harm and suicide-related content? A National cross-sectional survey comparing young people and adults. *BMC Public Health, 26*, 384. https://doi.org/10.1186/s12889-025-25646-0.
19. Speece, M. W., & Brent, S. B. (1996). The developmental understanding of death. In C. A. Corr & D. M. Corr (Eds.), *Handbook of childhood death and bereavement* (pp. 29–50). Springer.
20. Townsend, M. L., Barr, K. R., Miller, C. E., & Sanzone, G. (2024). Self-harm and suicidal behaviours in children: Perspectives of mental health clinicians. *Journal of Pediatric Psychology, 49*(8), 571–579, https://doi.org/10.1093/jpepsy/jsae044.
21. Van der Kleij, F., Taylor-Guy, P., Vaughan, T., Medhurst, M., & Rogers, C. (2023). *School Improvement Tool Elaborations: Student engagement and wellbeing. Background report and literature review*. Australian Council for Educational Research. https://doi.org/10.37517/978-1-74286-690-1.
22. Van Hove, L., Baetens, I., Simundic, A., Bloom, E. & Heath, N. (2023). NSSI in elementary school. In E. E Lloyd-Richardson, I. Baetens, & J. L. Whitlock. (Eds.), *The Oxford handbook of nonsuicidal self-injury* (pp. 500-512). Oxford University Press.
23. Wastler, H. M., Khazem, L. R., Ammendola, E., Baker, J. C., Bauder, C. R., Tabares, J., Bryan, A. O., Szeto, E., & Bryan, C. J. (2023). An empirical investigation of the distinction between passive and active ideation: Understanding the latent structure of suicidal thought content. *Suicide and Life-Threatening Behaviour. 53*(2), 219-226, https://doi.org/10.1111/sltb.12935.
24. World Health Organisation. (2024). *Suicide*. https://www.emro.who.int/health-topics/suicide/feed/atom.html#:~:text=Suicide%20is%20the%20act%20of,low%2Fmiddle%2Dincome%20countries.

headspace services operate across Australia, in metropolitan, regional, rural and remote areas, supporting young people and family to be mentally healthy and engaged in their communities.


headspace would like to acknowledge Aboriginal and Torres Strait Islander peoples as Australia's First People and Traditional Custodians. We value their cultures, identities, and continuing connection to country, waters, kin and community. We pay our respects to Elders past and present and emerging and are committed to making a positive contribution to the wellbeing of Aboriginal and Torres Strait Islander young people, by providing services that are welcoming, safe, culturally appropriate and inclusive.

headspace is committed to eliminating all forms of discrimination in its programs and services. headspace celebrates and values all identities, experiences, cultures, abilities, faiths, bodies, sexualities, and gender identities through continuous reflection and ongoing improvement. headspace celebrates and values the diverse and intersectional living experiences of lesbian, gay, bisexual, transgender and gender diverse, intersex, queer and asexual (LGBTIQA+) young people, family and communities.

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