THEORISING SCHOOLS' INFLUENCE ON ADOLESCENT SELF-HARM IN WALES

A QUALITATIVE, GROUNDED THEORY STUDY
TO UNDERSTAND THE ROLE OF THE SECONDARY SCHOOL CONTEXT
WITHIN PUPILS' EXPERIENCES OF ADOLESCENT SELF-HARM,
TO DEVELOP SYSTEM-LEVEL PREVENTIVE INTERVENTION

Rachel Parker

This thesis is submitted in fulfilment of the degree of Doctor of Philosophy

School of Social Sciences

Cardiff University

2024

I

ACKNOWLEDGEMENTS

SUMMARY

Theorising schools' influence on adolescent self-harm in Wales: a qualitative, grounded theory study to understand the role of the secondary school context in pupils' experiences of adolescent self-harm, to develop system-level preventive intervention.

In the UK adolescent self-harm is a serious public health concern. It is a multifaceted behaviour, sharing a complex risk continuum with suicide. There are increasing rates in UK hospital admissions and yet the majority population in the community do not access health services for support. There are some challenges in its public health surveillance, in service support provision capacity, and in understanding adolescents' support needs within their community. All of these issues present adolescent health risks. To help address these points secondary schools are posited as key community-based support settings, however this community context requires further research exploration.

This study theorised schools' influence on adolescent self-harm, undertaking a qualitative research study that utilised grounded theory for its analysis, informed by the perspectives of the research participants, centred upon the secondary school context in Wales. 76 research participants were gained from 5 purposefully sampled secondary schools in Wales and organisations within the wider youth support system network. A participatory approach informed the research interviews, through the use of Participatory Appraisal. A qualitative research safety protocol was designed to inform the research project, so that the ethical concerns which centred upon adolescent self-harm research with youth participants could be mapped and successfully navigated.

The results in this thesis illustrate: the significant adolescent self-harm research access barriers for pupils; the problems in pupils' and staff's adolescent self-harm health education and knowledge; the perceived school context factors in how adolescent self-harm came to be present in pupils' own lives; and stigma being the main institutional, socio-cultural level influence upon adolescent self-harm in the school context. This thesis furthers our understanding of the institutional-level conditions that can risk accumulative negative impacts at an individual-level for adolescent self-harm. These findings can be taken into account within system-level preventive intervention design for schools in Wales.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION

This chapter introduces the thesis, presenting a summary of the background context that informed the study, the study's aims and design, and a brief overview of each of the chapters.

1.1 Background

In the UK adolescent self-harm is a serious public health concern (OHID 2023a; Russell et al. 2021). This is due to a number of critical issues which are summarised as follows. It is a multifaceted behaviour which means there can be challenges in understanding and working with its complexity (National Collaborating Centre for Mental Health 2012; Geulayov et al. 2022a). It shares a complex risk continuum with suicide (Hawton et al. 2012a; 2015ab; Arensman et al. 2018; Geulayov et al. 2018) and a threat of accidental death and long term health consequences from physical injuries. There are increasing rates in UK hospital admissions (Hawton et al. 2015ab; Morgan et al. 2017; McManus et al. 2019; Witt et al. 2021). There are issues in the public health surveillance of adolescent self-harm and preventive intervention support because the majority of adolescent self-harm does not come to the attention of public health services (Hawton et al. 2012a; Geulayov et al. 2018), presenting barriers to understanding the needs of this much larger population group (Kapur et al. 2020). Stigma is also acknowledged to be a major problem, delivering manifold negative health impacts (OHID 2023a). There have also been calls for quality improvements in the intervention evidence (Hawton et al. 2015b; Witt et al. 2021) and health service support capacity (NICE 2022abc). These critical issues can lead to barriers in understanding adolescents' health support needs for community-based adolescent self-harm.

Additional research alongside that of population health surveillance and clinical health settings is therefore essential, which is why there have been calls made in research for

the use of qualitative research with those with lived experiences of adolescent self-harm, to help inform preventive intervention and understand the health support barriers for community-based adolescent self-harm (Hawton et al. 2015b; Lewis & Hasking 2019; Witt et al. 2021; Willis-Powell et al. 2022). Hence the term "community-based adolescent self-harm" may be utilised to denote when health support is not elicited for adolescent self-harm and thus external and not visible to health settings, in contrast to that which is treated within a health setting context and becomes visible to health services (Geulayov et al. 2018; McManus et al. 2019).

With this background context, secondary schools are posited as key community-based support settings (Wasserman et al. 2015; Geulayov et al. 2022b). Secondary schools in England and Wales have been positioned to provide a central support role within adolescent self-harm preventive intervention due to recent adolescent self-harm policy and practice guidance developments in England and Wales (Welsh Government 2019a; 2021a; NICE 2022a). These guidelines constitute a multilevel adolescent self-harm preventive intervention, designed to be applied within the school context. It is a complex system intervention because it consists of multiple new components that are to interact together within the school context (Moore et al. 2015a) to help improve the health support for adolescent self-harm from within a key youth community setting.

However research highlights how there may be some barriers for the provision of adolescent self-harm support in schools (Berger et al. 2014; Evans & Hurrell 2016; Parker 2018a; Evans et al. 2019; Pierret et al. 2022). School system-level factors influence the health support that is to be deployed within schools, and the impact of these may be not fully recognised (Bonell et al. 2013; Langford et al. 2014; Evans & Hurrell 2016; Littlecott et al. 2019). Attention has been called to the research gap regarding the institutional-level factors in schools upon adolescent self-harm, and in theorising the causal mechanisms in the school context that impact pupils' health outcomes, with a call for the use of qualitative research in order to generate quality constructs and explain their relationships through theory development (Evans & Hurrell 2016). Consequently, understanding and developing theory regarding the influence of the school context upon adolescent self-harm is an important component to incorporate within school-based adolescent self-harm preventive intervention research.

1.2 Study Aims & Design

This thesis aimed to make a contribution to the research gap that has been outlined in the background context, centred upon the secondary school context in Wales, to theorise schools' influence upon the youth health issue of adolescent self-harm for preventive intervention purposes. It aimed to develop socio-culturally-informed theory drawn from this qualitative study's grounded theory analysis of the research data from its key stakeholder groups. These stakeholders included pupils and school staff, but also professionals from within the wider network in community and national-level organisations in Wales that provided support to adolescents for their health and support needs. In this way multiple perspectives would be gained from the key stakeholder groups, to support a school system-level analysis drawn from these differing stakeholders from within the school and wider linked system. Hence a socio-ecological perspective shaped this project's exploration and multilevel analysis (Mcleroy et al. 1988; Inman et al. 2011; Golden & Earp 2012) , which incorporated individual, interpersonal, institutional, community and public policy factors. The use of data triangulation due to the different stakeholder groups would also strengthen the research validity (Kisely & Kendall 2011).

Pupils and school staff were gained from secondary schools in Wales that were purposefully sampled for difference, and their wider support network professionals. To facilitate a consultative, participatory approach and the Welsh Government's ethos of participation rights and co-production within public services support design (Public Health Wales 2012; Social Services and Well-being (Wales) Act 2014; Care Council For Wales 2017; Moore & Evans 2017), the qualitative interview method was informed by Participatory Appraisal (Theis & Grady 1991; Chambers 1992, 1994ab; Pretty et al. 1995).   The Participatory Appraisal interview methods facilitated participants to deliver their perspectives upon the research topic, centred upon their perceived needs from within their community context (Theis & Grady 1991; Chambers 1992; Rietbergen-McCracken & Narayan 1998; Laws et al. 2013). As adolescent self-harm is a sensitive research topic (McCosker et al. 2001; Hasking et al. 2015a; Lloyd-Richardson et al. 2015), a qualitative research safety protocol was designed in order that the ethical

concerns that centred upon adolescent self-harm research with youth participants could be mapped and successfully navigated.

The findings of this study aimed to inform adolescent self-harm preventive intervention in Wales, so that its results could be utilised within the framework of UK public health services and complex intervention design (Campbell et al. 2000; Craig et al. 2008; Moore et al. 2015ab; Skivington et al. 2021ab). A critical realist paradigm informed the study design due to the study being situated in a socio-cultural context and incorporating research participants` perspectives, in order to uncover the mechanisms which generated the outcomes within the chosen social system under investigation, and to develop theory (Pawson 1989; 1996; Archer 1998; De Souza 2013; Pawson 2013; Fletcher et al. 2016; Centre for Critical Realism 2017).The choice of grounded theory for the qualitative research data analysis was due to it being fit for purpose for the study's critical realist paradigm. It also enabled theory to be developed that was anchored in participants' lived experiences and informed by their perspectives, which aligned with the study's ethos to enable participation rights and co-production within adolescent self-harm preventive intervention design in Wales. The grounded theory analysis was anchored in participants' perspectives about the everyday social reality in their socio-cultural setting, with theoretical concepts being "abstracted" from this data to generate explanatory theory about the socio-cultural behaviours that were evidenced within the specific socio-cultural context of the secondary school. The grounded theory analysis examined the empirical data in order to theoretically describe the phenomena of interest and to offer an explanation for its existence (Charmaz 2006; Reichertz 2007; Oliver 2012; Corbin & Strauss 2015; Bunt 2016; Reichertz 2019), revealing the perceived micro and macro influences that surrounded adolescent self-harm within the secondary school context; the social norms, values and practices were brought to light, informed by the research participants' perspectives.

1.3 *Overview Of Chapters*

Chapter 2 is the literature review, illustrating some of the critical issues that surround adolescent self-harm and why it is a serious UK public health concern, with the school

context in England and Wales being recently positioned within adolescent self-harm preventive intervention support. This chapter demonstrates why generating theory regarding schools' influence upon adolescent self-harm is important for preventive intervention support design purposes, with a focus upon secondary schools in Wales. Chapter 3 centres upon the project's research methodology and methods, outlining the philosophical and theoretical foundations, and the research procedures that were chosen to investigate the topic under study. Chapters 4 to 6 present the study's research findings. Chapter 4 elicits some of the challenges and potential barriers upon adolescent self-harm health education and knowledge in schools, as perceived by pupils and staff in this community-based study. Chapter 5 centres upon the perceptions from pupils' lived experiences of adolescent self-harm in their secondary school context, the perceived school influences upon pupils' health behaviours and support within these experiences, and explores the main themes within these perceptions. Chapter 6 presents the main institutional, socio-cultural level influence upon adolescent self-harm in the secondary school context that was found within this study, which was grounded in the research participants' perspectives. Chapter 7 concludes the thesis, with a discussion of the results and their implications for research, policy and practice, for the purpose of system-level preventive intervention support for adolescent self-harm in Wales.

CHAPTER 2: UNDERSTANDING WHY ADOLESCENT SELF-HARM IS A SERIOUS PUBLIC HEALTH CONCERN, & THE ROLE OF THE SCHOOL CONTEXT IN ADOLESCENT SELF-HARM PREVENTIVE INTERVENTION SUPPORT

2.1 Introduction

The purpose of this literature review chapter is to present an overview of some of the critical issues that surround adolescent self-harm and why it is a serious UK public health concern, with the school context in England and Wales being recently positioned within adolescent self-harm preventive intervention support.

This overview information, and the themes contained within it, are presented in this chapter because they are the results of the PhD literature review which examined, critically appraised and synthesised the key research literature that informed the PhD research topic and its aims. A targeted and structured approach underpinned the literature review strategy (Huelin et al. 2015) which is briefly summarised here at the chapter outset. A systematic literature review was not available due to the scope of this study (which was defined by its research aim and research questions), for example due to: the study's exploratory nature; the study not being a scientific method study; the study aiming to provide some initial information to help inform current government policy, strategy and decision making for the topic under study, targeted to a sociocultural community setting (Huelin et al. 2015). In the first instance, electronic bibliographic databases were searched (e.g. PubMed Central, ScienceDirect, Scopus) using predefined keywords and terms which were focused upon the PhD research aim and research questions. Then further electronic database searches were completed, centred upon organisations that provide research and practice evidence that informs UK public health and social care services (e.g. The Cochrane Library, NHS Digital, National Institute for Health and Care Excellence, National Institute for Health and Care

Research, Social Care Institute for Excellence, World Health Organization) – once again predefined keywords and terms were utilised that were focused upon the PhD research aim and research questions. A spreadsheet was generated through the use of excel to create a literature review matrix which enabled the literature review data to be organised and a summary, critical appraisal and synthesis of the literature review data to be completed, which delivered the overarching critical themes (Shellenbarger 2016, Efron & Ravid 2019; Aveyard 2023). The literature review data analysis and its themes were subsequently peer reviewed by 3 senior academics in SOCSI at Cardiff University. This literature review strategy, as outlined in this introduction, enabled me to structure this chapter accordingly and present the critical issues herewith.

The chapter therefore offers an overview of self-harm in the adolescent population group, drawn from within the framework of UK public health services. It demonstrates some of the critical issues in understanding adolescent self-harm needs, why these impact the quality of the research, and the potential health support barriers that stem from these aspects. It introduces a multilevel preventive intervention approach which is a public health informed model that is incorporated within the recent policy and practice developments of 2022 in England and Wales, for the support that is to be put in place to facilitate quality improvements in the care and support of self-harm. It explains the central role of the school community context within adolescent self-harm preventive intervention, and how this central position has occurred due to the recent policy and practice guidance developments. An appraisal is given of the quality of the UK research evidence base regarding this school setting health support approach, and how much is understood about schools' influence upon adolescent self-harm for preventive intervention support. The chapter demonstrates why generating theory regarding schools' influence upon adolescent self-harm is important for preventive intervention purposes, with a specific focus upon secondary schools in Wales. The chapter is structured into three parts to present this information, entitled as follows: (1) A definition and overview of adolescent self-harm; (2) Public health services support issues; (3) The central role of the school context in adolescent self-harm preventive intervention. These three sections are followed by the chapter conclusion. Italicised section heading themes are provided throughout the chapter to help situate the reader for navigation purposes.

2.2 An Overview Of Adolescent Self-harm, From Within The Framework Of UK Public Health Services.

2.2.1 Definition & Aetiology Of Adolescent Self-harm

In the UK, adolescent self-harm may be defined as a non-fatal self-damaging act by a person aged from 13 to 18 years which causes them bodily injury, where there is also a purpose present for the person to cause the harm to themselves (Royal College of Psychiatrists 2016; NHS 2020). This initial definition stems from UK public health organisations and it encapsulates a number of dimensions which include the physical injury behaviour or action, and the intent or aim of an adolescent to cause themselves physical injury. A further important dimension that UK public health organisations apply within their definition of self-harm are the emotions, feelings, motivations and/or distressed state of mind that may give rise to the behaviour (National Collaborating Centre for Mental Health 2004; 2012; Royal College of Psychiatrists 2016; NHS 2020). These descriptive dimensions of self-harm are drawn from the biopsychosocial model in psychiatry (Lee et al. 2022) which encapsulates self-harm within biopsychosocial dimensions and is the dominant approach within UK public health services (Hawton et al. 2015a; Thapar et al. 2018; Bolton & Gillett 2019).

Adolescent self-harm is not a mental illness in itself, but it can occur as a condition within mental health needs such as anxiety and depression as well as in substance misuse (National Collaborating Centre for Mental Health 2012). For example, child and adolescence anxiety and depression may give rise to symptoms of psychological distress, of which self-harm is one representation (Zsamboky et al. 2021). Child and adolescent mental health needs stem from an aggregation of multiple risk pathways and components (Fryers & Brugha 2013; Cybulski et al. 2021), one consequence of these being detrimental impacts upon children's and adolescents' thoughts, feelings, moods and behaviours (Zsamboky et al. 2021). Developmental and support barriers may exist within the family, social and community settings that a child or adolescent is part of, placing stressors that may cause increasing levels of psychological distress, which for some adolescents can risk self-harm behaviours (Patalay & Fitzsimons 2021; Zsamboky et al. 2021). These types of barriers may be due to health inequalities which

are preventable population-level health differences that stem from disadvantage (World Health Organization 2008; Arcaya et al. 2015; National Institute for Health and Care Excellence 2023).

Adolescent self-harm is therefore a complex behaviour with characteristics more heterogeneous than homogeneous (National Collaborating Centre for Mental Health 2012; O'Connor & Pirkis 2016; Borschmann & Kinner 2019; Geulayov et al. 2022a). This fact may deliver some challenges in understanding adolescent self-harm or the multiple factors that may have led to it (National Collaborating Centre for Mental Health 2012; Windfuhr et al. 2016). The socio-cultural factors that are part of adolescent self-harm are at times minimised and poorly comprehended - there can be a strong focus on individual-level approaches which do not take account of the influence of wider societal factors (Millard 2015; Steggals et al. 2020a). Reductionist approaches might focus solely on individual neuropathology (Westlund Schreiner et al. 2015; Malejko et al. 2022; Won et al. 2023) which could risk the exclusion of the impacts from external socio-cultural factors, such as those from within a social setting (Millard 2015; Steggals et al. 2020a). However, this type of differing focus is an important feature of self-harm research, as in the professional fields that engage with the complexity of self-harm there are multiple approaches across different disciplines, meaning there is diversity and divergence (O'Connor & Pirkis 2016; Windfuhr et al. 2016); this is a strength when working with adolescent self-harm and its core characteristics of complexity and heterogeneity. One challenge here can be in gaining consensus at times, but all deliver critical insights. The biopsychosocial model within UK public health services incorporates biological, psychological and social factors within its conceptualisation of adolescent self-harm; for example, to explore the social factors of family, home, peer and school influences (Lascelles et al. 2022). A summary of these main factors are presented in *Table 1*, which is replicated from Hawton (et al. 2012a).

Table 1: Risk factors in adolescent self-harm (& suicide)

(1) Socio-demographic and educational factors	(2) Individual negative life events and family adversity	(3) Psychiatry and psychological factors
Sex[1] (female for self-harm and male for suicide)	Parental separation or divorce[1]	Mental disorder[1], especially depression, anxiety, attention deficit hyperactivity disorder
Low socio-economic status[1]	Parental death[1]	Drug and alcohol use
Lesbian, gay, bisexual, or transgender sexual orientation	Adverse childhood experiences[1]	Impulsivity
Restricted educational achievement[1]	History of physical or sexual abuse	Low self-esteem
	Parental mental disorder[1]	Poor social problem-solving
	Family history of suicidal behaviour[1]	Perfectionism
	Marital or family discord	Hopelessness[1]
	Bullying	
	Interpersonal difficulties[1]	

The above factors in the table have been shown to be related to adolescent self-harm.
Factors denoted by the symbol "1" have been shown to be related to suicide.
SOURCE: Reproduced from Hawton, Saunders and O'Connor (2012a, p.2375).

Public health views social, economic and environmental influences as an important and integral part of individual-level health outcomes (Public Health England 2017; 2018). For specific groups who are disadvantaged within these contexts there are critical negative health impacts which lead to poor health outcomes and health inequalities, which is why public health applies a system-level focus upon health determinants to address the social, economic and environmental factors that risk these inequalities and poor health (World Health Organization 2008; Hickman et al. 2013; Office for Health Improvement & Disparities 2022). For example, a number of studies have demonstrated low household socio-economic status as being a risk factor for self-harm in some adolescents (Hawton et al. 2012a; Page et al. 2014; Lodebo et al. 2017). Findings from research that included children, adolescents, young adults and adults (i.e. from the ages 10 years and upwards, including adults over the age of 55 years) highlighted that living in areas of geographical deprivation could be a factor that presents an increased risk of self-harm

and suicide behaviour for some individuals, particularly for males (Cairns et al. 2017; Geulayov et al. 2022a). Research in Wales that centred upon 10 to 24 year olds demonstrated a significant increase in the incidence of self-harm within areas of deprivation, where it was double in relation to the least deprived areas (Marchant et al. 2020a).

The heterogeneity of adolescent self-harm means that there are also differing groups within the generic terminology "adolescent self-harm"; each of these groups differ in regards to characteristics such as age, gender, developmental stage, self-harm method, psychosocial factors, cultural and geographical differences. For example, adolescence is a societal term applied to a biopsychosocial developmental period between childhood and adulthood, with unique needs that differ from that of children and adults (Newman & Newman 2011); there is much variation within this developmental period, such as societal-level issues which may impact the timing of transitions and adulthood roles, also within biological changes which can include puberty occurring at an earlier age than 13 years (Sawyer et al. 2018).

To accommodate these issues and to support the needs of adolescents from a child's rights-based and health inequalities perspective, the World Health Organization (WHO) defines adolescence as the period from 10 to 19 years (Patton et al. 2016; Sawyer et al. 2018). Another generic term, that of "young people", may similarly be applied to the age range of 12 to 25 year olds (National Collaborating Centre for Mental Health 2022). The United Nations applies the term "youth" for the age range of 15 to 24 years (1981, p.17; 2022). However these age ranges are also quite broad given the variation that occurs over this period. As a consequence, in adolescent health and well-being data, age groups may be more clearly differentiated for reporting purposes, such as 10 to 14 years as early adolescence and 15 to 19 years as late adolescence (Patton et al. 2016), to help capture the specific needs within these differing adolescent ages stages. In the UK the term "young adults" may also be used to differentiate the needs of 18 to 25 year olds (National Collaborating Centre for Mental Health 2022). Similarly in Wales, through the 2011 Rights of Children and Young Persons (Wales) Measure, the specific term "young person", that of "pobl ifanc" is applied within this measure, to mean "a person who has attained the age of 18 but not the age of 25" (nawm 2, section 9). Age range

can therefore at times be a fluid concept, which means defining the terminology and the applied age range is critical for clarity and quality purposes in adolescent-centred research.

Hence disaggregated data is important for self-harm as it can reveal differing characteristics and needs, such as within socio-demographic, adverse negative life experiences, psychiatric and psychological factors *(Table 1)*. The group risk factors that are gained from this type of research may also be representative of health inequalities and help to demonstrate the needs within marginalised groups. The differing groups within adolescent self-harm, each with specific characteristics and needs, may also present some challenges in making data comparisons if these are not factored in and planned for to address in research study design (Hawton et al. 2012b*;* Kokkevi et al. 2012). For example, a strong research impetus to explore the adolescent self-harm subgroups and their needs was given by the adolescent self-harm Cochrane systematic review (Hawton et al. 2015b) as this was a critical factor that was deemed lacking in self-harm randomised controlled trial intervention design for children and adolescents.

2.2.2 *The Prevalence Of Adolescent Self-harm - Public Health Services Surveillance Statistics*

Self-harm data from hospitals is an important public health data context that informs adolescent self-harm prevalence and incidence statistics (Windfuhr et al. 2016), for example in order to estimate the total amount of cases and also the proportion of new cases within a given time (Brookes & Ben-Shlomo 2013). In England, public health surveillance data in the 2021/2022 reporting period (OHID 2023b) drawn from the Hospital Episode Statistics (HES) for adolescent self-harm *(see Figure 1)* gives the following public health surveillance data: the prevalence count (i.e. total count of hospital-based self-harm cases for the 2021 to 2022 period) for 10 to 14 year olds was 10503, with a population-level prevalence value (i.e. count of self-harm in the 10 to 14 year old population group) of 307 per 100,000; the prevalence count for 15 to 19 years olds was 20675, with a population-level prevalence value of 642 per 100,000. This data is based on finished hospital admissions (FAEs) as a result of self-harm. FAEs are the first episode of patient care in a hospital, and these differ from Finished Consultant

Episodes (FCEs) which is the whole period of continuous care of a patient by a specific consultant that may cover a number of care episodes. Both these types of data do not give a count of individual patients in a given period of time, as one patient may have a number of FAEs and FCEs each year or within another specific time period (NHS Digital 2016).

Figure 1: Public Health Profile: Self-harm & Suicide in England

Office for Health Improvement & Disparities

Fingertips | Public health data
Guidance API Contact us Your data ▾

Q Search for indicators

Home

Public health profiles

Data view ▾	Geography	Indicator search
Area profiles	Q England	Results for: self harm

Indicator	Period	England count	England value	Recent trend
Emergency Hospital Admissions for Intentional Self-Harm [New data]	2021/22	93,895	163.9 per 100,000	—
Suicide rate (Persons)	2019 - 21	15,447	10.4 per 100,000	—
Suicide rate (Male)	2019 - 21	11,551	15.9 per 100,000	—
Suicide rate (Female)	2019 - 21	3,896	5.2 per 100,000	—
Hospital admissions as a result of self-harm (10-24 years) [New data]	2021/22	42,793	427.3 per 100,000	—
Suicide crude rate 10-34 years: per 100,000 (5 year average) (Male)	2013 - 17	4,595	10.5 per 100,000	—
Suicide crude rate 10-34 years: per 100,000 (5 year average) (Female)	2013 - 17	1,342	3.1 per 100,000	—
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Male)	2013 - 17	10,465	20.1 per 100,000	—
Suicide crude rate 35-64 years: per 100,000 (5 year average) (Female)	2013 - 17	3,175	6.0 per 100,000	—
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Persons)	2019 - 21	14,267	34.6 per 10,000	—
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Male)	2019 - 21	10,713	51.8 per 10,000	—
Years of life lost due to suicide, age-standardised rate 15-74 years: per 10,000 population (3 year average) (Female)	2019 - 21	3,554	17.3 per 10,000	—
Suicide crude rate 65+ years: per 100,000 (5 year average) (Male)	2013 - 17	2,721	12.4 per 100,000	—
Suicide crude rate 65+ years: per 100,000 (5 year average) (Female)	2013 - 17	1,157	4.4 per 100,000	—
Hospital admissions as a result of self-harm (10-14 yrs) [New data]	2021/22	10,503	307.1 per 100,000	—
Hospital admissions as a result of self-harm (15-19 yrs) [New data]	2021/22	20,675	641.7 per 100,000	—
Hospital admissions as a result of self-harm (20-24 yrs) [New data]	2021/22	11,615	340.9 per 100,000	—
Emergency hospital admissions for intentional self harm, standardised admission ratio ⚠	2016/17 - 20/21	-	100.0 per 100	—

SOURCE: Office for Health Improvement & Disparities (OHID 2023b)

14

For self-harm the majority of the hospital presentations occur in the Accident and Emergency Admissions department (A&E) due to the emergency health needs that stem from physical injuries (OHID 2023c). This is why it is important to explain where the HES data stems from and how it is counted, such as whether it is drawn from FAEs or FCEs for data comparisons, as sometimes these details are not made clear. The Office for Health Improvement and Disparities (OHID) uses FAEs and population estimates to give a representation of the self-harm prevalence in England within a specific time period (OHID 2023a), which the OHID states within its data indicator definitions is only a "crude rate of finished admission episodes for self-harm per 100,000 population", as the underlying HES data used for this calculation is not a per person count. Hence further public health data analysis would be needed to refine this estimate for more specific self-harm prevalence and incidence data.

Hospital setting informed research demonstrates that the majority of adolescent self-harm presentations to hospital are 12 to 14 year old females, illustrating age variables in the behaviour's onset and peak, and distinctions in regards to gender, so there are important age and gender group differences (Witt et al. 2021). There can also be annual changes in age peaks, as highlighted in the aforementioned 2021 HES public health surveillance data from the OHID (2023b), which demonstrates the peak amount in the 2021 reporting period in England being in the age group 15 to 19 year olds instead of 12 to 14 year olds. The 12 to 14 year old age peak summary characteristic within the HES research that Witt (et. al 2021) drew upon for their international-focused background summary of adolescent self-harm was from studies using registry data in Ireland and regional data in England from between 2014 to 2018 (McMahon et al. 2014; Diggins et al. 2017; Griffin et al. 2018). Hence this was research data from prior years as well as the data being drawn from differing UK geographic locations (i.e. both England and Ireland), and more limited regions in England to that of the HES data utilised in the OHID figures from all the counties in England, which may account for some of the differing characteristics.

A point to briefly highlight is that in Wales there is not a self-harm public health surveillance summary that is publicly available, like that of the public health profile from the Office for Health Improvements and Disparities (OHID 2023b). Hospital data

regarding self-harm in Wales can be gained by reviewing the Patient Episode Database for Wales (Digital Health and Care Wales 2023). PEDW (*see Figure 2 for an example*) provides counts of Finished Consultant Episodes and also admissions data and emergency admissions data for self-harm, but in this data the age groups are structured to span very large age ranges, for example from 0 to 14 years then 15 to 59 years, and it does not included population level prevalence or incidence rates. These issues demonstrate there may be some challenges within the use of HES data to inform the public health surveillance of adolescent self-harm in England and Wales, but also in gaining ease of access to relevant data for adolescent self-harm in Wales.

Figure 2: A segment of the Patient Episode Database for Wales (PEDW) external causes data for the period 2020 to 2021.

External Cause Code	Finished Consultant Episodes	Admissions	Male	Female	Emergency	Age 0-14	Age 15-59
X60 - Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antir	2,497	2,438	685	1,811	2,417	307	2,024
X61 - Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkins	2,051	2,005	851	1,200	1,993	78	1,836
X62 - Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinog	1,026	994	450	575	985	47	897
X63 - Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervou	164	163	51	113	161	8	133
X64 - Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments	712	686	293	419	683	68	562
X65 - Intentional self-poisoning by and exposure to alcohol	1,128	1,090	484	644	1,084	19	1,049
X66 - Intentional self-poisoning by and exposure to organic solvents and halogenated hydrocar	6	6	6	0	6	0	5
X67 - Intentional self-poisoning by and exposure to other gases and vapours	14	13	11	3	13	0	12
X68 - Intentional self-poisoning by and exposure to pesticides	1	1	1	0	1	0	1
X69 - Intentional self-poisoning by and exposure to other and unspecified chemicals and noxio	66	64	22	42	64	15	42
X70 - Intentional self-harm by hanging, strangulation and suffocation	76	74	53	23	73	16	54
X71 - Intentional self-harm by drowning and submersion	2	2	1	1	2	0	2
X74 - Intentional self-harm by other and unspecified firearm discharge	1	1	0	1	1	0	1
X76 - Intentional self-harm by smoke, fire and flames	7	7	2	5	7	0	5
X77 - Intentional self-harm by steam, hot vapours and hot objects	3	2	1	2	1	0	3
X78 - Intentional self-harm by sharp object	587	571	206	380	544	104	437
X79 - Intentional self-harm by blunt object	18	18	4	14	16	0	18
X80 - Intentional self-harm by jumping from a high place	24	24	10	14	24	1	22
X81 - Intentional self-harm by jumping or lying before moving object	4	4	1	3	4	0	3
X82 - Intentional self-harm by crashing of motor vehicle	3	3	3	0	3	0	3
X83 - Intentional self-harm by other specified means	68	64	23	44	57	7	55
X84 - Intentional self-harm by unspecified means	73	70	20	53	68	14	56

Self-harm is coded in PEDW using the ICD-10 codes X60 to X84. These were the latest publicly available figures in June 2023. SOURCE: Digital Health and Care Wales (2023).

Hence for this PhD study the most recent public health surveillance self-harm data in Wales that can be used that is publicly available is drawn from self-harm HES for

16

emergency admissions, for the yearly periods from 2007 to 2016 (Public Health Wales Observatory 2018), which was previously requested by a stakeholder (*see Table 2)*. However this data was not broken down into smaller age groups but spanned 10 years to 24 years. Emergency admissions are not the total admissions data for self-harm as these do not include inpatient or outpatient treatment, which the PEDW dataset does include. The prevalence rate given for 2014 to 2016 in Wales for 10 to 24 year olds was 321 per 100,000. For the 2021/2022 reporting period for England (one comparison barrier here being that it is not the same as the 2014 to 2016 reporting period in Wales), if this is grouped into the same age span of 10 years to 24 years as the data from Wales, the prevalence rate given is 427 per 100,000 (OHID 2023b) – *see Figure 1*.

Table 2: Emergency hospital admissions for self-harm in Wales from 2007 to 2016, prevalence count & 3-year rolling prevalence rate per 100,000, for males & females aged 10 to 24 years

	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016
Annual average admissions prevalence count	1754	1640	1613	1625	1744	1785	1886	1820
Prevalence rate	298	279	274	277	299	309	330	321

SOURCE: Public Health Wales Observatory 2018

A critical and fundamental challenge within the public health surveillance of adolescent self-harm and its preventive intervention support is that the majority of adolescent self-harm does not come to the attention of public health services (Hawton et al. 2012a; Geulayov et al. 2018). This presents a major public health surveillance barrier to understanding the needs of this much larger population group (Kapur et al. 2020). This is why the following caveat is made by the OHID in regards to their self-harm public health surveillance data, that "hospital admissions are being used as a proxy of the prevalence of severe self-harm, but these are only the tip of the iceberg in relation to the health and well-being burden of self-harm" (OHID 2023a). This is also why within self-harm terminology a distinction that may be made is between adolescent self-harm that is treated within a clinical or health setting context, and that of community-based

adolescent self-harm where health support is not elicited and thus is external to health settings (Geulayov et al. 2018; McManus et al. 2019). Hawton (et al. 2012a) presents a representative illustrative model that is shaped like an iceberg (p. 2374) to delineate the visibility modelling between adolescent self-harm that is visible to health services (which is only a small part of a large iceberg) and contrasting this with community-based adolescent self-harm where the greater part of the submerged iceberg resides, being invisible to health services. Within this "iceberg model", the very smallest tip of the iceberg which is visible to health services is suicide, which is defined within this model as self-harm but with a fatal outcome. The public health surveillance issues and the subsequent barriers these present in regards to understanding community-based adolescent self-harm needs are also factors for why adolescent self-harm is serious public health concern.

Research from specialist surveillance centres like the Multicentre Study of Self-Harm in England access both NHS self-harm data and community-based self-harm research data to help provide quality evidence-based self-harm data to infer population-level characteristics, in order to improve the epidemiology of both hospital presenting and community-based self-harm (Department of Psychiatry University of Oxford 2023). For example, the 2018 study by Geulayov (et al. 2018) drew upon both hospital and community-based adolescent self-harm data in order to give valuable detail to inform the adolescent self-harm "iceberg" visibility modelling of Hawton (et al. 2012a). The purpose of the study was to explore and provide an estimate of an incidence rate (i.e. the number of new cases within the adolescent population) for both hospital-based and community-based adolescent self-harm, drawing upon data from specific time periods and contexts (i.e. hospital data within 3 regions in England from 2011 to 2013, and 2015 community survey data from pupils aged from 12 to 18 year olds within 29 educational contexts in one county in England). The study calculated an incidence risk ratio between the incidence of hospital-based adolescent self-harm to that of community-based adolescent self-harm, demonstrating that there were some significant differences in the incidence risk ratio within the subgroups of age and gender, findings which are reproduced as follows (Geulayov et al. 2018, p.170): for 12 to 14 year olds the incidence risk ratio (i.e. hospital incidence rate to community incidence rate) for males was 1:28 and for females it was 1:18; for 15 to 17 year olds it was 1:7 for both males

and females. Applying the findings from this study, the community incidence rate for adolescent self-harm is therefore likely to be much greater than the hospital incidence rate, and there are variations in the subgroups of age and gender. Large-scale temporal trend incidence research that utilises UK health care records highlights the increasing incidence rates of adolescent self-harm since 2001 (Morgan et al. 2017; Cybulski et al. 2021; Trafford et al. 2023) as being a major concern, and this increasing incidence could also therefore be present for community-based adolescent self-harm.

Hence one way forward that can help to address the barriers in regards to the public health surveillance and support needs for community-based adolescent self-harm is to undertake public health research with community samples. There have been limitations in completing large scale community studies for the purpose of gaining prevalence estimates in England and Wales for adolescent self-harm (Morey et al. 2017). Self-reported survey data regarding adolescent self-harm from the community birth cohort sample of 4810 adolescents aged 16 to 17 years within the Avon Longitudinal Study of Parents and Children (ALSPAC) found a lifetime prevalence rate of 19% for adolescent self-harm, with the gender breakdown data being 9% males and 26% females (Kidger et al. 2012). A community sample study of 2000 adolescents aged 13 to 18 years that was completed in 2013 in England (Morey et al. 2017) gained a lifetime prevalence rate of 16% for adolescent self-harm, with the gender breakdown data being 7% males and 23% females; for adolescents aged 14 years the prevalence rate was 16% and for those aged 17 years it was 20%. In the UK Millennium Cohort Study and the surveys in 2015 and 2017 of their community sample of 8994 adolescents, the prevalence rate was 16% at 14 years with the gender breakdown data being 9% males and 23% females, and 23% at 17 years with the gender breakdown data being 20% males and 28% females (Patalay & Gage 2019; Patalay & Fitzsimons 2021; Yang et al. 2023). These community sample prevalence figures demonstrate that adolescent self-harm is prevalent in adolescent community samples, and also that the prevalence rates are a serious concern. An important context where community samples can be gained for adolescent self-harm is that of school, as in Geulayov's (et al. 2018) study (*as outlined in the prior paragraph*). Section 2.4 in this chapter provides more details upon this point.

2.2.3 Health Risks In Adolescent Self-harm

Adolescent self-harm presents a number of health risks. Firstly, one of the critical issues regarding adolescent self-harm is that it shares a complex risk continuum with suicide (Hawton et al. 2012a; 2015; Arensman et al. 2018; Geulayov et al. 2018). Secondly there are further health risks which include: accidental death; acute liver failure from poisoning from paracetamol; nerves and tendons may be permanently damaged due to cutting; disfigurement and scarring (OHID 2023a). Additional negative factors from adolescent self-harm that impair the health quality of adolescents' lives include the acute levels of psychological distress that may be present (Kidger at al. 2012).

An important measurement applied in public health is that of the Disability-Adjusted Life Year (DALY) which is an estimate of the years of healthy life lost due to the disability (YLDs) and the premature mortality (YLLs) as a result of the health issue (WHO 2020a). This measurement attempts to quantify the negative biopsychosocial health impacts upon individuals that are the result of a health issue, including the risk factors that are present. The measurement is applied within public health, such as in the Global Burden of Diseases, Injuries, and Risk Factors modelling (Murray et al. 2012), to enable comparisons to be made that delineate public health issues and concerns, in order to help understand the problems that are present and to apply public health system-level approaches to address them (Murray et al. 2012; WHO 2020). Using the DALY measurement system, this demonstrates that adolescent self-harm is a serious public health concern. For adolescents, due to the amount of years of life lost that stem from premature mortality as a consequence of self-harm, as well as the years of healthy life lost from the long term health consequences that can occur from the physical injuries, these deliver an unequal burden of disease (GBD 2019 Adolescent Mortality Collaborators 2021; Castelpietra et al. 2022), demonstrating the presence of health inequalities.

2.2.4 The Shared Risk Trajectories Between Self-harm & Suicide

One of the health risks that causes self-harm to be a major public health concern is that of its shared risk trajectory with that of suicide. In psychiatry stress-diathesis modelling

(Van Heeringen 2012) it is posited that risk factors that can lead to adolescent self-harm also strongly correlate with a number of those from within the aetiology of suicide (Hawton et al. 2012a). As a consequence there are shared complex causal pathways between each of these two behaviours (Hawton et al. 2012a; 2015ab; Arensman et al. 2018; Geulayov et al. 2018). It is theorised that differences in the risk trajectory between either self-harm or suicide stem from personality factors, exposure to the risk behaviour, and the lethality of the choice of method. *Table 1 above and Figure 3 below* illustrate key risk factors for adolescent self-harm and suicide, summarised in the research synthesis by Hawton et al. (2012a).

Figure 3: Key risk factors & their risk trajectories within adolescent self-harm & suicide
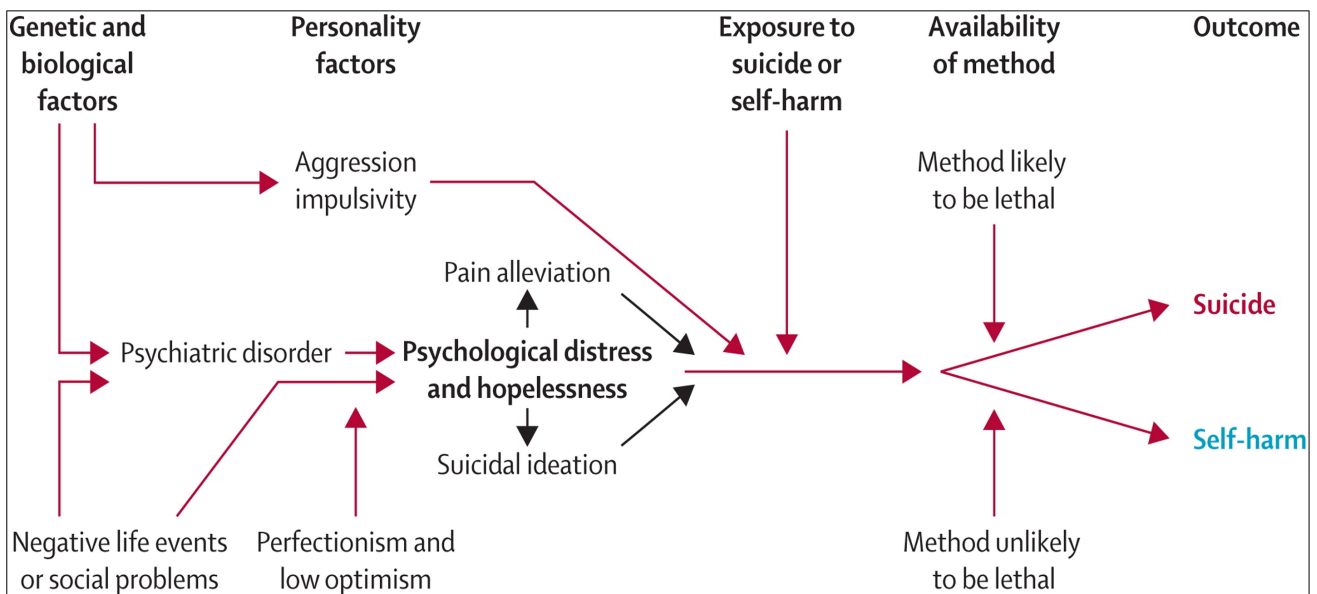
SOURCE: Reproduced from Hawton (et al. 2012a, p.2375)

Adolescent suicide is a devastating individual, family and community-level tragedy. A small number occur each year in England and Wales (*see Tables 3 and 4*), but they are a main cause of death in adolescents. For example in 2019, for 10 to 19 year olds in England and Wales, the Office for National Statistics (2020) stated that death by "suicide and injury or poisoning of undetermined intent" was the leading cause of death, with 17% of male deaths being as a result of this cause and 14% of female deaths. A further concern is the mainly upward trend from 2013 to 2021 (*see Tables 3 and 4*).

Table 3: Age-specific suicide rate per 100,000 population, England & Wales - deaths registered between 2013 & 2021

Ages	2013	2014	2015	2016	2017	2018	2019	2020	2021
10-14	0.2	0.2	0.3	(x)	0.3	0.3	0.3	0.4	0.4
15-19	3.9	4.6	5.5	4.8	5.4	5.9	5.7	4.9	6.4
20-24	8.3	8.4	8.9	9.5	7.8	10.4	11.0	9.1	11.0

SOURCE: Office for National Statistics 2022

(X) =source data, no entry due to number of suicides being less than 3 (see Table 4)

The figures in Table 3 are for deaths registered, rather than deaths occurring between 2013 and 2021. Due to the length of time it takes to complete a coroner's inquest, there can be a considerable delay between when a suicide occurred and when it was registered. Hence in the suicide data tables for registered suicide deaths these may not be in the year that the death by suicide took place.

Table 4: Number of suicides among 10 to 24 year olds in English regions & Wales - deaths registered between 2013 & 2021

Ages	2013	2014	2015	2016	2017	2018	2019	2020	2021
10-14	5	7	9	2	10	11	11	14	14
15-19	135	156	186	160	177	193	185	160	215
20-24	319	320	339	358	290	385	405	334	396

SOURCE: Office for National Statistics 2022

Therefore a critical issue for adolescent self-harm is that self-harm behaviours may be present within a suicide trajectory. A recent study drew upon 9303 adolescents from the years 2000 to 2013 who self-harmed, and their follow-up data from 5 hospitals in England, which enabled the study to explore the 55 deaths by suicide that occurred within this cohort (Hawton et al. 2020). This study demonstrated an elevated risk of future death by suicide for adolescents who attended hospital and who self-harmed repeatedly, particularly in males and older adolescents, a risk which could be present for a number of years. There was also a risk of accidental death due to poisoning, particularity for males. From 2013 self-harm hospital presentations of adolescent self-harm have increased (*see Table 5*) and as has been noted there has also been

increases in adolescents' and young adults' suicide *(Tables 3 and 4)*. Given the shared risk trajectory between self-harm and suicide, the increase in self-harm could be one factor within the increase in suicide. If drawing upon Hawton's (et al. 2020) study, the annual increases in self-harm could mean an increasing risk of adolescent and young adult suicide, and accidental death from poisoning. This could occur within the specific groups as outlined in the study (i.e. males and older adolescents) who presented to hospital for their self-harm, as these risks would have continued to be present for a duration of several years for these specific groups.

Table 5: A count of finished admission episodes (FAEs) for 'self-harm' & 'self-poisoning' by gender & requested age groups from 2005/06 to 2019/20 in England

Year	11 to 17 years males	11 to 17 years females	Totals
2005/06	2411	10439	12850
2006/07	2433	10345	12778
2007/08	2534	11081	13615
2008/09	2434	10331	12765
2009/10	2361	10425	12786
2010/11	2518	11330	13848
2011/12	2262	10794	13056
2012/13	2357	12220	14577
2013/14	2824	16533	19357
2014/15	2843	16571	19414
2015/16	3063	17583	20646
2016/17	3041	16113	19154
2017/18	3289	16193	19482
2018/19	3449	16808	20257
2019/20	3226	17307	20533

SOURCE: NHS Digital 2021

Hence for self-harm and suicide it is critical to disaggregate data to explore the needs and risk factors for specific groups, such as demonstrated in Hawton's (et al. 2020) study. For example, the suicide data *in Tables 3 and 4 (above)* masks significant differences in regards to gender, which *Tables 6 and 7 (below)* demonstrate when the

age group data is differentiated by gender: for 15 to 19 years olds the number of suicides for males each year from 2013 to 2021 was over double the amount of that of females each year; from 2013 to 2020, for 20 to 24 years olds, the number of males who died by suicide was over three times that of females. The majority of self-harm presentations to hospital services are female (*see Table 5*). Given Hawton's (et al. 2020) findings, in the 11 to 17 year old males who presented to hospital[1] (*which are presented in Table 5*), those males who repeatedly self-harmed and who were older adolescents could have been at a significantly increased risk of adolescent suicide and accidental death from poisoning. Knowledge of the long term and elevated risks for these males who self-harmed and accessed hospital could inform their support planning as part of targeted suicide prevention for these individuals, especially given the wider background context of death by suicide for older adolescent males being over double or triple the amount of that of females each year *(as demonstrated in Tables 6 and 7)*. It is not known how many of the adolescents and young adults who died by suicide *(Tables 6 and 7)* had had contact with health services prior to their deaths, and whether they had a history of self-harm. These points warrant investigation and research for adolescent and young adults' self-harm and suicide prevention, particularly for males.

---

1   Only FAEs are captured in table 5, which does not give a count of individual patients.

Table 6: Gender & age-specific suicide rate per 100,000 population, England & Wales - deaths registered between 2013 & 2021

Ages and gender	2013	2014	2015	2016	2017	2018	2019	2020	2021
10-14 males	0.2	0.2	0.2	(x)	0.3	0.4	0.3	0.4	0.3
10-14 females	(x)	0.3	0.3	(x)	0.3	0.2	0.3	0.4	0.4
15-19 males	6.3	6.5	7.7	6.7	7.1	8	7.2	6.8	8.8
15-19 females	1.4	2.5	3.1	2.7	3.5	3.7	4	2.8	3.9
20-24 males	13.3	12.7	13.9	13.9	11.4	15.6	16.6	13.6	15
20-24 females	3.2	3.9	3.6	4.9	3.9	4.8	5	4.2	6.7

SOURCE: Office for National Statistics 2022

Table 7: Number of suicides among 10 to 24 year olds & their gender, in English regions & Wales - deaths registered between 2013 & 2021

Ages and gender	2013	2014	2015	2016	2017	2018	2019	2020	2021
10-14 males	4	3	4	1	5	7	6	7	6
10-14 females	1	4	5	1	5	4	5	7	8
15-19 males	112	114	135	116	121	134	121	115	151
15-19 females	23	42	51	44	56	59	64	45	64
20-24 males	258	247	271	268	219	299	315	259	279
20-24 females	61	73	68	90	71	86	90	75	117

SOURCE: Office for National Statistics 2022

2.2.5 Differentiations In The Terminology Of Adolescent Self-harm

Hawton's (et al. 2012a) nuanced self-harm and suicide risk trajectory modelling of self-harm and suicide *(Figure 3)* captures the complex comorbidities within the two behaviours, which for understanding self-harm in the context of suicide means being aware of the dimensions for when it is a risk pathway to suicide and when it is not. This is not an easy or transparent process and is why expertise in both self-harm and suicide is required when working with adolescent self-harm (National Collaborating Centre for Mental Health 2018; Westers & Plener 2020; National Institute for Health and Care Excellence 2022a). There is a complex interplay of multiple factors, ranging from neurobiological to social (O'Connor & Portzky 2018).

Some UK-based research applies differentiated self-harm terminology to include the terms non-suicidal self-harm (NSSH) and suicidal self-harm (McManus et al. 2019), one reason for this being to improve research quality through the use of more specific nomenclature relevant to potential population group differences. This type of research posits that there can be important differences between NSSH and suicidal behaviour, with intent to die being targeted as the main differentiating factor (Muehlenkamp 2014; Posner et al. 2014). However intent may not be a transparent concept nor easily ascertained: there can ambivalent attitudes surrounding the intention of the self-harm (Kapur et al. 2013); there may be barriers which limit adolescents' disclosure of suicide ideation and behaviours to health setting professionals, such as concerns regarding information being kept confidential (McGillivray et al. 2022). Stigma may also act as a disclosure barrier and in ascertaining intent, such as in regards to the negative responses of healthcare professionals during adolescents' disclosure of self-harm behaviours (Staniland 2021) or thoughts of suicide (Willis-Powell et al. 2022) - research with adult participants demonstrated stigma to be a major disclosure barrier in suicide ideation and behaviour (Sheehan et al. 2019). The OHID (2023a) highlights that one major factor in why self-harm is a current UK public health concern is due to "self-harm ... (being) poorly understood in society and people who harm themselves … (being) subject to stigma and hostility" (Indicator ID: 21001, 07/03/2023. Indicator Number: C14b. Section: Public Health Importance). These are some of the challenges in discerning intent.

UK psychiatry informed research studies highlight limitations in the evidence base in regards to intent, and that it is not currently robust in demonstrating that a strong distribution difference exists between self-harm that is suicidal and self-harm that is not (Kapur et al. 2013; Russell et al. 2021). A longitudinal cohort study in the West of England which gained self-harm and suicide attempt data from the same participants at their different ages of 16 years, 21 years and 24 years demonstrated that there was an absence of such a division between NSSH and suicide attempts (Russell et al. 2021). The recent Cochrane systemic review of self-harm interventions for children and adolescents (Witt et al. 2021) strongly makes the point that suicide behaviour and non-suicidal self-harm may coexist, and that intent is not a consistent factor to use in order to differentiate between the two behaviours or base assessment upon. In their risk pathway modelling, Hawton et al. (2012a) do incorporate intent but they posit additional critical factors that are present which explain the difference between an outcome of self-harm or suicide; one factor is that of the lethality of the method that is chosen to self-harm, another is in having had close contact with peers' or family members' self-harm or suicide. As previously noted, Hawton et al. (2020) have highlighted the elevated risk with adolescent self-harm of subsequent death by suicide or accidental death, a risk that remains present for a number of consequent years. Hence these differences that are situated upon gaining professional consensus regarding the nomenclature of self-harm, its diagnostic criteria, as well as the risk modelling between self-harm and suicide behaviours, may each act as barriers for assessment and research purposes due to there being a lack of uniformity. This is a critical issue that surrounds self-harm which is well documented in research, negatively impacting for example the quality of the research data (Muehlenkamp et al. 2012; Silverman 2016; Kapur et al. 2020; Russell et al. 2021).

2.3 Public Health Services Support Issues

This section presents a brief overview of some of the public health service support issues for adolescent self-harm, such as within clinical health services. It provides an example of a public health services model that has been recently positioned in England

and Wales to inform adolescent self-harm support provision, as the model is a whole system-level approach for adolescent self-harm support quality improvements.

2.3.1 Support Barriers For Adolescent Self-harm Within Public Health Services

Due to the complexities and risks that are present with adolescent self-harm, with one critical point being the potential for those adolescents who are at risk of suicide not being recognised (Silverman 2016), a detailed psychosocial assessment is recommended in _every_ case of adolescent self-harm (Hawton et al. 2012b; Lascelles et al. 2022; NICE 2022a). Psychosocial assessment in the UK is a health and social care needs assessment process informed by the biopsychosocial model which explores a number of factors to help understand the health and support needs of an individual, for example the contributing factors, comorbidities, the type of support needs, the risk of harm, and the social and environmental influences (NICE 2004; Royal College of Psychiatrists 2010; Henderson & Martin 2014; Lascelles et al. 2022; NICE 2022a). This assessment is typically delivered by child and adolescent mental health services (CAMHS) multidisciplinary specialists. Problematically this type of expertise can be sparse due to public health services capacity barriers.

Public health services capacity challenges are present due to the UK adolescent population's rising mental health needs (Children's Commissioner 2018; Bould et al. 2019; Cybulski et al. 2021). A NHS survey (NHS Digital et al. 2018ab) identified and estimated the prevalence of probable mental health disorders in the whole of the child and adolescent population group in England and found that 13% of 5 to 19 year olds within the survey met the criteria for a mental health disorder in 2017: anxiety disorders were present in 8% of 11 to 16 year olds and 13% of 17 to 19 year olds; depressive disorders were present in 3% of 11 to 16 year olds and 5% of 17 to 19 year olds. A recent study (Edwards et al. 2023) illustrates the increase in CAMHS demand, with high thresholds in place for children and adolescents to become eligible for service access, large waiting lists that lead to long service support wait times, all of which means that there are now likely to be greater numbers of adolescents (and also young adults) in psychological distress and also experiencing mental health crises due to these service

support barriers. Given self-harm is a symptom of poor mental health and psychological distress, these issues outlined here may present self-harm risks.

An additional factor to consider in regards to the CAMHS capacity issues and service demands is the COVID-19 pandemic. The pandemic may have delivered specific negative mental health impacts upon children, adolescents and young adults, such as those which stemmed from the service support gaps and isolation that occurred, the disruption to their educational contexts, also from unmitigated critical stressors that were present at important developmental ages for at risk populations such as children and adolescents living in socio-economic deprivation (Cowie & Myers 2020). Research (Carr et al. 2021; Michaud et al. 2022) describes the COVID-19 pandemic's potential impact upon adolescent self-harm needs which include: increases in anxiety and depression which are risk factors for self-harm; self-harm help-seeking barriers being present; disproportionate negative impacts in areas of deprivation. A large population-based cohort study in Wales that used routine healthcare data from residents in Wales aged 10 years and over, for the period from 2016 to 2021, raised similar points regarding the self-harm help-seeking and support access barriers during the COVID-19 pandemic (DelPozo-Banos et al. 2022). Further research is needed to explore the potential long term negative impacts and subsequent support needs for children, adolescents and young adults that may have occurred due to the pandemic. Rising mental health support needs may lead to stronger CAMHS access barriers and longer wait times, with children and adolescents who are in need of support experiencing negative impacts over a much longer duration, increasing the risk of mental health crises, physical harm, mental ill health (Carr et al. 2021), suicide ideation and attempts, accidental death and suicide (Morgan et al. 2017). For example, there may be children and adolescents with self-harm needs who have already experienced service access barriers during the COVID-19 pandemic and who may now still not be able to access service support. All of these issues risk an increase in the prevalence and incidence of adolescent self-harm in the UK.

In addition to the increasing levels of service need for CAMHS, CAMHS has also been under strain due to its system-level poor data quality that negatively affects its service delivery and quality (House of Commons Health Committee 2014), and from service

cuts and staff shortages (Care Quality Commission 2017; Care Quality Commission 2018). The service cuts and staff shortages have also occurred in the wider public health and social care child and adolescent community support system which CAMHS is part of (The Lancet 2020). CAMHS also prioritised its own system needs over that of the mental health needs of children and adolescents, which was why it was deemed not fit for purpose by the 2018 CAMHS inquiry in England by the House of Commons Health and Education and Social Care Select Committees. A call was made for " a seismic shift" (p.9) through system transformation. A similar call for a CAMHS system change was made in Wales by the Children, Young People and Education Committee (2018), to include a public health focus upon prevention and health promotion.

To achieve these types of health system-level changes (such as those called for regarding CAMHS) presents many challenges (Khan et al. 2018; Maniatopoulos et al. 2020): they are extremely complex; they take time to establish; they are dynamic periods of innovation and change; they need to be integrative, interlinked and embedded within the wider public health and social care support system. All of these challenges can place additional stressors upon health service quality and capacity, particularly when system transformation is taking place in a context of limited resources and increasing levels of service demand within both the service system and the wider linked system. For example, in the Welsh Government's plan (2018) for transforming the health and social care system in Wales, the arduous nature of the transformation agenda, as well as the issue of the high costs of providing these types services are both brought to the forefront. These lead to "difficult choices" (Welsh Government 2018, p.4) needing to be made regarding what to prioritise, which means that some groups and their needs will not be deemed as important as others, and there also may be problems in gaining a consensus upon which groups are to be prioritised. However children's and adolescents' health and well-being needs are to be prioritised within this agenda as a consequence of the COVID-19 pandemic, and these are to be achieved through a whole system-level service integration within the new transformation agenda (Welsh Government 2021bc). For example, as in the recent NEST/NYTH framework which is a whole system-level approach in Wales for quality improvements in children's mental health and well-being services (Welsh Government 2023). These are complex system-level reconfigurations, but also a necessity in the context of sparse CAMHS

resources, mental health service access barriers and increasing needs (Kamody &
Bloch 2022). Hence the difficulties and wider system-level resource issues may lead to
some implementation and integration challenges, impacting service support.

In England and Wales self-harm has also recently been targeted in public health
services as a priority improvement area for self-harm and suicide prevention (NICE
2022abcd). NICE standards drive quality and prioritise areas where there is a need for
improvements. This is one of the main reasons for the new NICE self-harm practice
guidance (NICE 2022ab), meaning that there has been some quality challenges which
needed addressing. NICE aims to ensure that care and treatment decisions are
informed by this best practice guidance, in partnership with the population group, their
families or carers, their friends, and their support networks (NICE 2022d). There is also
an acknowledgement that this new practice guidance will take time and resources for
implementation purposes (NICE 2022a). Adding to these support quality issues, two
Cochrane reviews (Hawton et al. 2015b; Witt et al. 2021) have highlighted the
international-level problem of the quality of the intervention evidence that is used to
inform and make healthcare choices for adolescent self-harm support needs, with few
randomised controlled trials. Whilst increasing the treatment evidence base, both these
reviews also recommend that future intervention research explores what treatment is
acceptable to the population group and its feasibility. Another critical point to raise in
the context of these health care support and resource challenges is that adolescent self-
harm is a common and increasing health behaviour (Hawton et al. 2015ab; Morgan et
al. 2017; McManus et al. 2019; Witt et al. 2021). Therefore the health services support
system, the intervention quality issues, and the limitations in having the resources and
capacity to meet the service demand within the context of increasing needs, all deliver
critical risks factors in the health and provision of care for the adolescent self-harm
population group in the UK.

2.3.2 *An Overview Of A Multilevel Adolescent Self-harm Preventive Intervention Approach*

One public health services model that has been recently brought to the forefront to help
address some of the public health service support issues for adolescent self-harm in

England and Wales is the multilevel preventive intervention approach. Through recent policy developments this approach has been positioned to be the foundation for a whole system-level service transfiguration in regards to adolescent self-harm support quality improvements, as it also incorporates adolescents' social and community contexts. More details regarding these points are given below.

A core public health model within self-harm and suicide prevention (WHO 2012ab, 2016, 2018) is the multilevel socio-ecological approach within preventive intervention support design, where individual health needs are influenced by multilevel factors in the society that an individual is part of (McLeroy et al. 1988; Inman et al. 2011; Golden & Earp 2012). Within this social-context-orientated public health model these multilevel factors are at the intrapersonal, interpersonal, organisational, community and public policy levels, and the model also posits the principle of reciprocity which is where the individual is deemed to both influence and be influenced by these multilevel factors (National Cancer Institute and National Institutes of Health 2012, p.10). Due to this interconnectedness, health behaviour improvements which utilise the model aim to elicit changes in health behaviour throughout the whole system, for example at the individual-level but also across all the other levels including at the public policy level (Stokols 2000).

Differing population groups and their health needs are targeted within this public health system-level approach. For example, in mental health preventive intervention modelling (Mrazek & Haggerty 1994) a differentiation is made between general public needs and that of specific population groups as illustrated within a spectrum of needs, with preventive intervention measures targeted to: the general population (i.e. universal); subgroups within the population with above average risks of ill health but who have not become ill (i.e. selective); and individuals who are demonstrating some initial or small signs or symptoms that suggest there could be some ill health needs and are at a higher risk of severe illness (i.e. indicated). This preventive intervention approach aims to prevent or reduce the risk of new cases of ill health, as well as shorten illness progression to minimise severity risks. A further public health strand to add here to the universal, selective and indicated preventive intervention model is that of mental health promotion, which is not targeted to ill health but to a universal or whole group

population-level in regards to developmental, health, resilience and well-being positive outcomes (O'Connell et al. 2009).

The public health multilevel preventive intervention approach is embedded within the World Health Organization's violence and injury prevention training programme (2005; 2012) which has specialized resources for self-harm and suicide prevention. The programme builds system-level capacity and facilitates multiple sectors, agencies, audiences and key stakeholders to understand the extent of the problem and its health challenges for specific population groups (such as youth health needs in regards to adolescent self-harm), as well as to collaborate for injury prevention purposes tailored to local and community needs within differing countries, including government policy frameworks. This is to help establish or strengthen the system-level support provision for quality improvements.

Similarly, in England and Wales the public health multilevel preventive intervention approach is also now embedded within recent policy developments which outline the support that is to be put in place for self-harm to facilitate support quality improvements, such as in the recent NICE self-harm practice guidance (2022a). This guidance targets and specifies all of the social contexts that an individual resides within that the practice guidance is to be used for. For children and adolescents this includes (NICE 2022a, p.81): their families and/or carers and friends; their school or other educational settings; their health and social care support services within their community and public health support system, as well as the service commissioning and policy frameworks. Given this recent adaption of the public health multilevel preventive intervention approach for adolescent self-harm within England and Wales, there will be implementation barriers and facilitators, which demonstrates a need for the use of implementation science and research to help support the process (Moore et al. 2021; Skivington et al. 2021a). For example, the strong impact of context upon an implementation process can be unrecognised (Craig et al. 2018: Moore et al. 2021). This is particularly important for the school context, due to schools in England and Wales being positioned as a key support setting for adolescent self-harm within these recent policy developments, and the support role they are to provide within the public health multilevel preventive

intervention approach for adolescent self-harm. More details regarding this point about the school context are given in the following Section 2.4.

2.4 The Important Role Of The School Context In Adolescent Self-harm Preventive Intervention

This chapter has presented information upon why adolescent self-harm may be considered as being a serious public health concern, including the challenges in the public health surveillance of adolescent self-harm, the barriers in understanding adolescents' support needs for preventive intervention design (particularly for adolescent self-harm that does not become visible to health services), the health risks, and the health service support issues including the limitations in the health intervention evidence-base. These issues are well documented in research, including the risks and negative impacts to adolescents' health that stem from these issues, and the barriers in community-based adolescent self-harm health planning, support design and provision (Hawton et al. 2015ab; Geulayov et al. 2018; Witt et al. 2021). Against this background context, the recent self-harm multilevel policy framework (NICE 2022a) could be pivotal in improving some of these challenges for adolescent self-harm, given schools being positioned as a key support setting for adolescent self-harm. This policy directive means that schools are now to play a central role within adolescent self-harm preventive intervention in England and Wales. There is therefore a strong impetus to complete community-based adolescent self-harm research through the use of the school community context in England and Wales in order to help support population-level public health surveillance prevalence and incidence estimates, as well as for preventive intervention purposes, given this recent support directive.

2.4.1 The School Context In The Public Health Surveillance Of Adolescent Self-harm

Community-based surveys can support and improve population-level public health surveillance prevalence and incidence estimates of adolescent self-harm. The secondary school context in England and Wales is a key community context to deliver

these types of research surveys. There have been some large scale school-based research studies that have surveyed pupils in England (Brooks et al. 2015; Geuyalov et al. 2018; Brooks et al. 2020) and some examples of their adolescent self-harm school-survey questions to pupils are given in *Table 8*. In Wales there appears to be a research gap here. Regular school-based student health and well-being surveys do occur in Wales (Welsh Government 2022c), such as that of the School Health Research Network (SHRN 2023) in Wales. However, on reviewing the school health research surveys to date in Wales (Welsh Government Social Research 2015; Hewitt et al. 2019; Page et al. 2021) there have been no pupil survey questions for adolescent self-harm. There has also been no large scale school-context adolescent self-harm research in Wales that has included pupils as research participants. It is not known at this current time why this is the case, nor the potential school research participation barriers and facilitators for pupils in Wales. The PhD study may contribute more information regarding these issues.

School-based adolescent self-harm research with pupils has occurred in England. For example the 2014 Health Behaviour in School-aged Children (HBSC) collaborative study in England included specific adolescent self-harm measures to survey 15 year old pupils and demonstrated around 1 in every 5 pupils surveyed had self-harmed which the study posited as an increase from previous years (Brooks et al. 2017; 2020). There was a male to female self-harm ratio of around 1:3, i.e. 11% of males to 32% of females who reported they had ever self-harmed. Over half of the male pupils self-harmed once a month as well as over a third of the female pupils. In the 2018 survey there was an increase in self-harm, as 1 in 4 pupils surveyed had self-harmed (Brooks et al. 2020), and the male to female self-harm ratio had altered to around 1:2, i.e. 16% of males to 35% females who reported they had self-harmed.

Hence school-based surveys with pupils upon adolescent self-harm can give valuable information. However one possible restriction in a school survey research method for adolescent self-harm is that the information they can gather might be limited, such as through being restricted by the questions contained within the survey. Furthermore pupils might not be involved in their design, such as through initial participatory qualitative research work to develop relevant question content for pupils, to ensure that

key information about adolescent self-harm is not missing. For example, within this PhD study critical and specific information was gained from pupils with lived experience of self-harm regarding: the location and method of pupils' attempted suicide (2 male pupils use of a high bridge close to the school grounds) and suicide (a woodland close to the school grounds, where a female pupil's death by suicide occurred due to hanging); the everyday school item that was used in school for self-harm (a pencil sharpener and its blade); what location in school the self-harm took place (the school toilet). If this information from pupils is compared to the school survey questions in *Table 8*, there are no questions regarding the physical location of where the pupil was when their self-harm took place, the questions might also not capture the specific item that a pupil used for self injuring themselves nor the lethality risk. The school survey adolescent self-harm questions also do not include the risk trajectory relationship between self-harm and suicide, hence pupils' suicide attempts might not be captured and information pupils held about other pupils' death by suicide would be excluded. These are some examples why initial exploratory qualitative research in partnership with pupils in schools can inform adolescent self-harm school survey questions for subsequent larger scale school-based research to take place, to help improve the research quality in the public health surveillance of adolescent self-harm within community samples for preventive intervention purposes.

Table 8: Adolescent self-harm school survey questions

SELF-HARM SCHOOL SURVEY QUESTIONS IN THE EMOTIONAL HEALTH AND WELL-BEING SURVEY, 2015	SELF-HARM SCHOOL SURVEY QUESTIONS IN THE HEALTH BEHAVIOUR IN SCHOOL-AGED CHILDREN SURVEY, 2014
1. "Have you ever self-harmed or deliberately taken an overdose?" Response options: yes; no.	1. "Have you ever deliberately hurt yourself in some way, such as cut or hit yourself on purpose or taken an overdose?" Response options: yes; no.
2. "Have you ever self-harmed?" Response options: never; not often (e.g. once or twice); sometimes (e.g. monthly); quite often (e.g. weekly); most days.	2. "How often do you self-harm?" Response options: every day; several times a week; once a week; a few times a month; once a month; several times a year.
3. "When did you last self-harm?" Response options: in the last week; in the last month; in the past 3-6 months; 6 months to a year ago; over a year ago.	
4. "Have you ever deliberately taken an overdose (e.g. of pills or other medication)?" Response options: never; yes – once; yes - on more than one occasion.	
5. "When did you last take an overdose?" Response options: in the last week; in the last month; in the past 3-6 months; 6 months to a year ago; over a year ago.	
6. "In what way did you self-harm/ overdose?" Response options: free text.	
7. "Have you ever needed any medical treatment for your self-harm injury/overdose from?" Response options: my own first aid; family provided first aid; school nurse/first aid at school; friends helped me; GP (family doctor); hospital A&E; hospital without overnight stay; other.	

SOURCE Geuyalov et al. 2018, supplementary appendix, p.2

SOURCE: Brooks 2017, p.20

2.4.2 The Positioning Of The School Context Within Recent Developments In Multilevel Adolescent Self-harm Preventive Intervention

School is now a key context targeted in the public health multilevel model approach within the recent self-harm NICE practice guidance (2022a), establishing a duty of care for schools to help access and provide support for their pupils who may be experiencing adolescent self-harm needs, for example through facilitating these pupils to gain psychosocial assessment and care planning (*see Table 9 below*). School staff are specifically named within this guidance as "non-specialist staff" (NICE 2022a, p.64) who are to help provide support (*see Table 10*). The incorporation of the school context as an important community support setting for adolescent self-harm, with new responsibilities and duties present, is a fundamental shift in regards to previous self-harm health guidance which was limited to healthcare and clinical services support settings. Furthermore, government policy guidance in Wales has been issued (Welsh Government 2019a; Welsh Government 2021a) which also posits secondary schools in Wales as community-based support sites for pupils' health needs in regards to self-harm. In Wales these developments are embedded within a wider radical reform of schools to apply a whole school environment approach to promote pupils' emotional health and well-being (Welsh Government 2021a), an approach which utilises the physical and socio-cultural environment of school for pupils' health promotion (Bonell et al. 2013). This multilevel approach has been found to have small beneficial health impacts upon some health outcomes (such as physical fitness and tobacco usage), showing some promise for universal public health interventions but the research quality evidence including the range of health interventions needs to be much improved (Bonell et al. 2013; Langford et al. 2014).

Table 9: Schools' responsibilities & duties in regards to their pupils' adolescent self-harm care & support needs, as outlined within adolescent self-harm healthcare policy guidance

Educational settings should have policies and procedures for staff to support students who self-harm.	These should include: • how to identify self-harm behaviours; • how to assess the needs of students; • what do to if they suspect a student is self-harming; • how to support the student's close friends and peer group.
Educational settings should have a designated lead.	The designated lead is responsible for: • ensuring that self-harm policies and procedures are implemented; • ensuring that self-harm policies and procedures are regularly reviewed and kept up-to-date in line with current national guidance; • ensuring that staff are aware of the self-harm policies and procedures and understand how to implement them; • supporting staff with implementation if there are any uncertainties.
All educational staff should understand the school policies and procedures in regards to supporting students who self-harm.	Educational staff should: • be aware of the policies and procedures for identifying and assessing the needs of students who self-harm; • know how to implement the policies and procedures within their roles and responsibilities • know who to go to for support and supervision.
For students who have self-harmed, the designated lead should seek the advice of mental health professionals to develop a support plan with the student and their family members and carers (as appropriate) for when they are in the educational setting.	This should include guidance from other agencies involved in the person's care, as appropriate.
Educational staff should take into account how the student's self-harm may affect their close friends and peer groups.	Educational staff should provide appropriate support to reduce the distress to the person, their close friends and peer groups.

SOURCE: NICE 2022a, p. 28

Table 10: School staff's care duties in regards to their pupils with self-harm needs

When a pupil with self-harm needs presents to a member of school staff such as a teacher, the school-based professional should ascertain the following points as quickly as possible:
The severity of the injury and how urgently medical treatment is needed.
The person's emotional and mental state, and level of distress.
Whether there is immediate concern about the person's safety.
Whether there are any safeguarding concerns.
Whether the person has a care plan.
If there is a need to refer the person to a specialist mental health service for assessment.

SOURCE: NICE 2022a, p.21

Schools in England and Wales may be accessible and positive contexts to help deliver this type of community-based adolescent self-harm support, which adolescent self-harm and suicide prevention research perceives their potential in providing (Hawton et al. 2002; Wasserman et al. 2015; Geulayov et al. 2022b). For example, research posits that trained school staff could supply a key support role in pupils' self-harm needs which may come to light within the community school context (Evans et al. 2019; Robinson & Clarke 2019; Nawaz et al. 2023), due to staff's daily proximity with their pupils, their knowledge of their pupils stemming from the relational nature of the school setting, and staff's duty of well-being and care for their pupils through the school safeguarding protocols. The immediacy of this school-based support access approach could also mean that the risk to pupils and school staff (who have made a pupil referral to CAMHS) of being placed in a support limbo whilst awaiting CAMHS access is minimised, as this can be a situation which arises due to the high admission thresholds and long wait lists in CAMHS (Evans et al. 2019; Robinson & Clarke 2019) as well as other CAMHS factors as outlined previously in this chapter.

However, research highlights how the influence of school system-level factors may not be fully recognised. The impact of these factors, together with their variability, can be undervalued in respect of pupils' health and well-being (Bonell et al. 2013; Langford et al. 2014; Evans & Hurrell 2016; Littlecott et al. 2019). Evans and Hurrell's systematic review and meta-ethnography of qualitative research (2016) drew attention to the

research gap regarding the institutional-level factors in schools upon adolescent self-harm and in theorising the causal mechanisms in the school context that impact pupils' health outcomes. To address this gap they called for the use of qualitative research in order to generate quality constructs and explain their relationships through theory development. Consequently, understanding and developing theory regarding the influence of the school context upon adolescent self-harm is an important component to incorporate within school-based adolescent self-harm preventive intervention research.

The NICE self-harm guidance highlights how historically there have been challenges in the assessment and support of self-harm within non-specialist settings such as schools, with individuals who present with their self-harm needs to professionals in these settings having negative experiences (NICE 2022c). Hence the recent NICE guidance aims to train professionals in the school setting, who the guidance terms "non-specialist staff" (NICE 2022a, p.64) and differentiates them from "specialist mental health professionals" (*ibid.*), in how to provide quality support through its self-harm policy and practice guidance which is to be the routine approach in non-specialist settings such as schools, with the goal being health outcomes improvements for self-harm population groups within these types of settings (NICE 2022ab). In the rationale for providing the guidance, the NICE guidance (2022a) states that "the committee agreed that formal policies and procedures and a designated lead on self-harm would ensure educational staff would be equipped with appropriate means to respond to self-harm and be supported in their decision making, boosting staff confidence and competence, and improving the quality of care of children and young adults who have self-harmed" (p.64). This multilevel adolescent self-harm intervention designed for use within the school context consists of multiple new components that are to interact together within the school context, some examples of which include: school self-harm policy development; staff training and supervision; school staff working directly within pupils' self-harm care and support needs; engaging pupils and their families/carers within this recent support framework; also working closely with community multi-agency support services as part of the support frameworks. As such it is a complex system intervention (Moore et al. 2015a) to help improve the health support for adolescent self-harm from within a key youth community setting.

This system-level approach informed by public health socio-ecological theory to elicit quality health support for pupils, which also includes the use of standardised protocols that are to be implemented within each school, might lead to these types of improvements but currently the research evidence base is lacking. A recent international-based systematic review of the empirical evidence regarding school policy and training interventions for adolescent self-harm in schools found only 8 studies that met the systematic review criteria quality criteria, which included a pre and post test study design (Pierret et al. 2022). 3 of these studies were based in Australia (Robinson et al. 2008; Berger et al. 2015; Townsend et al. 2018), 3 were in the USA (Dorko 2010; Price 2015; Glennon et al. 2020), 1 was in Germany (Groschwitz et al. 2017) and 1 in the UK (Lee 2016). Community, regional and country-level variation occur in schools which may lead to key school socio-cultural differences, so a study in an educational setting within Australia or the USA may not be able to be replicated in a UK school setting due to different systems, support and resource frameworks in each of these countries, which is why drawing upon UK-based school research studies is important. The 1 study in the systematic review that was based in the UK (Lee 2016) centred upon the training of 10 pastoral school staff in 1 school with self-report outcomes measures, hence this UK study was limited due to its sample size and use of non validated outcomes.

The UK research evidence to draw upon for the recent NICE guidance (2022a) system-level approach is therefore sparse and of low quality. The systematic review (Pierret et al. 2022) highlighted the need for this type of approach to be tailored to each school within its linked system support services. Another need would be for the design and delivery of long term assessment and monitoring frameworks in order to provide the quality evidence and demonstrate the outcomes as stated in the NICE guidance (2022a). Prior self-harm and suicide prevention research has highlighted potential structural barriers that may be present in schools which arise from firmly established management practices in regards to self-harm and limited school resources, as well as quality issues in regards to the efficacy of staff training as an intervention approach (Evans et al. 2019). In an international large scale school-based suicide prevention RCT empirical evidence study in 11 European countries (which included schools in Ireland but not England or Wales), school staff gatekeeper training in recognising pupils' suicide

risk and supporting pupils to access help had no efficacy (Wasserman et al. 2015). School staff's concerns, lack of confidence and fears regarding working with adolescent self-harm within their school setting is also captured in research (Berger et al. 2014; Evans & Hurrell 2016; Evans et al. 2019). Hence given that the UK school intervention evidence quality for the NICE guidance (2022a) is very low, there is the need for significant improvement such as through conducting rigorous and large scale UK school-based research studies.

At the same time there is also a need to complete research that explores the differing contextual and wider system factors regarding schools, such as community, national and also country-level educational, health and social care frameworks and resources that are likely to influence a school setting and the implementation of the adolescent self-harm interventions that are proposed within the NICE guidance (2022a). Implementation science demonstrates that understanding the context within any new health intervention that is to be deployed within a real world context is of paramount importance (May et al. 2016). For example to help understand and support its successful translation into the organisational practice, but also to assess any unintended consequences as well as the context-based implementation barriers and facilitators. The recent NICE guidance (2022a) acknowledges that its implementation will be dependent upon how much change will need to take place within a setting, with the potential need for considerable resources and time in some settings if prior guidance has not been followed to support its implementation. Given schools' role as a community-based self-harm assessment, support and care planning site was not previously part of the prior NICE self-harm guidance, schools will therefore need to be given these considerable resources and time, and there will also be the need to understand, monitor and assess what resources are needed in schools as is usual within the implementation of any new health outcomes practices (Gagliardi et al.2011; Eisman et al. 2021).

Translating health and social care setting practices that are deemed routine in health and social care settings across to an educational setting may present some implementation issues that will require new systems and resources within the school context. One example is the practice of supervision as outlined within the NICE

guidance (2022a). Quality supervision is to take place to support the skills and training of non-specialist staff in educational settings to work with pupils' self-harm to achieve health and care support goals. This may be a new approach for schools (Bainbridge et al. 2022) as it differs from teaching supervision due to the outcome goals and the adolescent self-harm expertise required to deliver this type of supervision to non-specialist school staff, as well as there being new and increased demands and accountability upon schools to meet the new self-harm health and care outcomes which in the prior guidance was limited to health settings. Prior research with school staff from 59 secondary schools in the South of England and 84 in Wales has demonstrated that non-specialist school staff referred pupils' self-harm needs to specialists and did not work directly with pupils' self-harm needs (Evans et al. 2019), so implementing the recent practice guidance and its role of non-specialists (NICE 2022a) would mean a major cultural shift from the modus operandi in schools – it is likely that extensive resources will be required to support the school-context adolescent self-harm support transformation.

Therefore, just like any healthcare setting, an educational setting is a dynamic and active context within a linked system (May et al. 2016). Hence the implementation of any new adolescent self-harm preventive intervention support is a complex process. Some key factors that help to support a successful implementation process include its evaluation and monitoring, but alongside these the engagement of key stakeholders from within the proposed intervention context (as well as in the wider linked system) is of critical importance (Oh et al. 2021), particularly that of pupils who have lived experience of adolescent self-harm. If potential barriers are not assessed with the relevant stakeholders, and if their perspectives have not been included in the preventive intervention support design, such as in regards to the acceptability and feasibility of the proposed intervention or the resources needed to support its delivery in schools (Evans et al. 2019; Robinson & Clarke 2019), there can be a real risk with practice guidelines that they are not implemented or used within settings (Fischer et al. 2016), also that they will not be fit for purpose within the school context and that the support access barriers for pupils remain unaddressed. This is also why, within population and medical health intervention research guidance, understanding the context of the implementation is deemed a central factor, in order to map any contextual factors that may act as key

mechanisms within preventive intervention research design and the implementation process (Moore et al. 2015ab; Craig et al. 2018; Skivington et al. 2021). There is exactly the same need for the complex health interventions that are designed to take place within the school context, such as those for adolescent self-harm.

Hence although schools in England and Wales are now strongly positioned in their new role to help achieve quality improvements in adolescents self-harm care and support (NICE 2022a), the research evidence base for adolescent preventive intervention within the school context is limited. As previously noted, Evans (et al. 2019) raised the problems in the evidence-base for staff training as well as the quality of the training provision, also Pierret (et al. 2022) has highlighted the scant quantity and quality of the research evidence base regarding a school policy and staff training approach as a school-based self-harm support intervention. But Evans (et al. 2019) also discussed the need for school-context-based research in order to support the UK adolescent self-harm preventive intervention evidence base given its serious limitations. Similarly Pierret (et al. 2022) raised the critical point of the significant evidence-base and support challenges that stemmed from their results' finding of the limited research quality upon school-based pupil support interventions that work directly with pupils for adolescent self-harm. This limited research quality finding is mirrored in a systematic review of empirical quantitative research studies upon direct pupil support interventions in schools, colleges, universities in the UK and international settings (Nawaz et al. 2023). Out of 4254 research studies only six studies (Muehlenkamp et al. 2010; Stallard et al. 2013a; Fukumori et al. 2017; Roberts et al. 2019; Baetens et al. 2020; Argento et al. 2022) that provided inferential statistics regarding their results' findings met the systematic review eligibility criteria, which included each study needing to: be upon a self-harm intervention; have self-harm outcome measures; have taken place in an educational setting; and have undergone peer review. The studies were evaluated through a validated public health quantitative appraisal measure for bias risk (i.e. the Effective Public Health Project Practice Quality Assessment Tool for Quantitative Studies, in Armijo-Olivo et al. 2012), as bias represents the presence of systematic errors that negatively impact the validity of research findings. This problem of bias is a significant issue when larger scale studies are taken forward from earlier studies where bias was present but had not been rigorously evaluated (such as through a validated

measure for risk of bias), leading to replicability failure (National Academies of Sciences, Engineering and Medicine et al. 2019). Stallard (et al. 2013a) and Roberts (et al. 2019) were the only two studies based in the UK (England) and centred upon the secondary school context.

Stallard's (et al. 2013a) CBT classroom-based research study in UK secondary schools was the only study assessed as being of moderate quality (the rest were assessed as weak). Its primary outcomes measure was a reduction in the symptoms of depression in groups of pupils that were deemed "high risk" due to their elevated low mood symptoms. Reduction in self-harm was a secondary outcome measure due to the risk correlation between depression, anxiety and self-harm (Hawton et al. 2012a) and also to account for potential group differences within the CBT classroom intervention. This trial demonstrated no efficacy for self-harm thoughts or behaviours, as at six months there was no decrease in comparison with the control group which utilised a PSHE programme. More details and analysis are also needed regarding this study's finding from its subgroup analysis of the potential iatrogenic impact it reported upon the high risk group of participants who also had reported they self-harmed (Stallard et al. 2013a, p. 22) as few details are given in the study regarding this point. Given the potential iatrogenic impacts for the self-harm group, the study drew attention to UK research (Sayal et al. 2010) that has found iatrogenic impacts in school-based programmes for pupils with ADHD needs, with their outcomes getting worse after the intervention in comparison to the control group. The study by Sayal (et al. 2010), which was focused upon younger aged pupils in UK primary schools and not secondary schools as in Stallard (et al. 2013a), posited that this effect of the increased risk of negative outcomes could stem from negative labelling taking place in the school context, which the study thought may lead to school staff treating these pupils differently to other pupils.

Roberts (et al. 2019) study upon an eight week small group programme, which included three one-to-one sessions as well as a self-harm screening survey, reduced the self-harm thoughts in pupils who initially had disclosed these at the start of the study by 67%. As there was no follow up data, and also due to its risk of bias, further research investigation that incorporated methodological improvements for validity proposes would be needed. The community-based screening survey identified high numbers of pupils at

risk of self-harm or where self-harming behaviours were already taking place (18.6% of adolescents aged 13 to 17 years who completed the screening assessment, that of 1573 students out of a total of 8440), which this study stated was a surprising finding, although it is well documented in research regarding the potential high numbers of adolescents who self-harm within the community but who are not known to health or support services (Hawton et al. 2012a; Geulayov et al. 2018). However a strength of Roberts (et al. 2019) study is that it makes a valuable contribution to the community-based surveillance of adolescent self-harm, which could be completed on a much larger scale through the use of the study's screening survey within the UK school context. A concern to raise regarding this study's programme is that around a quarter of the adolescents stated an increase in self-harm thoughts after the programme, and the study did not give any details regarding their assessment and management of any potential iatrogenic impacts within the intervention (apart from the use of initial screening to assess the suitability of the programme for the pupil). This point warrants further consideration and investigation, as the study itself states, "it is notable that a sizeable minority of young people deteriorated during the course of the programme, and more exploration of the factors that may have contributed to their deterioration is needed" (p.19).

2.4.3 Adolescent Self-harm Preventive Intervention Research Within The School Context & Managing The Risk Of Iatrogenic Impacts Upon Pupils

One context-based factor to explore in regards to any school-context adolescent self-harm preventive interventions that are proposed as direct interventions with pupils is the potential iatrogenic impacts (Evans et al. 2019), such as the risk of harm from social contagion. Research centred upon clinical, institutional medical and community settings (Nock & Prinstein 2004; Jarvi et al. 2013; Walsh 2014) has demonstrated the potential for multifaceted causal pathways to the social contagion aspect of adolescent self-harm within these contexts. There is a limited quality of research that demonstrates a risk of social contagion for adolescent self-harm in community-based population groups (Jarvi et al. 2013; Heilbron et al. 2014). In the research it is posited that social contagion occurs because peers select other peers who are similar to them, but also through a socialization process of internalising peer-group norms and behaviours which increases

the risk of similar behaviours occurring within the peer-group such as self-harm (Jarvi et al. 2013; Heilbron et al. 2014). Further rigorous community-based research studies upon the UK school context are required for more details regarding the potential mechanisms of social contagion within this community context, as they may be complex with multiple factors for different pupil groups, including both the positive and negative role of social media (Lewis et al. 2011; House et al. 2020; Susi et al. 2023), and also to explore the risk and protective factors within the school context. For example, an international research study (Wester et al. 2018) posits a multilevel socio-ecological preventive intervention approach with its universal, selective and indicative modelling (*as outlined in Section 2.3.2*) to be implemented for adolescent self-harm within the school context, and that within this approach schools can also directly target the risk of social contagion for the potential spectrum of need that exists within the pupil population group.

There also appears to be a very limited UK research evidence base to draw upon regarding the potential iatrogenic effects for pupils involved in school-context adolescent self-harm preventive intervention research. This point can be contextualised within the wider research issues of the limited number of studies where potential research participation risks are included as a self-harm research outcome measure (Biddle et al. 2012; Muehlenkamp et al. 2015). Hence due to this sparsity, one very small potential UK source is Stallard's (et al. 2013a) CBT classroom-based research study in UK secondary schools (*as outlined in Section 2.4.2)*, where reduction in self-harm was a secondary outcome measure. Given one unintended consequence found in this study was the potential iatrogenic impact upon the "high risk" group of participants who had elevated low mood symptoms and who had also reported they self-harmed, this dimension of low mood symptoms and the risks here for pupils warrant further research investigation for UK school-context adolescent self-harm preventive intervention research. Specifically in regards to monitoring pupils' emotional mood and reactions in order to manage the potential risks. There is therefore a need for a particular consideration of the risks for pupils involved in a research study who self-report as part of the study that they have self-harmed, but also in regards to the risks for pupils who may self-harm but choose to not to disclose their self-harm behaviour within a research study.

In a UK study by Biddle (et al. 2012), participants' emotional mood and reactions within qualitative self-harm research were targeted, in order to understand their research participation experiences. For the purpose of UK adolescent self-harm research in secondary schools with pupils and understanding the potential iatrogenic impacts, one important set of data within the study by Biddle (et al. 2012) was drawn from a contributing qualitative adolescent self-harm research study by Klineberg (et al. 2013). This contributing study's community-based sample was 20 secondary school pupils aged 15 to 16 years who had reported they had self-harmed within this study's pupil screening questionnaire (Klineberg, 2010 p.359). Exploring the impact of these pupils' qualitative adolescent self-harm research participation upon their emotional state, 2 pupils demonstrated no change, 14 pupils demonstrated an improvement, but for 4 pupils there was a deterioration. However in their study's conclusions, Biddle (et al. 2012) stated that the participants' perspectives upon their own mood deterioration was that it would be short-lived, and also that participating in self-harm research to elicit positive changes for the population group needs was deemed as being an important protective factor. This study recommended targeting participant distress as a critical factor to support participants within qualitative self-harm research and address potential risks, but also to explore the potential longer-term emotional mood impacts of qualitative self-harm research participation. A further important point that may be drawn from this study is to undertake self-harm research that can facilitate the perspectives of the research sample population and their views upon the potential research participation risks for them, what they want to take forward in regards to this issue, what needs they might have, what resources they would like to have in place, to inform future self-harm research. This is a much more partnership-based approach, which could help to balance the potential power dynamics that can occur when people with authority take decisions on behalf of other people, without consulting them or understanding what they think about a situation. Given also that participation may elicit positive changes, Biddle (et al. 2012) highlighted that "overprotective gate-keeping could prevent some individuals gaining these benefits" (p.356).

2 international school-based adolescent self-harm preventive intervention research studies have considered the iatrogenic impacts upon pupils, in regards to the Signs of Self-Injury (SOSI) programme (Muehlenkamp et al. 2010) and the HappylesPLUS

programme (Baetens et al. 2020). SOSI was a 50 minute classroom-based programme that provided basic adolescent self-harm health information to pupils, and also aimed to facilitate pupils' help-seeking, as part of the training programme included help prompts for pupils (through facilitating a self-assessment of pupils' own support needs and in them making help requests, both of which were confidential).The pilot study by Muehlenkamp (et al. 2010) with 274 pupils (average age 16 years, 141 females, 133 males) in 5 schools in the USA also included a pre and post survey that utilised the Self-Injurious Thoughts and Behaviours Inventory (Nock et al. 2007). This enabled the intensity and frequency of self-harm thoughts and behaviours to be evaluated to assess any changes in these as a result of the programme. The study found no iatrogenic impacts, and also a decrease in self-reported adolescent self-harm thoughts and behaviours.

In the pilot study by Baetens (et al. 2020) in 6 schools in Belgium, 651 pupils (average age 13 years, 324 females, 327 males) were split into 2 groups. Both groups received general mental health and well-being training (the Happyles programme). However 1 group also received additional training in regards to adolescent self-harm (HappylesPlus), which incorporated an emotional regulation activity as a risk management strategy to help pupils' manage any strong emotions and emotional distress that might take place in regards to the specific adolescent self-harm training. A pre and post survey was also administered to all pupils, which utilised the Brief Non-Suicidal Self-Injury Assessment Tool (NSSI-AT) (Whitlock et al. 2014) to assess and evaluate any changes in self-reported self-harm, also the Difficulties in Emotion Regulation Scale (DERS) (Gratz & Roemer 2004). In addition qualitative interviews took place to gain pupils' feedback on their experience of the intervention they had participated in (i.e. Happyles or HappylesPlus). For both groups the study found no iatrogenic impacts in regards to the frequency of pupils' self-reported adolescent self-harm thoughts and behaviours. As posited by the study, the adolescent self-harm training (which included a documentary and a guided discussion) did provoke strong emotions in many pupils, which the qualitative interviews captured, demonstrating a range of positive and negative strong emotional reactions being present within pupils' participation experiences. Further research is warranted to explore this point further, specifically in regards to the potential protective factors and iatrogenic risks here for

pupils. For example, in regards to the emotional regulation activity that was utilised to help manage the risk of strong emotions, pre and post test data could be captured that is directly centred upon this activity so that more detailed data could be gained to assess its efficacy and protective factors. There may also be important differences for pupils who are older, and for pupils who have prior lived experience of adolescent self-harm. Additionally, the emotional regulation activity could have a wider application within adolescent self-harm research with pupils as a potential protective factor, such as in helping to manage the risks that stem from strong emotions and emotional distress that the research topic can evoke, if these are of a transient nature as the study by Biddle (et al. 2012) has demonstrated.

More recent research (Hasking et al. 2019) has offered ethical considerations and guidelines for conducting adolescent self-harm research in schools in Canada, New Zealand and Australia. The IACAPAP Task Force (established by the World Health Organization for youth self-harm and suicide prevention) recommended completing research upon providing an adolescent self-harm health topic in schools as a whole school health topic, and to work in partnership with pupils and staff to understand their perceptions about this school-based health education support provision (Hoven et al. 2013). A Lancet Psychiatry editorial has also recommended that a health discourse takes place about adolescent self-harm with young people but to address any risks of normalising self-harm within this health discourse (McManus et al. 2019). These research recommendations underpinned the PhD study which aimed to make a contribution towards helping to address the research gap, in order to deliver school context-based information regarding conducting adolescent self-harm health topic research in schools in Wales safely, for preventive intervention support design purposes.

Therefore Nawaz (et al. 2023) highlights the current evidence challenges and need for significant methodological and theoretical improvements in preventive intervention research that centres upon direct work with pupils regarding adolescent self-harm in schools, recommending that "experts in the field of self-harm should refer to the MRC complex intervention framework and produce a consensus on appropriate methods and measures to study self-harm to decrease the heterogeneity among studies and to

produce higher quality evidence" (p.12). However alongside this recommendation by Nawaz (et al. 2023) there is also an imperative to understand, assess and manage any potential iatrogenic pupil impacts prior to this type of direct pupil intervention in schools. This type of research has begun to be called for in regards to school-based mental health interventions due to an emerging body of research that demonstrates their iatrogenic impacts upon some groups of pupils (Foulkes & Stringaris 2023). Given the limitations in the research evidence base for adolescent self-harm, assessing and managing the risk of the potential iatrogenic effects for pupils involved in this type of adolescent self-harm research is warranted. This is a critical point which informed the design of the PhD study (more details are given within the methods chapter).

2.4.4 Empowering Pupils' Participation In Adolescent Self-harm Preventive Intervention Research Within The School Context

The need for research centred upon the school context within adolescent self-harm preventive intervention also raises the need to include pupils within this research. This includes the use of additional research approaches alongside population-level research methods (John et al. 2020), such as in qualitative research drawn from lived experiences of adolescent self-harm (Hawton et al. 2015b; Lewis & Hasking 2019; Witt et al. 2021; Willis-Powell et al. 2022). For adolescents there may be specific individual, interpersonal and community-level barriers in regards to gaining access to health services (WHO 2015ab) due to their unique needs. Some examples include: there are limitations in adolescent health literacy which mean they may not access health support for their needs; there may be restrictions that stem from dependency and privacy issues which mean adolescents may not be able to arrange their own independent access to health services; any absence from school must be an authorised absence which means pupils cannot leave school for a healthcare appointment during a school day without it being known to others; health needs that impact adolescents can be extremely stigmatised at a community-level, which could act as a deterrence for health services access (WHO 2015a). These health service support barriers may be present as explanatory factors within adolescent self-harm and suicide data (*such as in Tables 5 and 6)* although this is not known, hence qualitative research with pupils upon these points is warranted, with the school context having strong potential to complete this type

of qualitative research upon these issues, for example due to the accessibility to potential research participants within a community context where the majority of adolescents are present for long periods of time. Furthermore qualitative research in regards to pupils' perspectives upon the acceptability and feasibility of any adolescent self-harm support proposed within their school context is also warranted, like the recent NICE practice guidance (2022abcd). Specific to Wales, pupils' participation is empowered through Welsh policy frameworks. These include the Social Services and Well-being (Wales) Act 2014, which aims to strengthen people's ability to participate and their views to be incorporated in service support design to meet their specific needs, and also the 2011 Rights of Children and Young Persons (Wales) Measure, where children, adolescents and young adults in Wales have a right to be heard, and their views to be taken into consideration, upon any healthcare matters that affect them.

The NICE (2022a) intervention is for standardised school-based adolescent self-harm support through the supervision, training and education of all school staff, as well in the development of school policy frameworks for adolescent self-harm linked within the wider school support system. It is therefore an indirect intervention for pupils' self-harm needs, as it is targeted to school staff. Given the issue that has previously been noted in this chapter that the greater majority of adolescents who self-harm do not access health services or support, this may be a similar issue within the school context. Also there may be specific pupil support access barriers that are as yet unmapped, as well as the quality of the evidence-base for this type of support intervention being limited (*as demonstrated in Section 2.4.2*). Furthermore, gathering research evidence regarding the acceptability and feasibility of this proposed intervention from the majority group of stakeholders in schools, which is that of pupils, is likely to be critical. This mirrors the call from the two Cochrane Reviews (Hawton et al. 2015b; Witt et al. 2021) in regards to the need to design new adolescent self-harm interventions in partnership with adolescents who are to use this proposed support.

School-based surveys are one method that can be used to explore what types of support pupils use or don't use, what support is acceptable and feasible to pupils, as well as potential school-context support barriers and facilitators, as demonstrated within Geulayov's (et al. 2022b) large-scale school survey of 10,560 secondary school pupils

in the south of England. This study showed that in the pupil sample who had self-harmed (12.5% of pupils reported they had self-harmed during their lifetime) over a third of these pupils did not access any support at all, either formal (i.e. health services) or informal (friends, family members, carers). The help-seeking and support barriers that pupils gave included: not wishing to be a burden; fears about the negative opinions of others; concerns regarding potential confidentiality breaches; not knowing how or where to get support; and the issue of adolescent self-harm stigma with pupils not wanting to be in receipt of this.

These potential pupil help-seeking and support barriers captured from survey-data in England warrant similar investigation in Wales, including qualitative research centred upon the school context. For example, as previously highlighted, public health services acknowledges stigma to be a major problem for self-harm and one factor that contributes to why self-harm is a current and serious public health issue (OHID (2023a). In addition to Geulayov's (et al. 2022b) large-scale school survey, pupils' stigma concerns have been captured in prior school survey-based adolescent self-harm research in England (Fortune et al. 2008a). However a recent systematic review demonstrates the limited school-context research with pupils upon this topic (Waller et al. 2023). Given pupils' stigma concerns are present in school-based research and that these act as a health support barrier within pupils' adolescent self-harm, further in-depth research and analysis is needed to unpack the full nature of the concept of stigma in the UK secondary school context.

2.4.5   *The Development Of Multilevel Stigma Theory Modelling For Adolescent Self-harm Preventive Intervention Research In The School Context*

Stigma is a critical issue for self-harm and suicide preventive intervention that is well recognised in public health organisations (WHO 2012a; 2015; 2018; NICE 2022ade; OHID 2023a). This is due to the risks that stem from stigma in regards to very negative impacts upon an individual's health and the quality of support provision, but also that stem from its characteristics of pervasiveness and entrenchment at a whole system level (Hatzenbuehler et al. 2013; Major et al. 2018). Stigma is a risk factor within the social determinants of health, where structural level conditions such as societal and

cultural values influence the daily life and psychosocial conditions of specific population groups, which may engender health inequalities (i.e. the unfair, avoidable differences and variations in health) for specific population groups (Galobardes et al. 2013; Hatzenbuehler et al. 2013). In the context of health inequalities, understanding and addressing stigma is therefore an important consideration within public health (Faculty of Public Health 2023). Furthermore, the critical issues delineated within this chapter (including stigma) demonstrate that adolescent self-harm is a serious public health concern, a point which illustrates the risk of health inequalities being present in regards to adolescent self-harm and adolescent health needs.

From a socio-ecological system-level perspective, stigma can exist at an individual level, an interpersonal level, and also at a structural level (Hatzenbuehler 2016; 2017). The theoretical modelling of stigma draws upon the seminal work of the sociologist Goffman who conceptualised stigma from within a sociocultural lens (Goffman 1963). His social theorising upon stigma incorporated both the individual and interpersonal level, of the person who is stigmatised and the person who stigmatises, of the individual-level internalisation of the stigmatising societal norms and values, and the societal disqualification processes of social exclusion (Goffman 1963; Sheehan et al.2022).

Within the context of mental health, three important conceptual models of stigma are that of self-stigma, public stigma and structural stigma (Corrigan et al. 2005; Sheehan et al. 2022). In self-stigma (Corrigan & Watson 2002; Rüsch et al. 2005), which exists at the individual level, the stigmatising societal norms and values that are situated upon mental ill health are internalised by an individual with mental health needs. Individual-level negative impacts can be shame, depression and a lack of help-seeking. Public stigma (Corrigan & Watson 2002; 2005; Rüsch et al. 2005; Bos et al. 2013), which exists at the interpersonal level as it is situated within the general public, involves stereotyping (i.e. negative beliefs are held about mental illness), prejudice (i.e. negative emotional reactions occur that stem from the negative beliefs) and discrimination (i.e. the behavioural response to the prejudice). These risk taking place within the general public in their interactions and relations with others who have mental health needs. At the interpersonal level, stigmatising societal norms and values about mental health

inform the stereotyping, prejudice and discrimination. In structural stigma (Hatzenbuehler & Link 2014; Hatzenbuehler 2016; 2017), the stigma exists at the socio-cultural and wider societal level. For example, as within the socio-cultural characteristics of an institutional setting, its organisational norms and practices, which may also be influenced by larger societal factors such as health or educational policies and resources that could contribute to health inequalities for specific population groups. Hence for a specific population group within a specific context, these issues risk delivering structural stigma.

Stigma research has been critiqued for its research focus and level of inquiry being at the micro-level at the expense of a wider socio-cultural system-level approach (Hatzenbuehler 2016). Link and Phelan (2001) highlight that by focusing upon the individual-level in stigma research this can come at the expense of a focus upon the structural-level in stigma. By incorporating a structural-level stigma analysis of the socio-cultural conditions, institutional practices and norms, this offers a structural-level approach to address stigma, with the potential for a reframing of stigma as a responsibility to be addressed within the specific socio-cultural of an organisational context (such as the school) and at the institutional-level (Link and Phelan 2001).

For the purposes of adolescent self-harm research and stigma modelling that is informed by a public health multilevel preventive intervention approach *(as in Section 2.3.2)*, a multilevel socio-ecological research lens is warranted. This is due to the complex system-level dynamics and mechanisms that engender stigma (Link & Phelan 2001; Hatzenbuehler et al. 2013; Rao et al. 2019). A public health multilevel approach to stigma can incorporate all three models of mental health stigma, that of self-stigma, public stigma and structural stigma (Cook et al. 2014; Rao et al. 2019), as it is informed by the social-context-orientated public health model (McLeroy et al. 1988; Inman et al. 2011; Golden & Earp 2012). As previously outlined (*in Section 2.3.2),* this is a system-level approach that positions health and health outcomes as a consequence of multilevel factors, such as intrapersonal, interpersonal, organisational, community and public policy (Stokols 2000; National Cancer Institute and National Institutes of Health 2012).

Multilevel stigma intervention research is limited by the research challenges such as the complexity and increase in resources needed within multilevel stigma research, and also that key levels may be excluded from the research analysis, such as the institutional or community-level influences (Link & Phelan 2001; Hatzenbuehler 2016; Rao et al. 2019). However, given stigma is posited as a risk factor in health inequalities, a multilevel stigma analysis can incorporate the structural level conditions which engender stigma and shape the daily life and psychosocial conditions at individual and interpersonal level for specific population groups. This is why a multilevel approach to stigma is valuable as it can capture all three of these levels in its analysis, even though there are the aforementioned research challenges. For adolescent self-harm within the school context, there may be specific influences in the school socio-culture that stem from the institutional practices and norms in school, which can risk structural stigma being present and its negative impacts upon pupils' health and support needs for adolescent self-harm.

There is limited research upon stigma modelling for self-harm preventive intervention purposes which is why a call was made in 2021 (by Staniland et al.) for the use of theoretically grounded and multilevel stigma research for self-harm, in order to improve the research quality. Hence there has been little development of multilevel stigma modelling in order to to take this theorising forward for adolescent self-harm, such as in generating stigma theorising situated upon the school context. Theoretically grounded and multilevel self-harm research has also been called for in the systematic review by Evans and Hurrell (2016) (*as outlined previously in Section 2.4.2*) which centred upon understanding the institutional-level influences within the school context upon adolescent self-harm. This research recommendation was made in order to further understand the role of schools within adolescent self-harm, and also that qualitative research studies were needed to understand the institutional-level factors upon pupils' self-harm. The systematic review found that there were research limitations which had led to the influence of the school-context being under theorised. This presented a strong barrier for the development of theory within adolescent self-harm preventive intervention support, and in understanding the mechanisms within the school context. Hence this research recommendation by Evans and Hurrell may also be situated alongside the research call from that of Staniland (et al. 2021). Therefore, if exploring stigma in the

secondary school context for the purposes of adolescent self-harm preventive intervention, an institutional-level analysis is warranted to generate theory in order to understand the influence the socio-cultural conditions, institutional practices and norms.

There has been some initial research regarding stigma theory for adolescent self-harm centred upon the secondary school context in Wales. This took place within the recent small scale pilot study that I completed prior to this PhD. This study found that stigma was a predominant and institutional-level issue within the schools in Wales that took part in the study, leading to the design of a preliminary stigma model (Parker 2018a). This small-scale research project also stemmed from a prior adolescent self-harm school-based support study that I was part of which had surveyed staff in 148 secondary schools in the South of England and Wales, whose findings included that schools did very little preventive work or pupil health education about adolescent self-harm (Evans et al. 2019). Also my previous work as the lead CAMHS consultant in an adolescent self-harm complex intervention that was designed for use in secondary schools in a county in England (Parker 2015) demonstrated the urgent need for school-context research with key stakeholders (i.e. pupils, school staff, linked support system professionals, parents/carers) to generate and help improve the knowledge and evidence-base that could inform these types of whole system level complex interventions for adolescent self-harm (Parker 2015; Parker 2017ab). A key research recommendation from this project was to explore adolescent self-harm stigma in the school context and wider linked system within the county due to its potential barriers in this type of adolescent self-harm complex intervention and also due to stigma's potential role within perpetuating discrimination and health inequalities (Parker 2015).

Strengths of the initial small-scale grounded theory exploratory study (Parker 2018a) was in its use of a qualitative participatory research approach with staff and pupils who each had lived experience of adolescent self-harm, within two secondary schools in Wales that were purposefully sampled for variation. Consequently rich detail was elicited for the study's grounded theory analysis of the key issues that influenced adolescent self-harm within the school context. The study's limitation was in its small-scale nature, with research participants being only six pupils and six school staff in two secondary schools in Wales. However, given its research findings of institutional-level

stigma and the negative impacts it captured upon pupils' adolescent self-harm health support needs which risked discrimination, its key recommendation to complete larger scale research was justified. This recommendation included incorporating wider system-level perspectives from within organisations that were linked to the school context in Wales, for a larger scale multilevel analysis of the institutional-level factors that could have an impact upon adolescent self-harm in the secondary school context.

This PhD study aimed to make a significant contribution to this initial research recommendation. Given stigma could also risk implementation barriers for the NICE school-context complex intervention (2022a) as well as the adolescent self-harm school policy and support frameworks in Wales (Welsh Government 2019a; Welsh Government 2021a), there is the potential of the PhD study to deliver context-based information to aid this work in Wales. Furthermore, given the initial stigma model situated upon the school context (Parker 2018a) has now begun to be applied within adolescent self-harm research to aid stigma intervention design (Westers & Plener 2019; Staniland et al. 2021; Waller et al. 2023), these developments demonstrate the potential use of this type of model. It is therefore a promising new research direction, but further larger scale school system-level research is needed in England and Wales. For the purposes of theorising schools' influence upon adolescent self-harm, stigma may be a critical issue. For this PhD research project, where a grounded theory data analysis will take place for theory development, being attuned to stigma is therefore an important aspect.

2.5 Chapter Conclusion

This chapter has demonstrated some of the critical health and support issues that surround adolescent self-harm, including the challenges in its public health surveillance and preventive intervention support, all of which underpin why adolescent self-harm is a current and serious UK public health concern (Russell et al. 2021). Furthermore the research quality limitations and challenges have been consistently highlighted for a number of years (Hawton et al. 2002; 2012a; National Collaborating Centre for Mental Health 2012; Posner et al. 2014; Hawton et al. 2015ab; Borschmann & Kinner 2019; Townsend 2019; Witt et al. 2021). The recent positioning of the school within UK public

health services and Welsh policy frameworks as an important community support context for adolescent self-harm has been presented, which now delivers a directive that may help address some of these issues.

However, although UK schools are posited as having the potential to provide quality support for adolescent self-harm, emerging research upon schools in England and Wales demonstrates that there may be some challenges and barriers at present in achieving this community health support goal within the secondary school context (Parker 2015; Evans et al. 2016; Parker 2018a; Evans et al. 2019; Pierret et al. 2022). These challenges centre upon the research evidence base and the structural-level issues within schools . Therefore more research is needed with key stakeholders in schools, including the wider system that schools are part of, to understand and explore the school context further, to map and analyse any structural-level mechanisms or influences that need to be taken into account for adolescent self-harm preventive intervention support designed for use in schools. This is why completing research to generate theory that is situated upon understanding schools' influence upon adolescent self-harm is important for current preventive intervention support design, particularly when schools are positioned as a community-based focal point within this type of support. This thesis aimed to make a contribution to this work, centred upon the secondary school context in Wales and to theorise its influence upon the youth health issue of adolescent self-harm for preventive intervention purposes, in order to develop socio-culturally-informed theory drawn from this study's analysis of the research data from its key stakeholder groups of pupils, school staff and wider support network professionals in Wales.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter is a reflexively-informed summary (Malterud 2001; Breuer & Roth 2003; Attia & Edge 2017) of my project's research methodology and methods. It outlines the philosophical and theoretical foundations, and also the pragmatic research procedures that I chose in order to investigate the topic under study. Each of the chapter sections present a brief synopsis of the research design and rationale which underpinned the research investigation.

The chapter's starting point is an overview of the research aims. Factors influencing the project's ontology and epistemology are then discussed, the conclusions of which give rise to the methodological approach and methods sections. I then briefly outline the influence of my professional and personal experience. The next part of the chapter is concerned with the study's research ethics and leads on to the study recruitment. It is followed by a summary of the data analysis approach, and the chapter concludes with an overview of the study's results chapters. The aim of this chapter is for reflexivity upon my research choices to facilitate transparency and scrutiny. This enables my perspectives and their impact and limitations upon the construction of knowledge to be exposited, in order to address potential bias, and to demonstrate the research integrity of this project (Malterud 2001; Noble & Smith 2015).

3.2 The Research Aim & Questions

My aim was to theorise schools' influence on adolescent self-harm through undertaking a qualitative research study that utilised grounded theory for its analysis, centred upon

secondary schools in Wales. Four research questions (RQ) structured the inquiry, in order to generate theory regarding schools' influence upon adolescent self-harm:

- RQ1 – How do staff and students conceptualise adolescent self-harm (within their institutional setting)?

- RQ2 – What are the existing organisational management practices for adolescent self-harm?

- RQ3 – What do staff and students think are the institutional socio-cultural features in the school setting that influence adolescent self-harm (for example, what are the institutional norms, values and assumptions) ?

- RQ4 – What types of preventive intervention support[2] do staff and students think is viable within the secondary school context for adolescent self-harm?

This research project commenced in September 2017. The main purpose of the study was to make a contribution to adolescent self-harm preventive intervention through exploring the influence of the school context in pupils' self-harm.

As demonstrated in Chapter 2, since 2019 there have been significant developments in regards to schools in England and Wales being positioned as key support settings for adolescent self-harm. For example, within the public health services preventive intervention framework (NICE 2022a), also in recent Welsh policy developments for schools regarding adolescent self-harm (Welsh Government 2019a; Welsh Government 2021a). As Chapter 2 has outlined, preventive interventions are heavily influenced and strongly shaped by their implementation context, an aspect that may not have received sufficient attention in public health research (Craig et al. 2018; Bauer & Kirchner 2020). The results from this study would therefore be able to offer key recommendations in regards to these recent developments. This information is provided in Chapter 7.

---

2   I.e. universal, selective and/or indicated preventive intervention support (Mrazek and Haggerty 1994)

My research investigation would also attempt to both incorporate and address the potential structural constraints stemming from within the secondary school context and the subject under study, to try to understand, map and address the research access barriers that could take place and those that actually occurred. Barriers could stem from a number of issues. The proposed research context of school is external to traditional public health services research infrastructures, in that schools are separate organisations that are not administered by public health services. For example, health research may not routinely take place in schools, schools may not be set up to be health research sites, practical and logistical challenges within schools means that there might be very limited resources in schools to facilitate school-based health research (Stallard et al. 2013a). I was able to draw upon concrete information about potential and actual research access barriers from the preliminary small-scale study I completed (Parker 2018ab) before embarking on this larger PhD project, which Chapter 2 has described. For example, the sensitive and potentially confidential nature of the topic (Santelli et al. 2003; Langhinrichsen-Rohling et al. 2006: Lloyd-Richardson et al. 2015) might act as a research barrier if not planned to be addressed, as demonstrated in the smaller-scale study. Because these barriers might be entrenched, difficult to overcome and worst case risk the project's completion, they were at the forefront of the PhD project.

Chapter 2 has drawn attention to emerging research which demonstrates that there are some challenges in completing adolescent self-harm preventive intervention research with pupils in schools, an issue which negatively impacts the research quality and development of community-based adolescent self-harm preventive intervention support. Therefore mapping and trying to address the research access barriers that could occur when trying to complete adolescent self-harm research in schools was embedded within the research aim at the outset, as an essential aspect in understanding the school context to help support adolescent self-harm preventive intervention research in schools in Wales. This thesis would be able to deliver specific details regarding this issue.

3.3 Factors Influencing The Project's Ontology & Epistemology

3.3.1 The Influence Of Public Health Complex Intervention Design

This study is concerned with theorising schools' influence on adolescent self-harm in Wales, in order to understand the role of the secondary school context in pupils' experiences of adolescent self-harm, to develop system-level preventive intervention. The health issue of adolescent self-harm is situated within a specific community context, for preventive intervention purposes. This study resides within the framework of UK public health services. Adolescent self-harm preventive intervention that is designed to be applied within the school context consists of multiple and multilevel components. For example, Chapter 2 has demonstrated how the recent multilevel adolescent self-harm preventive intervention that is designed to be applied within the school context (NICE 2022a) is a complex system intervention (*see Chapter 2, Sections 2.3.2 and 2.4.2*).

The Medical Research Council (MRC) provides guidance for developing and evaluating complex interventions (Craig et al. 2008; Moore et al. 2015ab; Skivington et al. 2021ab). In public health the process of complex intervention design and testing is time consuming, expensive and intensive, involving many phases. A prevailing practice in this phased model has been to evaluate the impact of the intervention context through the use of process evaluation at the end of the intervention process, in order to understand outcome variations (Craig et al. 2008). However an emerging perspective that is beginning to take centre stage when devising complex interventions is the need to fully understand the context and socio-ecological system first in which the planned intervention change is to take place (Moore & Evans 2017; Moore et al. 2017; Craig et al. 2018; O'Cathain et al. 2019; Skivington et al. 2021ab). There are specific conditions, influences, behaviours and/or dynamics within a setting that impact the implementation of an intervention – these can be both positive and negative (Moore et al. 2015ab; O'Cathain et al. 2019; Skivington et al. 2021ab). This is what the PhD study aimed to help make a contribution towards, in regards to exploring and understanding the secondary school context and socio-ecological system in the first instance, in order to support adolescent self-harm preventive intervention (as within the exploratory phase of complex intervention design). The nature of reality, what exists within it, and how this

reality can be known is legitimised through a number of philosophical and conceptual frameworks, each of which delivers its own specific consensus upon what is acceptable for knowledge generation within the respective paradigm (Khun 1970; Benton & Craib 2011). In the PhD project this was shaped by the MRC's public health complex intervention design model.

3.3.2 The Influence Of The Socio-cultural "Real World" Open System

Schools reside within socio-cultural systems and have multilevel influences. This is why a socio-ecological perspective shaped this project's contextual exploration and analysis, through the use of the public health socio-ecological model (Mcleroy et al. 1988; Inman et al. 2011; Golden & Earp 2012). Also, as discussed previously, after the start of this research project secondary schools in Wales (and England) were positioned as a preventive intervention site due to the recent adolescent self-harm policy frameworks as outlined previously. As Chapter 2 has outlined, from a socio-ecological systems perspective, the secondary school context resides within these wider policy frameworks which act as influences upon the institutional setting, but the socio-culture in the school context also influences the adolescent self-harm complex intervention that is proposed for schools and its implementation. This study therefore aimed to generate theory from within a "real world" open systems context of a complex natural setting, with multiple system-level and interrelated influences with contextual issues. This is in contrast to that of a closed system which is isolated from its environment (Bruce et al. 2008; Gauch 2012). Generating theory in this way was for the purpose of contributing to public health complex intervention design modelling within an open systems context, that of the secondary school community context, for adolescent self-harm.

3.3.3 The Influence Of Pragmatism In Order To Translate Research Evidence Into Practice

This research study was grounded in pragmatism, in regards to the research project aiming to contribute research evidence that could be successfully translated into practice in Wales (Social Care Wales 2018; Social Care Institute for Excellence 2021), for the purpose of supporting adolescent self-harm preventive intervention within the

secondary school context. For example as Chapter 2 has discussed, although there is now a strong socio-political force shaping the role of the school within preventive intervention support due to the recent government policy frameworks (Welsh Government 2019a; Welsh Government 2021a; NICE 2022a), there may still be some barriers present in schools that might act as limitations in regards to the systematic uptake of this policy (which is one of the policy's main aims) to standardise support for quality improvements, which are as yet unmapped. In health research these types of factors can severely limit or negate the uptake of evidence-based practice which is why implementation science is utilised to support the uptake process of new interventions in specific settings for standardised practice (Bauer & Kirchner 2020).

Translating research evidence into practice is a complex, challenging and multi-systems levered process, requiring targeted resources and key stakeholders with strong organisational leadership who are invested in evidence-based practice to act as catalysts for knowledge mobilisation purposes across the research/practice potential interface (Rycroft-Malone et al. 2015). This was one reason why the PhD study was focused upon exploring the school context through an analysis drawn from the perspectives of key stakeholders in schools and its linked system, to ensure that the information and its analysis was fully centred upon the views held within these stakeholder groups, who were invested in the research, as the results findings would be targeted to their needs which could help facilitate the translation of the research evidence into adolescent self-harm preventive intervention practice.

I also had first hand experience of these types of implementation issues in prior school-based adolescent self-harm preventive intervention work, as the lead CAMHS consultant within the adolescent self-harm Task and Finish Group of a large scale multilevel project within Child Safeguarding and Support Services (Parker 2015; 2018ab), and some of the barriers that can occur in translating adolescent self-harm research evidence into front-line practice in schools. One key recommendation that was made in this prior project was for research to explore the school context within multilevel adolescent preventive intervention design, to facilitate implementation (Parker 2015). Because of my real world experience this was pragmatic knowledge that had led me to focus upon the potential strong impact of the school context upon the implementation of

any new adolescent self-harm preventive intervention planned for use in schools, for the purposes of my current research project and its methodology, aiming to make a research contribution to help map and theorise the influences within the school context.

As Chapter 2 (S*ection 2.4.2)* has demonstrated, the recent adolescent self-harm complex intervention that is designed for use in schools in England and Wales is not underpinned by a rigorous evidence base, hence the intervention has not been fully theorised such as in regards to the active elements that deliver change and its mechanisms of action or the potential unintended and negative consequences (Evans et al. 2015; Moore et al. 2015ab; Skivington et al. 2021ab). These types of considerations informed my main research aim to theorise the influence of the school context upon adolescent self-harm, for the purposes of adolescent self-harm preventive intervention.

A further example of pragmatism was my decision to apply an outreach-based research approach within the school community to access the research participants, particularly pupils. Chapter 2 (*Sections 2.2.2 and 2.2.4)* has demonstrated why completing research in the school context could be a way of accessing the community-based adolescent self-harm population group. The World Health Organization recommends this type of outreach approach to support the health needs of adolescents (WHO 2015ab) in order to facilitate access to public health services and support, and understand and meet the population's needs. This was another factor for the project's research aim, to contribute information about the feasibility of schools for this type of access for pupils in regards to adolescent self-harm research.

3.3.4 *Ontological & Epistemological Conclusion Stemming From These Influences*

The aforementioned influences were critical factors in shaping my choice of the ontology and epistemology selected for the current project. I chose a critical realist paradigm. This views reality as stratified, complex (no linear modelling) and multifaceted, with more layers beneath every event that is observed (Bhaskar 1989; Sayer 2000). Critical realism accepts the tenet of logical positivism within the scientific model that an objective reality exists which can be observed and measured, but

critiques its simplistic causality (Sayer 2000). Critical realism concludes that when undertaking the development and evaluation of complex interventions these are always embedded within the socio-cultural contexts that impact their implementation and efficacy (Fletcher et al. 2016), bringing attention to the open systems context, its nature and characteristics (e.g. complexity, natural setting, multiple variables, contextual issues). Critical realism enables the open social system (such as the secondary school context) to be appropriate to scientific investigation due to its stratification of this social reality into the real, the actual and the empirical (Archer et al. 1998; Centre for Critical Realism 2017). In this way the actual mechanisms are uncovered which generate the outcomes within the chosen social system under investigation (Pawson 2013; Fletcher et al. 2016). Theory can be developed through the use of critical realist epistemology to shed light on the complex mechanisms underpinning each layer.

Critical realism is both an ontology and epistemology, in the sense that it is a meta-theory reflecting upon the nature of reality, what exists within it, and how this reality can be known (Danermark et al. 2002; Bhaskar 2014; Fleetwood 2014; Mingers 2014). From an epistemological perspective for exploring social reality, critical realism is able to incorporate research participants` perspectives. This is through its critical realist theoretically-informed interview process centred upon exploring context, mechanisms and outcomes or "CMOs" (Pawson 1989; Pawson 1996; De Souza 2013). This approach is used within my PhD to deliver the CMO configurations to uncover the institutional mechanisms that can influence adolescent self-harm in the secondary school context. For example, using this approach enabled theory to be generated from the socio-culturally-situated knowledge of the research participants, and this theory was able to capture and explain the particular type of interaction that occurred between the context and the individual (Fletcher et al. 2016) in regards to adolescent self-harm. This also included the social and health outcomes that stemmed from this interaction. This context-based theory could inform adolescent self-harm preventive intervention. For example it would be able to contribute school context-based information that could be incorporated within the recent adolescent self-harm service frameworks whereby schools are now key support settings (Welsh Government 2019a; Welsh Government 2021a; NICE 2022a).

3.4 Methods & Data Generation Using Qualitative Research Methods

3.4.1 Qualitative Research

A critical realist-informed study generates rich and concrete detail about the subject under enquiry to generate explanatory theory, which is why I chose to use qualitative research methods to support this (Sayer 2000). Qualitative research facilitates a plurality of perspectives from research participants to deliver their knowledge and accounts about the contexts they are part of. These accounts can be both elicited and captured to offer partial understandings and diverse viewpoints that are situated within their specific social and cultural contexts (Corbin & Strauss 2015; Creswell & Poth 2016). Qualitative research generates intensive data from the research participants' perspectives, and is especially useful within exploratory research to gain highly detailed information about the phenomenon under study (Sayer 2000). It differs from "extensive" research study design which is typically quantitative and restricted in its provision for explanatory theory (Sayer 2000). Engaging with complexity and mapping each of its facets was part of the qualitative research process within this project to fully explore and understand the institutional context upon the behaviour under study.

Given qualitative research can help to facilitate a plurality of perspectives to be incorporated for a topic under study, groups of "key stakeholders" (Hamilton & Finley 2019, p.5) were able to be planned as the research participants in this study, to ensure multiple perspectives could be incorporated within the research analysis. These were to be pupils and school staff, and wider network professionals in community and national-level organisations in Wales that provided support to adolescents for their health and support needs which included adolescent self-harm. It would be from within this multilevel system, from schools and the wider linked system of community and national-level organisations, that community-based self-harm preventive intervention support would be implemented in Wales. Hence the socio-ecological public health model informed this approach, in order to gain a system-level analysis regarding individual, interpersonal, institutional, community and public policy factors (McLeroy et al. 1988; Golden & Earp 2012).

The choice to have these differing stakeholder groups and apply qualitative research methods meant that diverse perspectives would be able to be gained and detailed information to be drawn from the study's research participants for the system-level analysis. The use of 3 participant groups also strengthened the credibility of the research study findings, as having different group sources is a data triangulation method for research validity (Kisely & Kendall 2011). Further validity quality included: the study gaining participants from schools that had been purposefully sampled for key differences (the key variables being socio-deprivation indicators, academic attainment levels, language medium, and the school size in regards to pupil numbers) and their linked system organisations; gathering data from across a period of time; the use of researcher observations (when in situ) and field notes. All of these are data triangulation methods that help to improve the quality of the research data and its findings (Morris 2017; Campbell et al. 2018).

3.4.2 A Participatory Approach

I wanted to work with the key stakeholders of pupils, school staff and wider support network professionals in order to enable a reflexive approach that would facilitate discussion and their perspectives upon the research questions, to generate the overarching theory. Hence the theory would be informed by the perspectives of the research participants. The research project had therefore been planned to enable specific groups of stakeholders to take part who were affected by the research topic under study, who would have valuable ideas and contributions to make, which the research project could facilitate. My research questions and research method (qualitative, grounded theory method) were designed to support participants' perspectives to help facilitate their views upon their needs and concerns regarding adolescent self-harm preventive intervention, for support design and delivery in Wales. My outreach research design was that of going to schools and organisations where the research participants were present, which provided accessible locations for the research participants. This was done in order to make it physically easier for them to attend and to help address research participation barriers. These steps were taken in order to facilitate a participatory approach, that of supporting the research participation

of key stakeholders who would be directly concerned with and impacted by adolescent self-harm preventive intervention in Wales.

One main influence that informed my participatory approach was that of Welsh policy which centred upon promoting participation rights within public services. For example, there was a recommendation in self-harm and suicide prevention policy (Public Health Wales 2012) for the development of processes to engage with young people, to ensure that services are tailored to meet their needs, and also that these services are appropriate and acceptable to them. The principle of co-production informs social service provision and individual support through the Social Services and Well-being (Wales) Act 2014, hence a participatory approach could support this in order to work in partnership with research participants to facilitate their perspectives to help inform service support design and understand health support needs (Care Council For Wales 2017; Moore & Evans 2017). In addition, Welsh policy has enshrined the United Nations Convention on the Rights of the Child (Office of the United Nations High Commissioner for Human Rights 1989) in law within the 2011 Rights of Children and Young Persons (Wales) Measure, of which agency and participation are core values. Participation standards have therefore been developed in Wales to promote child, adolescent and young adult participation, such as in regards to Welsh Government policy, social care and health services development for young people (Young Wales 2016). Within these legal frameworks that promote participation as outlined here, the views, decisions and perspectives of the person who is to be in receipt of service support are positioned as being at the centre point within this process.

For the purpose of school-based qualitative research and a participatory approach with pupils in regards to adolescent self-harm, Chapter 2 (*Sections 2.4.1 and 2.4.5)* has illustrated some of the background context research challenges that may be present. For example, in schools in Wales there has been no large scale school-context adolescent self-harm research that has included pupils as research participants, such as in school health research surveys. In England this has taken place. Also, in my prior exploratory research study in 2 secondary schools in Wales which was the pilot to this larger scale PhD study, the results demonstrated that the topic of adolescent self-harm (such as in regards to health knowledge and health support) was excluded from the

socio-cultural school norms at an institutional-level within the secondary school context (Parker 2018ab). A consequence of this was that there was no health information about adolescent self-harm provided to pupils within the whole-school public environment. School staff were also apprehensive of teaching pupils about the health topic, fearing iatrogenic impacts such as social contagion, but also fearing that talking about adolescent self-harm with pupils would cause pupils to self-harm. These issues could act as pupil research barriers in schools for the current PhD project, because schools might not permit health research with pupils that was concerned with the topic of adolescent self-harm, with school staff acting as gatekeepers. This could be a major barrier to pupils' research participation.

Therefore, given the health topic under study in this research study was to be that of adolescent self-harm in the school context, it was important to ensure that youth perspectives were positioned as being the central focus within the research project, given adolescent self-harm is a specific adolescent health topic, for consideration by youth. School staff and other professional would have very important information to share, but it would be vital to place youths' perspectives and their lived experiences of adolescent self-harm at the heart of the research analysis. For example, due to power inequalities there might be an unequal status between pupils and professionals which could lead to participation barriers for pupils, adults in educational settings might take decisions on behalf of pupils instead of consulting with them about their research engagement, or holding the stance that adults know best. There could also be a risk of professionals' perspectives shaping the research analysis instead of that of youths' perspectives, all of which could lead to youth being marginalised within this project's adolescent self-harm health research agenda (Ozer et al. 2020; Teixeira et al. 2021). Having an understanding of these challenges as well as a focus upon promoting youth participation and methods to support these within the research project might help to address and manage these types of issues (Ozer et al. 2020; Teixeira et al. 2021).

Another strong influence here was my multidisciplinary professional experience of education, health and social care statutory services, in my professional role over 3 decades which was centred upon the mental health, well-being and safeguarding of children and adolescents. Facilitating and listening to the voice of the child was

paramount within the type of services I was part of. Hence it was essential that I chose a research method that would respect and promote youths' knowledge and participation rights, and also one that was appropriate for youths' needs (Sudarsan et al. 2022). My choice of research method should provide opportunities for youths to provide in-depth information regarding what they wanted to discuss in regard to adolescent self-harm preventive intervention and the school context. This is why I chose qualitative research and a participatory approach as the research methods to facilitate the youth research participants to actively deliver their perspectives about a chosen topic of interest or problem, and to help find solutions for their needs that the participants had exposited, from within their community (Chambers 1992; Laws et al. 2013).

A participatory approach validates the knowledge and understanding of the research participants, and is concerned with their lived everyday reality and experiences (Bergold & Thomas 2010; Laws et al. 2013). It is mindful of the potential power inequalities that can exist between the interviewer and interviewee (Kvale & Brinkmann 2009). A proactive stance is taken by the researcher at the interview design outset with measures in place to actively address the potential power imbalances that may arise from the interviewing process (Shaw & Gould 2001). The focus is upon the researcher respecting the knowledge held by the interview participants (Chambers 1992) and facilitating their perspectives within the interview through a high quality interactive interview process that includes shared learning resources and activities specifically designed for this purpose; this is in contrast to an expert-driven results-orientated end-goal knowledge "extraction" format (Pain & Francis 2003; Laws et al. 2013). This is why I chose to use Participatory Appraisal (Chambers 1992; Pretty et al. 1995) in order to meet the aims of my research project, with its focus upon learning about the perspectives of the research participants upon the specific research issue, to inform complex intervention design for adolescent self-harm. There is a rich history of PA being used to help deliver meaningful participation in democracy, decision-making and governance (IIED 2002; 2023).

3.4.3 Participatory Appraisal (PA)

Participatory Appraisal stems from Participatory Rural Appraisal (Chambers 1992). This was a participatory approach designed for use in rural development agency work from the 1970s onwards. It aimed to empower local people within their communities to unlock their own wealth of expertise from locally situated information to find local solutions to solve local issues. It is also an approach that can promote the principles of participation that are enshrined in human-rights informed legislation, such as those in Wales within the Rights of Children and Young Persons (Wales) Measure (2011) and the Social Services and Well-being (Wales) Act 2014, but also enables these principles to be applied practically. Hence it is a pragmatic approach directed towards bridging the gap between principles and actual practice (Chambers 1994a).

At the heart of Participatory Appraisal are its goals to understand and proactively address potential power inequalities in order to equip members of the local community with the skills to engage with and contribute their knowledge within community issues, to facilitate their perspectives, and to enable shared learning and appraisal, upon a specific research topic under investigation within the community (Chambers 1992). The researcher goes into the community context acting in the role of a highly trained and quality facilitator (Pretty et al. 1995) to achieve these goals as a PA facilitator, which also means holding an attitude and behaviour informed by PA principles which are of a proactive nature (Chambers 1992; 1994ab; 1997). These principles involve the need for the facilitator to take a proactive stance to promote rights-based practice and community empowerment, and also to understand and work to address inequalities in society, such as through facilitating the participation of marginalised groups to enable the redistribution of power and resources specific to their needs. Key methods include: an outreach approach; rapport building; semi-structured interviewing; and focus groups (Theis and Grady 1991; Chambers 1992; Pretty et al. 1995). This way of working is undertaken to draw upon local expert knowledge about a community-based problem, to facilitate inclusivity and diversity through accessing a range of key stakeholders to take part in the study, and to help to begin to provide community solutions to the community issues. Through its key methods PA generates intensive and rich quality data (Chambers 1992), and encompasses the complexity of the lived social reality under

investigation (Chambers 2013), which are necessary for the purposes of this critical realist informed study.

Appendix 1 provides an overview of the qualitative research interviews designed for this study. The interviews utilised a semi-structured focus group discussion in the community context. This is a key PA approach (Theis & Grady 1991; Rietbergen-McCracken & Narayan 1998) that is applied "to help draw out and build upon the existing knowledge and experience of the research participants" (Pretty et al. 1995, p.71) within their community context, through the use of the PA facilitator skills such as using sensitive questioning and listening in the interviews. Furthermore PA creates a research interview space which promotes dialogue and input centred upon the context and real world of where the question/problem resides, from the research participants' analysis of the current situation. The PA approach may also mean that the knowledge is acceptable to the setting it is generated within, in that it is based on the research participants' perspectives of the issue/problem within their community context. This may help to facilitate its implementation within the "real world" setting as the knowledge is accepted by the community due to the way it has been generated. Hence PA could be a useful and pragmatic approach within implementation science research, such as in translating research evidence into practice.

3.4.4 Approaches & Routines In The School Context That Are Facilitative Of PA, That Support Participation

The school socio-cultural context has approaches and routines that take place within it, which can be utilised to support PA. This was another reason that informed my choice of PA for use within the school context. I appraised these factors carefully and considered how they could support the use of PA. Given PA places responsibilities on the facilitator to actively promote and deliver quality participation and to establish rapport which are critical to the success of PA (Theis and Grady 1991; Chambers 1994a; 2002), some of the key concerns I held were in how to enable the research participants to feel at ease within my PA interviews, and how to establish rapport.

Therefore it was important for me to understand and draw upon the approaches and routines in the school context, for the PA research method planning and design. Fortunately I had prior knowledge of these aspects as I had previously completed mental health training in schools in Wales for staff and their sixth form pupils, and had gained knowledge from my prior small scale study that had successfully applied PA within the adolescent self-harm research topic (Parker 2018ab), which I drew upon. I knew that to meet the PA criteria I would need to actively create opportunities and also give time to establishing the professional relationships with key stakeholders, in order to generate trust and rapport, which I did. For example, I went to the school settings (or other organisational settings) and enabled potential research participants to see me a number of times and to meet with them, so they became familiar with who I was, what I was doing, and what would be being asked of them within the research interviews. Potential research participants became used to seeing me in their school context; wider support network professionals were given regular access and contact with me by whatever method they wished, and I met up with most of these types of research participants prior to the research interviews. Through these methods, by the time the research participants came to be interviewed with me they were comfortable with me, and familiar with the way I worked. I had attempted to carefully integrate within their settings, to respect their ways of working, to fit in with their routines, and had been successful. Furthermore, after the research took place, I gave my time and resources[3] to support schools and other organisations who had been involved in the research, as part of maintaining this trusted relationship which is critical in PA. One additional point to highlight here is that although all of these steps were taken to support the use of PA they were also useful in overcoming some (but not all) of the strong research access barriers that occurred during this project *(more details about these barriers are given in Section 3.7.3)*. Some examples of the factors I appraised to support PA within the school context are outlined below.

Secondary schools have teaching methods and pedagogical approaches within their teaching curriculum that are designed to facilitate pupils' learning and critical thinking

---

3   These are examples of some of the resources I designed to support schools and the wider support network organisations: (1) https://talkresearchblog.wordpress.com/health-promotion-resources/   (2) https://thewellbeingdoc.com/   (3) https://decipher.uk.net/blog/working-with-youth-mental-health-services-during-covid-19/

skills (Welsh Government 2022d). This means school staff and students are familiar in participating in a range of classroom-based learning activities to generate new learning in the scheduled classroom time. For example, critical thinking and problem solving are essential skills within the Welsh Baccalaureate (WJEC CBAC 2016; 2022). This approach is facilitative of the use of PA, which I found was indeed the case in the interviews with pupils and school staff.

Pupils were very familiar with the routine of a professional adult coming to their school to talk with them and generate learning activities that they participated in. The use of PA within the interview sessions with pupils created a shared learning space regarding the topic under discussion which pupils fully engaged with. The school context was therefore a beneficial environment for this purpose, and was extremely facilitative for the use of the PA research method with pupils. For example, the initial PA activities that I chose to use were designed to focus the pupils upon the topic under study, generate rapport, and also create a space where pupils understood that their views would be respected and taken seriously by the PA facilitator (i.e. myself), and that they had knowledge and expertise about the school context that was very important for the research project *(see Appendix 1A)*, which the PA approach elicited. All of the sixth form pupils and young adults who participated in the interviews responded positively to PA.

The routines in the school context for school staff and wider support network professionals were also facilitative of PA. For example, school staff were accustomed to having meetings and discussing school-related topics (including with a range of multidisciplinary professionals). They were engaged in giving their views and feedback, in assimilating new information and giving their appraisal, in thinking about pupils' needs such as regarding classroom learning activities or pupils' health and well-being or resources that were needed. Furthermore once school staff became aware that my professional background was in CAMHS, I was perceived as a familiar professional to them and a member of their school services system, which supported PA (and my research access) - for example this helped to quickly establish trust and rapport, and staff acted toward me as if I was a familiar type of professional who was part of their system. Hence in my use of PA I was able to draw upon these approaches and routines

that took place in the school or in the linked school system settings for its successful implementation within the interviews.

3.5 Researcher Positionality

3.5.1 The Influence Of My Professional & Personal Lived Experience Of Adolescent Self-harm Upon The PhD

The PhD is shaped by my assumptions and beliefs that stem from my professional and personal lived experience regarding adolescent self-harm (Savin-Baden & Howell-Major 2013). I have briefly outlined within Chapter 2 (*section 2.4.5*) some of my work regarding adolescent self-harm in my role as a professional, working within CAMHS in front-line practice but also in larger scale adolescent self-harm multilevel preventive intervention projects as a CAMHS consultant. This professional role and work has shaped my view of adolescent self-harm, of which some examples include: in how I understand adolescent self-harm, such as in balancing both the medical and social models of disability; in establishing how I behave when I come into contact with the health topic and behaviour of adolescent self-harm, through my responsibilities and duties which are also informed by my professional codes of practice, which are the foundations for how I provide care and support; in the use of an evidence-based approach within my work, applying the best available research evidence which includes NICE practice recommendations for working with adolescent self-harm; in capturing evidence for support quality monitoring and improvements, such as through establishing and monitoring outcomes; in the support system I am part of giving me the statutory mandate to provide targeted support, but also in generating the clear professional boundaries within my CAMHS network that defines my professional role and work; in supporting and protecting the rights of the child and adolescent in the context of CAMHS, managing the inherent tensions and complexities that occur, such as through the use of legal and safeguarding frameworks. My worldview of adolescent self-harm therefore stems from my professional role and work.

During my 7 years as a postgraduate researcher at Cardiff University (2016 to 2023), a major and new influence occurred through that of my own personal experience of youth self-harm, suicide attempts, suicide and suicide postvention in my own social community setting where I lived in a rural part of Wales. I came into contact with these community-based issues as a trusted adult, and not as a CAMHS professional, at crisis points in the lives of 10 youths who were aged from 16 to 23 years (7 males and 3 females). These personal lived experiences that continued for the duration of my PhD study had a profound impact, and delivered a paradigm shift due to me being a member of the public trying to provide community-based support in youth crisis points as a trusted adult with no professional mandate. I experienced many new challenges and intensive stresses because I did not have the mandate to work as a professional within these incidents, only to try to provide support as a trusted adult. These experiences deepened my understanding about community-based youth self-harm and thus influenced my PhD.

Furthermore, due to my PhD I was also positioned in the role of a researcher. 4 of the youths that I provided support to as a trusted adult (as outlined above) asked to talk about my research work, as they knew of my research and its topic. My qualitative research methods drew upon rights-based practice, participation, co-production and PA to help empower youth, in regards to their views and their voices upon the health topic and behaviour of adolescent self-harm for preventive intervention. Consequently I drew upon these principles and discussed the project with these youths, from these foundations, and listened to their valuable input. It also would have been unethical to not do so. For example, under Article 12 of the UNCRC, "the child who is capable of forming his or her own views (has) the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child". In addition, under the Social Services and Well-being (Wales) Act 2014, the emphasis is upon increasing participation and engagement with individuals who are in need of care and support through promoting their "voice and control" (Care Council for Wales 2017, p.2) in the design and deliver of support services to meet their needs. Therefore all children, adolescents and young adults in Wales have a right to participate in health topics that are relevant to them, especially if they are

experiencing the health issue themselves. This includes participating in health research, such as adolescent self-harm.

Another factor that enabled me to discuss my research with these 4 youths was due to the following point. Around this same time I had attended Health and Care Research Wales workshops to help engage and involve the public of Wales in health and social care research, because this was something I was personally interested in and wanted to learn more about and help promote. These workshops were centred upon the public's participation in research so the public's views could be heard and embedded in health and social services design and delivery, to be focussed upon their needs and concerns. This work was completed as part of the development of the UK Standards for Public Involvement (National Institute for Health Research et al. 2019). By this time my own study had already been designed, and had received ethical approval, so I could not make any amendments. But as part of these workshops I reflected upon the concept of public involvement within my research project, specifically for adolescent self-harm preventive intervention in Wales. Hence when the 4 youths asked to discuss my research project I therefore encouraged them to do so and for them to give their feedback. I drew upon these UK Standards for Public Involvement (National Institute for Health Research et al. 2019) to help improve my researcher behaviour and practice, as these four youths were members of the public. For example, I reflected upon, applied and acted upon the standards of "inclusive opportunities" (p.5), "working together" (p.6) and "communications" (p.8) in regards to these four youths due to them being members of the public; they were interested in the research topic; they had experience and insight to share in regards to adolescent self-harm; they would be impacted by service support issues in Wales; I was able to undertake relevant communication with them in their community setting; I used everyday conversation style; I offered and gathered their feedback; I recognised their ideas and contributions which I applied in my research project. In these ways, the UK Standards for Public Involvement informed my practice as a researcher.

Hence these 4 youths (as outlined above) gave feedback upon a number of aspects, such as my scripts that I had designed and planned in regards to the contact I would have with pupils during this study, which I subsequently incorporated. One youth

highlighted that it was very important to help pupils to take part, particularly those who might be struggling, or feeling disempowered, or who didn't feel confident, or had low self esteem, in order to reach these adolescents. Advice was given regarding addressing potential research access barriers for pupils. Some of the main changes were situated upon the language and communication style I should use, and the content, such as for me to directly ask pupils to help with the study, why it was an important project for pupils to be involved in, and using a more relaxed and open communication style to talk as their equal rather than as a professional. The advice and feedback that I was given was invaluable and also successful, as the majority of pupils who did participate stated that the way I communicated about the research project with them in their sixth form assembly, such as how important their views would be for adolescent self-harm preventive intervention research and that it was an important topic for young people, these had all been factors for why they had decided to participate in the research project – they felt that they could help and that they had valuable information to give.

Hence my personal lived experience led to reflections and changes in my understanding and knowledge about community-based adolescent self-harm, which in turn influenced my role and behaviour as a researcher. I was given a community-based viewpoint upon the complexities in adolescents' lives that may risk adolescent self-harm, suicide ideation and suicide attempts. I was also able to embody as a researcher some of the key principles that informed the research method, that of participation and empowerment, as a direct consequence of this personal lived experience.

3.6 Ethics

In this section I outline how I planned to ethically manage the research process within this study, and some of the ethical considerations that informed this work.

3.6.1 Ethical Issues Surrounding The Research Topic Of Adolescent Self-harm: Avoiding Harm To The Research Participants

Adolescent self-harm is a sensitive qualitative research topic due to specific characteristics that are present which require ethical research consideration (McCosker et al. 2001): it is of a private and personal nature; it may evoke strong emotions; it may be a stigmatised topic; and there may be safety concerns such as research participation leading to a potential risk of harm to youth participants. The consideration of ethical issues due to the sensitive nature of the research topic was therefore central in the design and delivery of this project, in order to attempt to understand, address and manage these ethical concerns, of which some examples are given below.

At the research project's outset, a key ethical question that might be raised is whether pupils should be contacted and offered the choice to participate in adolescent self-harm preventive intervention research. However adolescent self-harm is an adolescent health topic and behaviour. Health equity legislation in Wales places an individual and their views at the centre of all decision making for their health needs (such as within the 2010 Equality Act, 2011 Rights of Children and Young Persons Measure, 2014 Social Services and Well-being Act). This legislation therefore gives the right for young people in Wales to participate in adolescent self-harm preventive intervention research, especially youth with lived experience of adolescent self-harm.

There would be a likelihood of my research project having contact with the adolescent self-harm population group in the school context. For example, as part of the informed consent process in schools and the school research interviews. To understand how likely this would be I applied the most recent UK modelling at the time for community-based adolescent self-harm prevalence rates for 15 to 17 year olds – this ranged from 11% (Brooks 2020) to 22% (Geulayov et al. 2018). This gave a relatively high percentage. This data demonstrated there would be a relatively high likelihood of any potential interview participant from within the community-based school pupil population having some (either current or historical) experience of adolescent self-harm. This would include the youth population who did not access health services for their self-harm needs (as demonstrated in Chapter 2), who were deemed as being "invisible" to support services, who may never have had any contact with a professional regarding

the topic of adolescent self-harm. Furthermore I had completed a prior small scale adolescent self-harm qualitative research study (Parker 2018ab), which acted as a pilot to inform the current PhD study. 6 pupils aged 16 to 18 years had participated (1 transgender, 2 male and 3 female). I had therefore gained some information and experience regarding the ethical issues within this type of research and the strategies which had been successful in addressing the ethical concerns, which centred upon pupils' informed consent and safety (see Parker 2018ab). But my pilot study also demonstrated that all of the pupils I interviewed had experience of adolescent self-harm, either through their own behaviour or that of their peers' self-harm. This suggested that the youth research participants who might choose to take part within the PhD study would probably have lived experience of adolescent self-harm. Therefore the initial work completed within the pilot study regarding understanding and managing the ethical issues in pupils taking part in adolescent self-harm qualitative research needed further exploration, with particular focus upon the high likelihood that my youth participants would have lived experience of self-harm, and also that they may not have accessed health support for their adolescent self-harm needs.

 As was the case within my pilot research study, I would not be in a CAMHS role when coming into contact with youth with lived experience of self-harm regarding the qualitative research topic of adolescent self-harm. This meant I could not access the CAMHS resources and organisational support frameworks for safeguarding and managing the potential safety risks here. I therefore needed to plan to address these issues from within a researcher's role and professional boundaries. The limited guidance upon understanding and appraising the ethical challenges in adolescent self-harm research with young people has been raised as a fundamental and critical issue by Lloyd-Richardson (et al. 2015). This point is problematic, for example if there is not a body of specific research to draw upon for research guidance it could lead to challenges centred upon ensuring the safety of youth participants taking part in community-based adolescent self-harm research, and also in regards to the safety of the researcher undertaking this research within a community setting. These would mean that the research could not take place due to the risk of harm. One study (Lakeman & Fitzgerald 2009a) that centred upon ethics committees' concerns within suicide research demonstrated that this was indeed the case, and that established methods

were needed to address these immense challenges that were presented to ethics committees for their approval and research monitoring. A more recent suicide and suicide prevention research study (that took place after my study's ethics design and data collection) has similarly demonstrated that ethics committees and researchers require ethical guidance and resources as these are still limited, in order that this type of research can receive ethical approval and be conducted ethically, including to support the needs of researchers who have less experience in this research field (Barnard et al. 2021). A particular concern is the need for ethical guidance and resources to support qualitative self-harm and suicide research studies that are to take place within community contexts, as these factors (i.e. the qualitative nature of the study within a community context and being external to clinical health settings) bring additional ethical challenges and complexity (Lakeman & Fitzgerald 2009b).

I therefore drew upon my CAMHS professional knowledge of working with adolescent self-harm, where safety management protocols are applied to help manage risk of harm. Self-harm and suicide have complex shared risk trajectories which is a key point that informs self-harm support and safeguarding assessments in CAMHS. Clinical health setting research also utilises self-harm and suicide risk safety management protocols (Vannoy et al. 2010; Herbeck-Belnap et al. 2015; Stevens et al. 2021). Two ethical concerns that arise for community-based adolescent self-harm qualitative research with youth is that research participation may aggravate suicide ideation and behaviours, and that research participation in self-harm and suicide research may cause distress to the research participants - the design of specific risk management and safety protocols by experienced professionals is a key method to managing these concerns (Lakeman and Fitzgerald 2009b; Biddle et al. 2013). As demonstrated in chapter 2 (*section 2.4.3*), a UK qualitative research study upon the suicide research interview experiences of individuals with lived experience of self-harm (and of suicide behaviours, suicide ideation and suicide attempts) revealed that being given the opportunity to participate and contribute to suicide research was an important protective factor for participants' well-being (Biddle et al. 2013). Although distress could be present, it was specific (i.e. centred upon the disclosure of past or current challenging issues within their lived experiences), transient and mitigated by participants' desire to contribute to the research. This UK study also had important conclusions to help inform

the ethical concerns within my own research project because out of the 63 research participants with lived experience of the self-harm and suicide research topic, 20 were pupils aged from 15 to 16 years. The study concluded that participation for the greater majority did not cause harm, however strong emotions could arise which would require researcher skill to provide support and manage the interview when this took place as well as to maintain professional research boundaries (for example, to not provide therapy), and also to undertake an active approach and surveillance of participants' potential distress.

Another important research study relevant to the ethical concerns in my project was that of Lloyd-Richardson (et al. 2015) as this study centred upon adolescent self-harm research ethics. This study raised the ethical issue of a researcher considering the type of research context that the adolescent self-harm research was to take place within. This was an international study centred upon the United States adolescent self-harm population group. This study also discussed the vulnerability and psychiatric characteristics of the adolescent self-harm population group (i.e. mental health co-morbidity, risk issues with suicide). Its ethical recommendations were for the researcher to be fully apprised of the clinical issues in working with adolescent self-harm to inform the research ethics. My professional clinical background in CAMHS and working with adolescent self-harm could therefore be used to inform my perspective upon the potential ethical issues here that needed to be planned for and addressed within a qualitative research interview upon the health topic of adolescent self-harm. I also situated these issues within the Economic and Social Research Council's guidance (ESRC 2018) upon research with potentially vulnerable people. However even though I could draw upon my CAMHS knowledge, there would still be major ethical challenges centred upon the actual context of where the research was to take place - CAMHS is a clinical health setting which is a very different to context to the school community context. For example, as outlined previously, I would not have access to the resources available in CAMHS to help manage the risk of harm.

A much greater degree of responsibility therefore fell upon me as a researcher than for research that did not potentially access individuals with these characteristics of psychiatric need and vulnerability. These additional responsibilities centred upon:

understanding and actively addressing imminent risk to ensure safety; tensions in confidentiality which are breached under safeguarding protocols due to risk from harm; self-harm disclosure management; how and when to deploy risk and safety interventions; in interviews, ensuring the whole group safety in the face of any of the above, and managing the potential for iatrogenic effects upon the group; also the researcher having the professional competencies and training to manage all of these aspects, as well as requiring immediate access to targeted support located in the community context where the interviews would occur. An immediate resource challenge that faced me was that unlike being a professional within CAMHS I was only in the role of a researcher and I was also not working within a project team, so I had very limited resources to draw upon to manage these responsibilities.

To meet these responsibilities I therefore drew upon the conclusions within the aforementioned research (McCosker et al. 2001; Lakeman & Fitzgerald 2009ab; Biddle et al. 2013; Lloyd-Richardson et al. 2015), my professional knowledge and training in working with adolescent self-harm in CAMHS (e.g. National Collaborating Centre for Mental Health 2004; 2012; 2018; National Institute for Health and Care Excellence 2004; 2013; 2016a; Hawton et al. 2015b), and also an example of interview distress management protocols for youth research participants (Draucker et al. 2009). I subsequently designed and implemented a qualitative research safety protocol to inform the research project's stages where there would be any potential or actual contact with youth from the project, in order to understand and successfully navigate these ethical concerns (Parker 2021ab; 2022).

The research safety protocol design is summarised in *Figure 4.* It included the development of two specific research interview safety protocols to establish the support that would need to be in place in order to help manage the risk of potential harm to the research participants within the research interviews (*see Appendix 2)*. The study's research contract with schools enabled key school staff to be identified whose pastoral and safeguarding support would be available for the purposes of the interview safety protocols (*see Appendix 3*), to facilitate the research in the school context. The research interview safety protocols incorporated the school safeguarding framework in Wales (Welsh Government 2015a) and resided within this framework, which meant the

school context and school staff provided a safeguarding role for the research that took place within their school. An adolescent self-harm signposting and support sheet was also designed as a protective factor to equip any student, their parents/and or carers, and school-based staff with signposting information and support resources about adolescent self-harm (*Appendi*x 4). An intensive and rigorous informed consent process for all of the potential research participants was designed in order to facilitate this research safety protocol informed approach. All of this work enabled the successful management of the complex ethical issues that are present in completing qualitative community-based adolescent self-harm research.

Figure 4: The Research Safety Protocol Design

FLOW CHART.
Steps that structured the adolescent self-harm qualitative research safety protocol design, for the youth participants.

DECIPHer
Centre for Development, Evaluation, Complexity and Implementation in Public Health Improvement
A Public Health Research Centre of Excellence

STEP 1 – Core ethical issue:
Completing research about adolescent self-harm in any context involves managing a "myriad" of complex ethical issues (Lloyd-Richardson et al. 2015).

informs & leads to

STEP 2 - Principles:
Principle: 1. Ensure familiarity with the major clinical and ethical issues when completing research with adolescent self-harm.
Principle: 2. Give an account of these issues that need to be appraised within a specified research project.

informs & leads to

STEP 3 - Research Safety Protocol Design Strategy:
Specification 1. Research to be undertaken by a clinical health professional with front-line experience and professional competencies in working with adolescent self-harm.

Step 3 (cont). *Specification 2.* This individual must have professional practice knowledge of the major clinical and ethical issues that inform quality support work with adolescent self-harm. *Specification 3.* This professional must know the clinical and ethical issues in completing *research safely with adolescent self-harm.*

SPECIFICATIONS 1, 2 & 3: *These deliver the professional practice skills for the* **ACTIVE RISK ASSESSMENT & MANAGEMENT** *that are necessary and specific to this "in vivo" & "in situ" research study.*

Informs & leads to

STEP 4 - Specific research safety protocols design within the current project:
Example 1. The safety protocol for managing participant distress in the interview.
Example 2. The safety protocol for managing participant disclosure of *current* self-harm and/or suicide ideation and behaviours.

CARDIFF UNIVERSITY

Figure 4 Details: In order to navigate the ethical challenges of completing research about adolescent self-harm safely in the secondary school context the flow chart (Parker 2021ab) shows the steps (1 to 4) that structured the research safety protocol design and planning for the specific needs of the current PhD project, targeted to the needs of the research population group and specific research interview context. The protocol was therefore designed to be applied and situated within the school community context for the needs of the youth research population group, to help understand, navigate and manage the complex ethical challenges that could arise within the adolescent self-harm research project.

3.7 Sampling, Study Recruitment, Informed Consent, & The Study Recruitment Barriers & Facilitators

3.7.1 Sampling, Key Stakeholder Groups & Study Recruitment

8 secondary schools in Wales were to be recruited in order to gain 2 key stakeholder groups of research participants, that of sixth form pupils and school staff. Both of these key stakeholder groups would take part within small focus groups or one-to-one qualitative interviews in the school context. The schools were purposively sampled for difference, with the variables of difference being: socio-deprivation indicators (use of FSM levels – low, medium, high); academic attainment (key stage 4 indicators – low, medium, high); school size, through the use of pupil population numbers (small, medium, large); language medium (Welsh language, bilingual or English language). An additional purposefully sampling measure was the National School Categorisation quality indicators (Welsh Government 2019b): Red (in need of greatest improvement), Amber (in need of improvement), Yellow (an effective school) and Green (a highly effective school). This data was drawn from the detailed school data contained in "My Local School" website (Welsh Government 2018b) which is a government resource that provides school contextual data (e.g. pupil numbers and characteristics and school performance figures), and details within Estyn's school inspection reports (2018).

Table 11: The characteristics of the purposefully sampled schools in this study

Secondary school ID	Socio-deprivation indicators: FSM level	Academic attainment: Key Stage 4 indicator	School size	Language medium	National school categorisation quality indicator
1	low	medium	medium	bilingual	red (in greatest need of improvement)
2	medium	low	medium	English medium	amber (in need of improvement)
3	low	medium	medium	English medium	yellow (an effective school)
4	low	high	small	English medium	green (a highly effective school)
5	low	high	small	Welsh medium	green (a highly effective school)

Linked to the purposefully sampled schools in the study, a third key stakeholder group was also planned to be recruited of wider support network professionals from within each of the local authorities that the 8 secondary schools resided within, and also the wider support network system in Wales. This group of key stakeholders would also take part in small focus groups or one-to-one qualitative interviews, delivered within the organisations they were part of. The study recruitment was informed by the socio-ecological public health model (McLeroy et al. 1988; Golden & Earp 2012), to gain research participants within organisations that could facilitate system-level information and analysis, such as in regards to individual, interpersonal, institutional, community and public policy factors. The was due to the study focus being upon the school context and the influences within it upon adolescent self-harm. For example, schools reside within a wider set of societal influences which may both inform and shape their institutional-level practices and responses to adolescent self-harm within their setting (such as governmental policy frameworks and directives).

Ethical approval for the study was gained in August 2018 and the purposefully sampled schools were approached from this date to begin the informed consent procedures for the study recruitment.

3.7.2 *Informed Consent, Confidentiality & Data Protection*

To ensure the fully informed consent of all research participants I strove to design an informed consent process that would deliver quality information and resources about the project (*see Appendix 5)*, through a number of formats prior to the interviews (i.e. handouts, website, face-to-face, as well as email and telephone contact). This included planning for participants to have the time to study these resources, and to have good access to me for questions and information in order to provide decision-making support. For example: I visited each school in the study from 4 to 6 times (prior to the interviews taking place within the school), so that staff and sixth form pupils had access to me, could discuss the research project, and also so that I would become a more familiar person to the potential research participants in order to build trust and rapport; I met with the majority of wider support network professionals within their local settings at least twice prior to their interviews; I set up and designed an online blog site (*see Appendix 5e*), to enable online access to me for information and questions - this approach was created to deliver information for students through a medium they were most comfortable with, and for their parents/carers to have ease of access to me; on all of the project information sheets for pupils, parents/carers, school and wider support network professionals I highlighted my email and encouraged contact with me for more information and questions.

On the information sheet forms I also explained about confidentiality, and how any identifiable information would be anonymised in the research process (for example, through the use of pseudonyms, or any identifiable characteristics to be transformed). The limits of confidentiality due to safeguarding concerns was highlighted, an issue which I would revisit in discussion with all of the research participants prior to the interviews taking place. Also through talking participants through the interview safety protocol centred upon current self-harm and/or suicide ideation disclosure that had been designed for this project.

The details of the data anonymisation process included specific information for participants about the project's data protection and management. Furthermore, the new General Data Protection Regulation (ICO 2018) set the legal standards for consent which was why I designed explicit and detailed "opt-in" consent statements in the consent forms for research participants *(see Appendices 5b-d)*. The GDPR also requires personal data processing to be a transparent process, which I was able to embed in the informed consent information given to all of the potential and actual research participants within this project *(see Appendix 5a, the section in the information sheet on "How is data managed in this project? Will information I give be anonymous and confidential?")*.

3.7.3 *Study Recruitment Barriers & Facilitators*

During the initial study recruitment period there were significant research access barriers that emerged which risked achieving the project's aim. Adolescent self-harm is acknowledged as being a sensitive research topic (Hasking et al. 2015a; Lloyd-Richardson et al. 2015; Lockwood et al. 2018). Hence ethics was a central feature within this project's research design and implementation as outlined in the previous section, in order to help manage the ethical complexities that might arise within this project (Parker 2021ab) but also to help address potential study recruitment and access barriers. Consequently new information was gained during this project regarding some of these barriers which centred upon: gaining schools to participate in this study; schools acting as gatekeepers to sixth form pupils' access to the study; gaining access to county council staff that were linked to the school system.

The full extent of these barriers had been demonstrated by the end of December 2018, where after 4 months of intensive work of having contacted 16 purposefully sampled schools only 1 school and 1 local authority had agreed to have an initial meeting about the study. Unfortunately no specific reasons were given by schools and local authorities for why they would not consider taking part in the research study – these organisations were asked but declined to comment. One positive finding in regards to study recruitment and access facilitators during this period was that senior staff within the public health system did agree to participate, and there was little delay in arranging

these research interviews – each of these senior staff were from organisations concerned with youth and their public health needs at a national policy level, including adolescent self-harm.

Hence more planning and stakeholder activities took place from January 2019 targeting these initial study recruitment and access barriers through the use of an extended informed consent process to continue to try to build positive relationships and work in partnership with the organisations to help address them. Senior staff within schools and their local authorities were visited by the researcher a number of times as part of this process, using community engagement principles from within a community health outreach approach (National Institutes of Health 2011; Public Heath England 2015; National Institute for Health and Care Excellence 2016b; Shin et al. 2020) to help schools and their local authorities to engage with the research topic and understand why it was important for them to take part in this research study. These settings were also informed about the study's adolescent self-harm research safety protocol to help support any youth participants to safely take part in adolescent self-harm qualitative research. Within the extended informed consent process, an additional measure that took place from January 2019 was approaching third sector community organisations that were charities who delivered local authority services relevant to youth self-harm to be included in the study. Each one of these charity organisations who were contacted agreed to take part, so this successfully addressed some of the study recruitment and access barriers. For example, a youth charity facilitated 7 youth participants to take part in the research project.

For the schools and local authority that engaged with this project, these initial visits were 3 or 4 times each site, with senior staff meetings and discussion about the project. This approach enabled 5 purposefully sampled schools (*Table 11 in Section 3.7.1 above provides the characteristics of the purposefully sampled schools in this study*) and one local authority to take part – originally 8 schools had been planned together with their local authorities. In each of the schools the school leadership staff acted as gatekeepers to pupils' access to this study. In 3 schools this was a positive gatekeeping role which facilitated the sixth form pupils' research access and the informed consent process, it also helped to address the research access barriers; in 2 schools it was a

negative gatekeeping role which restricted sixth form pupils' access due to senior staff's fears regarding the research topic.

As a consequence 76 research participants were gained for the study which included: 30 sixth form pupils aged from 16 to 18 years (in three secondary schools in Wales); 7 young people aged from 17 to 24 years (in a community youth centre); 19 school-based staff (in five secondary schools in Wales); 20 wider support network professionals (from 13 wider support network organisations in Wales). *Appendix 6* gives a summary of the research participants and their organisational settings.

For all of the schools and wider support network organisations who participated in the study, the qualitative research interviews took place within these settings from the period of January 2019 through to August 2019. *Appendix 1* gives an overview of the participatory research interviews. The interview length had been designed to be flexible, to suit the participants' schedule, wishes and needs. I had therefore planned the length of the interview to range from between 40 to 60 minutes, the interview duration being dependent upon the participants' wishes and their organisational schedule. The PA interview method *(see Section 3.4.3)*, through the use of the PA facilitator skills, such as in establishing trust and rapport with the research participants, is designed to create a positive and supportive interview environment that facilitates discussion. I had also planned the use of "interview welcome" resources in the interview, which had been designed to target the physical environment of the interview setting, to make it feel comfortable and welcoming to the participants (which included light refreshments being present), to show that they and their views were valued. These resources also served a dual purpose, in that they were part of the resources within the interview safety protocols for the youth research participants (*see Appendix 2A*, the mini risk assessment details). The "interview welcome" resources were in place within the interviews for all of the youth participants, as in each case the school provided me with an interview room, which was an invaluable resource to have and without which the research interviews could not have taken place. For school staff and wider support network professionals, interviews took place in staff meeting rooms, which schools and the organisations invited me to attend at a date and time to suit their convenience, all of which was invaluable for the research interviews. In the role of PA facilitator, I also

utilised "warm up" generic school well-being discussion interview activities to support the research participants to feel more confident about expressing their views, and these "warm ups" enabled a gradual transition process in the interviews towards speaking about the sensitive topic of adolescent self-harm.

The PA approach therefore enabled me to keep the interview space a positive one. Reflecting further upon this point, I also drew strongly upon my CAMHS professional background to create a safe, boundaried and welcoming space for the research participants, in regards to a potentially sensitive topic. For all of the research participants except 2 (these 2 had prior meetings they had attended, and their schedule was subsequently limited), the interview length ranged from 60 minutes to 90 minutes. I did give regular prompts throughout the interview to check if participants needed or wanted to leave the interview. However, they were interested and absorbed in the research topic, and they gave more of their time because they wanted to continue the discussion. This meant I was fully able to focus upon what the participants wanted to discuss in regards to the project's research aims and topic under study, in a safe and boundaried manner.

Therefore the research study's design and methods as outlined within this chapter, these enabled rich and quality data to be gathered, achieving the project's aim due to the breadth, depth, diversity and multiplicity of the 76 perspectives upon the topic under study, enabling many (but not all) of the study's research access barriers to be addressed.

3.8 Data Analysis

3.8.1 Grounded Theory Method

To achieve the study's research aim of theorising schools' influence upon adolescent self-harm, for the purposes of adolescent self-harm preventive intervention in Wales, grounded theory was chosen for the qualitative research data analysis. The use of the grounded theory method was fit for purpose for the study's critical realist ontology and

epistemology, and it also enabled theory to be developed that was anchored in participants' lived experiences and informed by their perspectives. Brief details regarding these points are given below.

In order to attempt to understand the socio-cultural world as it resides within the secondary school context, knowledge needs to be gained of events at both the micro and macro level. A very broad example would be: structural event causation resides at the large-scale macro level, small-scale individual details occur at the micro. Both levels are part of the same event depending on the scale level applied (Ransome 2010). Critical realism's ontological positioning centres upon the stratification of reality (Mingers 2014). Stratification occurs across 3 domain levels: the empirical (events that are experienced or observed), the actual (generated events of activated mechanism) and the real (all of the structures and mechanisms that can generate each and every event). The research task is to explore the realm of the "real" and how it relates to the other two domains (Danermark et al. 2002; Mingers 2014; Alvesson & Skoldberg 2017).

Within critical realism therefore, inferential reasoning through abduction and retroduction is utilised to uncover the mechanisms and generate explanatory theory about the social phenomena under investigation (Sayer 2000; Danermark et al. 2002; Bhaskar 2008; Meyer & Lunnay 2013; Mingers 2014; Mingers & Standing 2017). Inductive reasoning directs the research process to evolve from its foundations of the empirical evidence it has captured to generate theory. Abduction and retroduction are the inferential processes used to deliver this explanatory theory. This is achieved through an examination of the empirical data in order to theoretically describe the phenomena of interest (*abduction*) and to offer an explanation for its existence (*retroduction*). For the theoretical description and explanation that is to emerge from the intensive empirical data, grounded theory meets these needs (Oliver 2012; Bunt 2016). Grounded theory is embedded within the intensive and rich empirical data it produces from the sample under study. It is "grounded" in the research participants' perspectives about the everyday social reality in their social cultural setting. Theoretical concepts are "abstracted" from this data to generate explanatory theory about the socio-cultural behaviours that are evidenced within the specific social context; grounded theory's use

of the logic of abduction and retroduction delivers theory (Charmaz 2006; Reichertz 2007; Oliver 2012; Corbin & Strauss 2015; Bunt 2016; Reichertz 2019).

Kempster and Parry (2014) outline characteristics of a critical realist grounded theory for studying organizations which centre upon the situated nature of the research – all stages that inform the theory generation and development are context dependent. The constant comparative grounded theory method of Corbin and Strauss has the ability to focus upon axial coding for context (2015). This grounded theory method utilises a conditional/consequences paradigm which is an analytical tool to facilitate axial coding. Corbin and Strauss offer a conceptual guide to help support this process (2015, p.163) through an abstracted matrix of the conditional/consequences paradigm. This abstracted matrix is fully informed by the public health socio-ecological model, as it is a complete reproduction of this model (McLeroy et al. 1988). Micro and macro analysis are therefore embedded within the matrix to socio-ecologically appraise the multifaceted interactions of individual, relationship, community, and societal factors; the underlying macro-level structures that generate individual micro-level events can both be captured. This approach means that the context, mechanism and outcome configurations which represent the ontological stratification perspective of critical realism can be undertaken through the use of grounded theory; for critical realism, the context is everything, as knowledge is always context dependent (Bhaskar 2014). Hence the grounded theory data analysis in this study would reveal the micro and macro influences that surrounded adolescent self-harm within the school context; the social norms, values and practices could be brought to light, informed by the research participants' perspectives.

One final point to highlight concerning the grounded theory method is the importance of reflexivity upon the "positioning" of the researcher (Birks & Mills 2022, p.21), in regards to the researcher's ontological and epistemological positioning that informs their research, as these influence the researcher's grounded theory analysis and knowledge construction. Researcher positioning in grounded theory incorporates the concept of "theoretical sensitivity (which) is the ability to recognise and extract from the data elements that have relevance for a developing theory" (Birks & Mills 2022, p.17). A researcher's ontological and epistemological positioning, also their personal and professional experiential knowledge, are all critical elements that can facilitate

theoretical sensitivity (Orland-Barak 2002; Hesse-Biber 2007; Kelle 2007; Hoare et al. 2012; Corbin & Strauss 2015; Vollstedt & Rezat 2019).

Therefore, in regards to theoretical sensitivity, the information I have outlined in this section as well as section 3.3 demonstrates my ontological and epistemological positioning. The researcher positionality section in this chapter *(Section 3.5)* provides information regarding my professional and personal experiential knowledge which has shaped my view of adolescent self-harm, and will have informed my theoretical sensitivity, such as being attuned to the lived experiences of youth with adolescent self-harm within the data analysis, and also the complex risk relationship between adolescent self-harm and suicide. Furthermore, in Chapter 2 (*i.e. in Section 2.4.5, the development of multilevel stigma theory modelling for adolescent self-harm preventive intervention research in the school context*) I have also provided details regarding my prior professional work and research in the field of adolescent self-harm preventive intervention as a CAMHS consultant and researcher. This is why being attuned to the concept of stigma is an important aspect of facilitating my theoretical sensitivity as a researcher to relevant data within the PhD study. In addition, my initial pilot study that was completed prior to this thesis (Parker 2018ab) has subsequently undergone peer review by Birk and Mills and has been used within their grounded theory textbook to demonstrate that through my use of the critical realist paradigm and grounded theory method I "produced the grounded theory of 'stigma' … (and) was able to identify the influence of the institutional context on adolescent self-harm behaviours" (Birks & Mills 2022, p. 32). This helps to develop, enhance and increase my theoretical sensitivity as a critical realist grounded theory researcher for the purpose of theorising schools' influence upon adolescent self-harm, which includes being attuned to the concept of stigma in the data within this PhD study.

3.8.2 *The Grounded Theory Analysis Of The Qualitative Interview Data*

Grounded theory is an iterative approach (Corbin & Strauss 2015; Birks et al. 2019; Birks & Mills 2022), and my data collection and analysis mirrored this process. From October 2018 through to July 2019 qualitative research data was collected from the study's research participants. During this period the interview data was transcribed

verbatim by myself which delivered important benefits in that it enabled me to become fully immersed in and familiar with the data. Using grounded theory the interview data was coded and analysed through the constant comparative approach. The initial analysis therefore began during the same time as the research interviews and their transcription period. The iterative nature of grounded theory meant that I continued the analysis until June 2022, refining categories and their subcategories further in order to generate the explanatory theory.

The grounded theory analysis process was focused upon exploring what was of interest to the research participants, what their main concerns were regarding the research topic under study, what were the similarities and differences within these concerns, centred upon the secondary school context, in order to generate theory.   I coded what was perceived as important to the research participants, informed by their perspectives. As my computer operating system was open source (Linux) I utilised the open-source computer assisted R-based Qualitative Data Analysis package (Huang 2016; Chandra & Shang 2019) to support the coding process. RQDA supported the inductive coding process of grounded theory, and also the practical data management of the analysis of the very large amount of qualitative data that this study generated. For example I could complete very detailed labels for each of my initial conceptual codes which made certain that my codes were anchored in the interview data. I could also review the data contained in each of these conceptual codes easily at any given point in time, which was facilitative of grounded theory's iterative process, such as within the theoretical sampling that is used to saturate categories and their subcategories.

Three stages of coding took place to fully refine the data for saturation purposes, that of open, axial and selective (Corbin & Strauss 2015). In open coding the data was ordered into small units, with the data being interrogated and questioned through the constant comparative technique where each unit was compared for similarities or differences. These captured the concerns of the research participants in regards to the research topic. Through open coding I was therefore able to create conceptual labels that captured the meaning of the data. This enabled the key concepts that were repeatedly present in the data to emerge (Corin & Strauss 1990; 2015). Through axial coding the connections and relationships between the key concepts could be delineated, analysed

and subsequently grouped together. From this process the categories and sub-categories with their properties and dimensions were generated, including the contextual factors and conditions that gave rise to them and their consequences. Selective coding enabled me to draw all of this work together, to deliver the all-encompassing category that each of the categories and their sub-categories resided within. In this way I was able to undertake an analysis of the data to theoretically describe and explain the core and main phenomena of interest.

Integral to grounded theory is the use of analytical memoing which I applied upon the emerging codes and throughout the exploratory investigation. Throughout this process the results of the open, axial and selective codes were reviewed by three senior academics within the School of Social Sciences at Cardiff University as part of the thesis supervision and monitoring. Hence the theory that emerged from the subcategories and their core categories was fully grounded in the research data. Grounded theory's inclusive, encompassing, iterative and systematic approach (Corbin & Strauss 2015) enabled the development of socio-culturally-informed theory embedded in the research participants' perspectives upon the research topic under study.

3.9 *An Overview Of The Study's Results Chapters*

Chapters 4 to 6 present the results findings in this study, which I chose to structure in the following way, mirroring the grounded theory qualitative data analysis and its iterative journey (*as outlined in 3.8.2*). Chapter 4 understands the health education and knowledge that pupils and staff held about adolescent self-harm, illustrated from within their definitions of adolescent self-harm. Due to some of the challenges that surrounded their health education and knowledge, as well as the significant difference between pupils' and school staff's contact with pupils' adolescent self-harm behaviour, Chapter 5 is focussed upon the youth research participants' lived experience of adolescent self-harm in their secondary school context. Chapter 6 presents the main institutional, socio-cultural level influence upon adolescent self-harm in the secondary school context, which is also an explanatory framework that the results findings of Chapters 4 and 5 can be situated within.

The results chapters therefore provide information to understand the study's research questions, drawn from the differing groups of stakeholders in this study. The stakeholder groups are: sixth form pupils from 3 secondary schools in Wales; young people from a community youth centre in Wales; school staff from 5 schools in Wales; and wider support network professionals from 13 wider support setting organisations in Wales (*see Appendix 6* for the full details of the research participants).

The study's research questions are:

- RQ1 – How do staff and students conceptualise adolescent self-harm (within their institutional setting)?

- RQ2 – What are the existing organisational management practices for adolescent self-harm?

- RQ3 – What do staff and students think are the institutional socio-cultural features in the school setting that influence adolescent self-harm (for example, what are the institutional norms, values and assumptions)?

- RQ4 – What types of preventive intervention support[4] do staff and students think is viable within the secondary school context for adolescent self-harm?

In the following sections, a brief summary is given of the results chapters' reporting and the type of information that each chapter provides in regards to understanding the research questions. Each chapter reports information in regards to the study's research questions, drawn from the multiple stakeholder perspectives (brief details are also given regarding which stakeholder groups the qualitative data was gained from, and how it was collected via focus groups or one-to-one interviews). This elicits an in-depth analysis of the topic under study, in order to theorise schools' influence on adolescent self-harm in Wales and understand the role of the secondary school context within pupils' lived experiences of adolescent self-harm, for the purpose of system-level preventive intervention.

---

4   I.e. universal, selective and/or indicated preventive intervention support (Mrazek and Haggerty 1994)

3.9.1 Chapter 4. Understanding Pupils' & Staff's Health Education & Knowledge About Adolescent Self-harm, In Their Secondary School Context

This chapter provides results information regarding the study's research questions (RQ1 to RQ4), drawn from pupils' and school staff's perspectives.

Chapter 4 presents the main themes in pupils' and school staff's definition of adolescent self-harm as a health topic, providing illustrations of their health education and knowledge regarding adolescent self-harm. This health education and knowledge was context-based, shaped by the secondary school context that pupils and staff were part of. The chapter elicits some of the challenges and potential barriers that were centred upon the health education and knowledge about adolescent self-harm in schools, as perceived by pupils and staff in this community-based study.

The qualitative data from pupils and school staff was collected through focus groups and/or one-to-one interviews as demonstrated below:

- **For the 30 sixth form pupils** (*see Appendix 6A for their full research participant details*), the data was collected from 6 focus group and 3 one-to-one interviews (*summary details are presented below*).

ID participant codes and data collection details	*Participant details*
P1, P2 and P3 participated in a focus group together	3 females aged 16 and 17 years
P4, P5 and P6 participated in a focus group together	3 females aged 17 years
P7, P8, P9, P10 and P11 participated in a focus group together	1 female aged 17 years, 4 males aged 17 and 18 years
P12, P13, P14, P15, P16, P17 and P18 participated in a focus group together	6 females aged 16 and 17 years, 1 male aged 16 years
P12 participated in a one-to-one interview	1 male aged 16 years (*P12 chose to have an additional one-to-one interview after he first participated in a focus group*)
P19, P20, P21, P22, P23 and P24 participated in a focus group together	4 females aged 17 years, 2 males aged 16 and 17 years
P25, P26, P27 and P28 participated in a focus group together	4 females aged 17 years
P29 participated in a one-to-one interview	1 female, aged 17 years
P30 participated in a one-to-one interview	1 female, aged 17 years

- **For the 19 school-based staff** (see Appendix 6B *for their full research participant details*), the data was collected from 2 focus group and 12 one-to-one interviews (*summary details are presented below*).

ID participant codes and data collection details	Participant details
S1, S2, S3 and S4 participated in a focus group together	4 females
S3 participated in a one-to-one interview	1 female (*S3 chose to have an additional one-to-one interview after she first participated in a focus group*)
S5 participated in a one-to-one interview	1 female
S6 participated in a one-to-one interview	1 female
S7 participated in a one-to-one interview	1 female
S8 participated in a one-to-one interview	1 female
S9 participated in a one-to-one interview	1 female
S10 participated in a one-to-one interview	1 female
S11 participated in a one-to-one interview	1 female
S12 participated in a one-to-one interview	1 female
S13 participated in a one-to-one interview	1 female
S14 participated in a one-to-one interview	1 male
S15 participated in a one-to-one interview	1 female
S16, S17, S18 and S19 participated in a focus group together	3 females, 1 male

3.9.2 *Chapter 5. Understanding How Adolescent Self-harm Came To Be Present In Pupils' Lives, & The School Context Influences*

This chapter provides results information regarding the study's research questions (RQ1 to RQ4), drawn from the youth participants' perspectives upon their lived experiences of adolescent self-harm in the school context.

Chapter 5 centres upon the youth research participants' perceptions of their lived experiences of adolescent self-harm in their secondary school context. It presents their views regarding the school-context influences upon their health behaviours, needs and support within these experiences, exploring the main themes in their perceptions. This chapter's focus stems from the results findings in Chapter 4 regarding: (1) all pupils

perceiving themselves as having common contact and lived experiences of adolescent self-harm in the school context, either of their own self-harm or that of their peers, and a lack of health education and contact with school staff regarding adolescent self-harm; (2) the majority of staff viewing themselves as having little contact with pupils regarding the health topic and behaviour of adolescent self-harm in their school, and these staff's perceptions as having received very limited or no adolescent self-harm health education in school themselves.

The qualitative data from the youth research participants in this study was collected through focus groups and/or one-to-one interviews (*this information regarding the sixth form pupils has been provided in section 3.9.1 above*).

- **For the 7 youth participants** from a youth community centre (*see Appendix 6C for their full research participant details*), the data was collected from 2 focus group and 3 one-to-one interviews (*summary details are presented below*).

ID participant codes and data collection details	Participant details
SUYP1 participated in a one-to-one interview	1 male aged 18 years
SUYP2 participated in a one-to-one interview	1 female aged 24 years
SUYP3, SUYP4 and WYP8 participated in a focus group together.	2 females aged 17 and 22 years, 1 male aged 22 years
SUYP3 participated in a one-to-one interview	1 female aged 17 years (*SUYP3 chose to have an additional one-to-one interview after she first participated in a focus group)*
WYP8, WYP9 and WYP10 participated in a focus group together	1 female aged 22 years (*WYP8 chose to participate in 2 focus group interviews*), 2 males aged 21 years

3.9.3 *Chapter 6. Understanding The Core Institutional, Socio-cultural Level Influence Upon Adolescent Self-harm In The Secondary School Context*

This chapter answers the main research aim of this study, to theorise schools' influence on adolescent self-harm in Wales, drawn from the perspectives of the youth research participants, school staff, and wider support network professionals.

Chapter 6 presents the main institutional, socio-cultural level influence upon adolescent self-harm in the school context that was found within this study. This is demonstrated by the study's theoretical model, with the model's categories and subcategories illustrating how adolescent self-harm was structured by this main influence. This model supports the theorisation of what causes and sustains adolescent self-harm within the secondary school context.

The qualitative data from the youth research participants, school staff and wider support network professionals in this study was collected through focus groups and/or one-to-one interviews . This information has been provided regarding the sixth form pupils and school staff in section 3.9.1 above, as well as for the youth participants from a community centre in section 3.9.2 above.

- **For the 20 wider system support network professionals** with knowledge of adolescent self-harm (*see Appendix 6D for their full research participant details*), the data was collected from 2 focus group and 10 one-to-one interviews.

ID participant codes and data collection details	*Participant details*
W1 participated in a one-to-one interview	1 male
W2 participated in a one-to-one interview	1 female
W3, W4, W5, W6 and W7 participated in a focus group together	4 females, 1 male
W11 participated in a one-to-one interview	1 female
W12 participated in a one-to-one interview	1 female
W13 participated in a one-to-one interview	1 female
W14, W15, W16 participated in a focus group together	3 females
W17 participated in a one-to-one interview	1 female
W18 participated in a one-to-one interview	1 female
W19 participated in a one-to-one interview	1 female
W20 participated in a one-to-one interview	1 female
W21 participated in a one-to-one interview	1 female

CHAPTER 4: UNDERSTANDING PUPILS' & SCHOOL STAFF'S HEALTH EDUCATION & KNOWLEDGE REGARDING ADOLESCENT SELF-HARM IN THEIR SECONDARY SCHOOL CONTEXT

4.1 Chapter Introduction

The aim of this chapter is to understand pupils' and school staff's conceptualisation of adolescent self-harm, and how this is grounded in their health education and knowledge about adolescent self-harm from within their secondary school context. This is explored through the definitions of adolescent self-harm that pupils and staff held. The chapter is structured in two parts, the first section presenting the main themes within pupils' perspectives and the second those of school staff. The chapter elicits some of the challenges and potential barriers that were centred upon the health education and knowledge regarding adolescent self-harm in schools, as perceived by pupils and staff in this community-based study.

The results in this chapter provide information that contributes towards understanding the research questions in this study, in regards to: (RQ1) how pupils and staff conceptualised adolescent self-harm (within their institutional setting); (RQ2) what some of the existing organisational management practices for adolescent self-harm were; (RQ3) the institutional socio-cultural features in the school setting that influenced adolescent self-harm (the institutional norms, values and assumptions); (RQ4) the type of preventive intervention support that pupils and staff felt were viable within the secondary school context for adolescent self-harm.

4.2 Themes In Pupils' Definitions Of Adolescent Self-harm

4.2.1 The Dimensions Of Self-harm

Pupils defined self-harm using a dimensional approach, applying three dimensions simultaneously which were: (A) the physical self-harm injury; (B) psychosocial factors that were perceived as being detrimental to pupils' well-being; (C) strong negative emotions/feelings that occurred due to or in the context of (B).

In one dimension (A) the physical nature of the self-harm behaviour was defined; it was a physical act where a young person delivered an injury upon themselves, which hurt and harmed them. Descriptions of these harmful physical actions were given by some pupils to delineate them clearly, demonstrating the "doing action" of the self-harm (*see extracts 1*).

Extracts 1

Extract 1.1
    It's[5] damage to one's body, for example cutting. (*P19 male 17yrs*)

Extract 1.2
    It's[6] intent to injure or cause harm to themselves, for example hair pulling, hitting, cutting. (*P10 male 18yrs*)

A second dimension (B) centred upon the psychosocial factors that a pupil might currently be experiencing or facing in their lives, which were perceived as being detrimental to pupils' well-being. These psychosocial factors included: self-deprecation; difficult times; being alone and not having support when needed; mental health needs; societal pressures; stress; self-identity issues, such as perceptions of difference and not fitting in within important youth social contexts (such as school). These psychosocial factors were causal factors in pupils' self-harm behaviour. Pupils did not separate these factors from the physical self-harm injury (A), as in pupils' definition both of these dimensions were interconnected.

---

5 Self-harm

6 Self-harm

Extract 2.1

It's[7] people who harm their legs or/and wrists when feeling upset and down about themselves. (*P3 female 16yrs*)

Extract 2.2

It's[8] a common option when people feel upset and that they don't fit into tight norms and they feel ugly and different. (*P2 female 16yrs*)

Extract 2.3

It's[9] when someone hurts themselves when they are upset and having feelings of depression, stress or other mental health issues. (*P7 female 17yrs)*

Extract 2.4

It's[10] hurting yourself to cope with different things, to take your mind off stress and pressures.(*P10 male 18yrs)*

Extract 2.5

It's[11] when someone is going through a tough time. They might not have anyone to talk to. They feel stressed and upset, and they hurt themselves.(*P13 female 16yrs*)

A third dimension (C) focused upon pupils' strong negative emotions and feelings which were present due to the psychosocial factors that a pupil faced (B). These psychosocial factors meant that pupils felt upset and unhappy, and were experiencing strong negative emotions and feelings *(extracts 2.1, 2.2, 2.3, 2.5)*.

In this way, the physical nature of the self-harm behaviour, the detrimental psychosocial factors that were present, as well as the strong negative emotions and feelings, all of

---

7 Self-harm

8 Self-harm

9 Self-harm

10 Self-harm

11 Self-harm

these were brought together in pupils' definition of self-harm. Therefore for pupils, in order to define self-harm, all three dimensions would be required, as all three points were interconnected. A model of pupils' dimensions of self-harm is presented in *Figure 5* below.

Figure 5: Pupils' definition of adolescent self-harm: The dimensions of adolescent self-harm.

A three dimensional model drawn from pupils' perspectives

(A) The physical self-harm injury

(B)
The psychosocial factors
*These are causal factors that are
detrimental to pupils' well-being*

(C)
Strong negative emotions/feelings
These are present due to (B)

Pupils' definition of adolescent self-harm encompasses
all three points of the triangle.
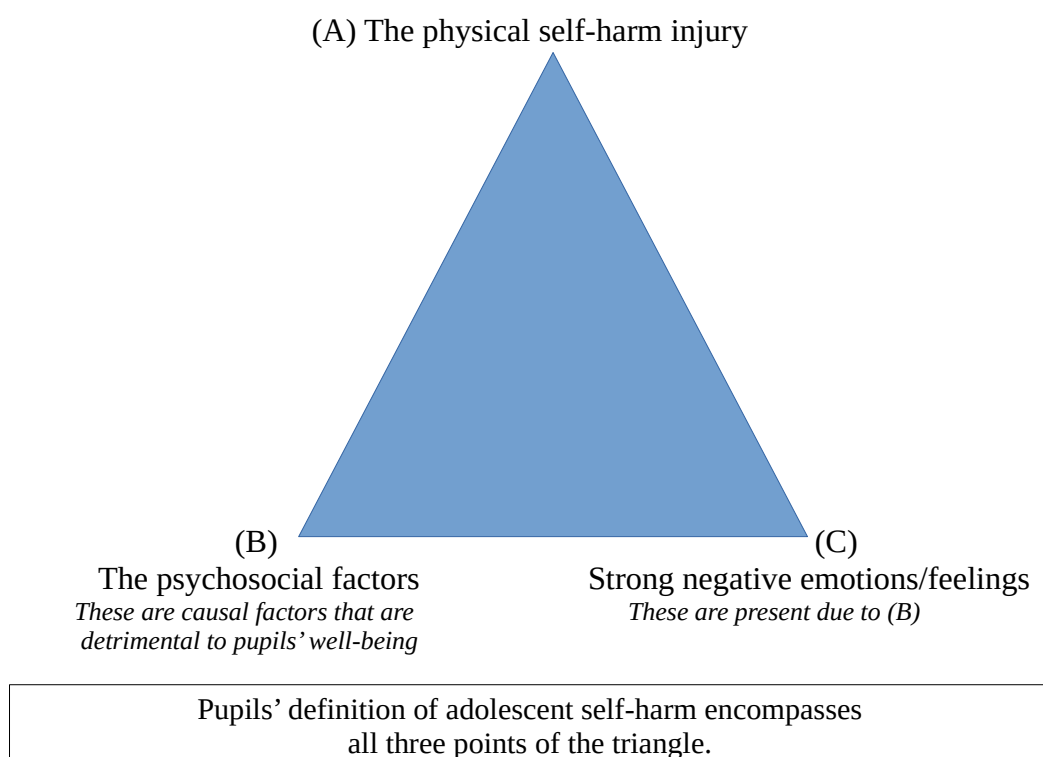
A key feature that was demonstrated within pupils' definition of adolescent self-harm in this way was of self-harm being very specific to what each individual was experiencing in their own lives. Pupils viewed the behaviour of self-harm as being used to cope in many different situations, that it occurred in various individual circumstances, and was diverse in its character and content. Hence through their three-dimensional modelling pupils encapsulated the heterogeneity of self-harm. This heterogeneity is recognised in research, which indicates that adolescent self-harm is associated with multiple

psychological, social and biological factors (Hawton et al. 2012a; Borschmann and Kinner 2019; Townsend 2019).

4.2.2 A Perception Of Self-harm As Common

Pupils defined self-harm by applying the descriptor of "common". Pupils contextualised this descriptor experientially, delineating their perceived common contact with self-harm *(extracts 3)*. Research demonstrates that adolescent self-harm is a common health behaviour (Hawton et al. 2015ab; Morgan et al. 2017; Geulayov et al. 2018; Mars et al. 2019; National Institute of Health and Care Excellence 2022a). This is one reason for why pupils' definition of self-harm (*in section 4.2.1 above*), with its characteristics across three dimensions and complexity, may have a precision and specificity that is significant; all pupils in this study had lived experiences of self-harm, either through their own self-harm or that of their peers' self-harm. Hence pupils were drawing upon their perceptions of their actual experiences.

Extracts 3

Extract 3.1
> I've had quite common contact with it[12] over the last year. Many of my friends have told me they have done it. (*P1 female 17yrs*)

Extract 3.2
> Over the last year it has been quite common for me to have contact with it[13], through my own[14]. But no-one talks about it in school. (*P4 female 17yrs)*

Extract 3.3
> Over the last year, it[15] has been quite a common thing for me. (*P12 male 16yrs*)

---

12 Self-harm

13 Self-harm

14 Self-harm

15 Self-harm

Extract 3.4

Almost bi-weekly in school it[16] was brought up in a significant manner with peers I knew. And often there were hours of intense contact with it due to these peers, for long periods of time, trying to support them. (*WYP9 male 21yrs*)

Pupils' perceptions of them having common contact with self-harm were divided into two groups: those pupils with their own self-harming behaviours, and those pupils who had been made aware of their peers' self-harm and tried to provide support. For both groups self-harm was defined as prevalent, and also a behaviour that they had experiential knowledge about which they chose to share in this study. A sharp contrast was made by pupils regarding their contact with school staff about self-harm, which pupils delineated as "none" or "very small". The majority of pupils highlighted how they perceived they had no contact about adolescent self-harm from school staff, nor any quality health education in school about self-harm such as in Personal and Social Education (PSE) lessons *(extracts 4)*. Therefore for the majority of pupils in this study their definition of self-harm within three dimensions and its specificity was drawn from their own lived experiences and subsequent experiential knowledge, which they perceived was without having any school staff's contact, input, training or teaching. Pupils in this study felt that they had no quality health education from school to draw upon to learn about adolescent self-harm. As such, pupils' knowledge about adolescent self-harm being a common youth health behaviour was not drawn from school health education but from their own lived experiences of self-harm.

Extracts 4

Extract 4.1

We never come into contact about it[17] with teachers. *(P1 female 17yrs)*

Extract 4.2

We have barely ever had contact with teachers about self-harm. I think teachers think it's an awkward subject so they avoid it. (*P24 female 17yrs)*

---

16 Self-harm

17 Self-harm

Extract 4.3

> We never have any contact with staff about it[18]. I haven't been taught
> about it at school, as far as I can remember. (*WYP9 male 21yrs*)

Extract 4.4

> P8. They will tell us a little bit about it[19] in PSE. (*Male 17yrs*)
>
> P10. But only very little, and not often. (*Male 18yrs*)
>
> P11. I don't remember any in PSE lessons. (*Male 18yrs*)
>
> P7. I can't remember one about it[20]. (*Female 17yrs*)
>
> P9. No, me neither. (*Male 18yrs*)

Extract 4.5

> P21. You know with the PSE lessons you had in year 7, 8 and 10. I wasn't
> here for these lessons. Was there something in those lessons about self-
> harm? (*Female 17yrs*)
>
> P19. No, I am pretty sure there wasn't. (*Male 17yrs*)
>
> P23. No, nothing. *(Female 17yrs)*

4.2.3 A Self-harm & Suicide Risk Correlation

Pupils defined self-harm in a risk relationship with accidental death and suicide,
differentiating between self-harm and suicide *(extracts 5)*. In extract 5.2 a number of
factors are given for this relational suicide risk for young people which include: potential
avenues of help or choices closing down when in need of support; a lack of help or
choices in a significant crisis situation (which could lead to pupils as feeling they are on
a cliff edge); having "tunnel vision" which stems from the crisis situation, which leads to
a restriction upon a young person's perceptions of the choices available to them; having
no where else to turn to in this crisis situation. These factors could lead to self-harm
being viewed as the only thing that could help, with a diminishing or lack of options or
choices or help in this crisis trajectory increasing the suicide risk. Pupils felt that this
chain of events might eventually place pupils in an accentuated and precarious position

---

18 Self-harm

19 Self-harm

20 Self-harm

that could lead to the only perceived option remaining for a young person being that of suicide.

Extracts 5

Extract 5.1

> When I think of self-harm it's unlikely that they are going to die. But there is a chance of this. (*P26 female 17yrs*)

Extract 5.2

> I've heard people likening it[21] to …[22] at that point *(coughs)*… there was nothing else that was going to help them … This was ... the only thing ... that was. So they had tunnel vision, and all the avenues, they were running out of them, and that was the only thing at the end of the tunnel. So maybe there is a lack of support networks … maybe, in identifying it[23], and we should be picking them up before they get to the end of the tunnel … *(coughs)* … because if someone is in that position, there is going to be a reason why they are in that position. Maybe things aren't right at home. Maybe they are being bullied at school. So … if your areas of support are cut off, it's like being on a road, and you haven't got anywhere to turn off. There is a cliff at the end, and you have no where to turn off. And that's it … and they could turn around and actually … *(coughs)* kill themselves. (*P10 male 18yrs*)

Extract 6 demonstrates a nuanced exposition of the self-harm and suicide risk correlation. It discusses the differences between self-harm and suicide behaviour, centred upon suicide ideation, and the risks that are present with self-harm. The lethality of the actual behaviour is also highlighted, which could lead to accidental death but this would not be death by suicide. There are therefore challenges in understanding and differentiating when self-harm behaviour is suicide behaviour and when it is not. Health setting research similarly recognises these same challenges and also incorporates lethality of method within a suicide risk trajectory (Silverman 2011; Muehlenkamp 2014;

---

21 Self-harm

22 … denotes long pause

23 Self-harm

Posner et al. 2014; Hawton et al. 2015a), developing a continuum model of self-harm for these purposes (Hawton et al. 2012a; Turecki & Brent 2016) in which adjacent elements are not perceptibly different from each other, but the extremes are quite distinct.

<u>*Extract 6*</u>

> WYP9. Self-harm and suicide, they are linked together. (*Male 21yrs*)
> WYP10. I think strongly. (*Male 21yrs*)
> WYP9. You are very likely risking suicide. But I don't think self-harm is necessarily suicidal in its thought. I would say more often than not, it's not suicidal thoughts. It's a different thing. But by doing it. It's like driving a car fast. One could argue, if you are speeding along the road at 100 miles an hour, going around bends, you are being suicidal. But the thought process isn't "I am trying to kill myself".

As outlined previously in extracts 4, pupils in this study perceived themselves as having had a lack of health education about self-harm, and also a lack of contact with school staff about self-harm. One important influence therefore upon these pupils' health knowledge and understanding about self-harm, suicide ideation, suicide attempts and suicide was their own lived experiences *(these details are presented in Appendix 6A).*

4.2.4 *An Authenticity Assessment Of Self-harm, Being Dependent Upon Its Visibility*

Pupils applied the concept of authenticity to define self-harm *(see extracts 7)* which centred upon its disclosure to others. A distinction was made between either "authentic" self-harm or "inauthentic" self-harm which had an attention-seeking purpose. The "authenticity" of a pupil's self-harm was delineated through an assessment process based upon whether the self-harm was made public through its disclosure to others or not. Any self-harm disclosure in public was deemed as only "for attention" and therefore not very serious *(as in extracts 7)*. For some pupils the "attention-seeking" was caricatured, through the public disclosure of self-harm as being likened to pupils going about the school and "shouting" about their self-harm *(extract 7.2)*. This was contrasted

114

sharply with an opposite group of pupils who kept quiet about their self-harm, which was not disclosed to others – a few pupils also felt this group had complex and "deep" problems *(extract 7.2)* who were in need of actual support. As this latter group's self-harm was not made public it was therefore assessed as "authentic" self-harm by some pupils, in contrast to their perceptions of "inauthentic" self-harm. Hence the "authenticity" assessment centred upon pupils' actions, of pupils either bringing or not bringing their self-harm to the attention of others. Bringing any attention to the self-harm was defined pejoratively as "attention-seeking".

Extracts 7

Extract 7.1
> P1. I think they were struggling, but only a little, and it was almost like, they are definitely doing it[24] so someone could see. (*Female 17yrs*)
> P3. And it's almost as though, it sounds bad again, for getting the attention. People do it for the attention. (*Female 16yrs*)

Extract 7.2
> P11. They like to tell you when they do it[25]. (*Male 18yrs*)
> P7. [No, no no. That's a very general statement. That's the only way we find out about it.] (*Female 17yrs*)
> P8. [No, that's not right. Not many at all. That's a bit] (*Male 17yrs*)
> *Pupils (P7, P8, P9 and P11) begin to talk all over each other.*
> P10. Now then. (*All the other pupils go quiet at this point - this is the head boy speaking*). You've highlighted it there. There's the people that have got deep problems that need solving, they are the ones who aren't telling you. It's the ones that are shouting about it[26], they are just looking for attention. (*Male 18yrs*)

This dichotomous framing of self-harm in this way by young people has been recognised in previous community-based youth-centred qualitative research (Scourfield et al. 2011; Klineberg et al. 2013). A minority of pupils flagged up the limitations of

---

24 Self-harm
25 Self-harm
26 Self-harm

defining self-harm in this way, questioning and opposing it. They disagreed with its negative portrayal of self-harm disclosure to others, perceiving the disclosure as a positive way of finding out about their peers' self-harm *(extract 7.2)*. However the portrayal of the disclosure of self-harm as "attention-seeking" was viewed by many pupils in this study as being held by the majority in the school context *(for example, as in extract 8)*. Community-based research with young adolescents has also highlighted their perceptions of the dominance and prevalence of this negative lens (Chandler 2017).

<u>*Extract 8*</u>

> WYP9. So I'm looking back and seeing a group of people trying to look after one person who was self-harming. Seeing it spread. And then school just leaving it for that group of 15 year olds to deal with, and not fixing it. I think maybe they didn't see it as a big deal. And they were like, "well, it's just a thing", or "they are just doing it for attention". *(Male 21yrs)*
>
> WYP10. There was a general attitude in school that if someone is self-harming they want attention. If you don't give them the attention, they will go away. *(Male 21yrs)*
>
> WYP9. Yes, you just leave them doing something that can risk suicide. They'll be fine (*he sighs heavily*).
>
> WYP10. And this ethos was coming from friends. Teachers. The media as well. In the media that view would come out. Not in like the BBC news, but it was often a general outlook in the media. Like on social media. Also on shows we watched.

One consequence from pupils defining self-harm in this way, in making an assessment of its authenticity, was that it risked delivering negative impacts upon pupils who self-harmed. Pupils cited examples, such as of their friends who had applied the negative attribute of "attention-seeking" to their own self-harm behaviours, judging themselves harshly as a consequence, which led them to confusion about their own reasons for their self-harm *(extract 9.1)*. It also led to pupils keeping their self-harm to themselves *(extracts 9)* because it risked them being disparaged within their potential help-seeking points in school. Community-based research also highlights that this negative portrayal

may act as a significant help-seeking barrier for pupils (Fortune et al. 2008b; Klineberg et al. 2013; Long et al. 2015), points which are also found in health-based setting qualitative research with young people such as those within in-patient units for their support needs (Crouch & Wright 2004; Smith-Gowling et al. 2018). Hence there is a risk that some pupils could use this self-harm definition theme to try to understand either their own self-harm, but it also risks pupils' help-seeking and disclosure barriers *(extracts 9)*.

Extracts 9

Extracts 9.1

> And that sort of thing[27] … it affects the people who genuinely self-harm. I have a friend … She self-harms … she didn't tell anyone … but she sort of convinced herself that she was doing it for attention. She sees that some people think, "oh some people who self-harm do it for attention". So she's convinced herself, that's why she's doing it. And that has just sort of made her think, "oh I must be a horrible person that does this for attention". And that's not why she does it. *(P8 male 17yrs)*

Extract 9.2

> People often think, if you bring it[28] forwards, at least for guys, it's just a … what the word, that you are pretending? Something like that. That it's not that serious. So then we just keep it to ourselves. And it gets worse over time. *(P19 male 17yrs)*

Pupils also gave some further illustrations of the specific health challenges in school, that they viewed as stemming from this negative definition of self-harm. These perceptions centred upon staff not taking self-harm seriously as well as staff choosing to not give their attention to the behaviour or support *(extract 8)*. Some consequences of these issues that pupils perceived were: the behaviour of self-harm appeared to increase within their school community; pupils providing care to their peers were unsupported in school; pupils providing care also had additional and accentuated caring responsibilities due to their peers' increasing self-harm needs; and there was the

---

27 I.e. conceptualising self-harm negatively as "attention-seeking"
28 Self-harm

potential for an increasing risk of suicide in some pupils. Hence pupils perceived this definition of self-harm as attention-seeking to be in itself problematic, generating many negative impacts within their school context. Pupils' authenticity assessment that centred upon self-harm, and the public disclosure of self-harm being deemed as attention-seeking, these were not informed by adolescent self-harm health education as this did not take place in the school context. This conceptualisation may therefore have been informed by the social norms that were held about adolescent self-harm in the school and wider social context. Social norms are shared beliefs regarding behaviour that are held in settings, their wider system and at a societal level (WHO 2010a; Short & Mollborn 2015; Bicchieri et al. 2018; UNICEF 2021; Monaghan & Gabe 2022). They can be of an implicit nature, being unwritten societal rules that govern standards of behaviour held by a dominant social group, and as such can strongly influence the conceptualisation of a behaviour within an institutional setting and at a whole system-level, such as within the school context.

4.3 Themes In School Staff's Definitions Of Adolescent Self-harm

4.3.1 The Physical Dimension Of Self-harm

School staff defined adolescent self-harm by the physical dimension of the harm behaviour, that of the physical harming behaviour that caused the injury to a young person *(extracts 10)*. This differed from pupils' three-dimensional modelling (*Section 4.2.1 above*) which incorporated psychosocial factors and the emotional impact of these within pupils' definition of self-harm.

<u>*Extracts 10*</u>

Extract 10.1
> For me it[29] would be someone who … I would probably think about it in terms of physical harm. So cutting themselves. Erm … Taking … erm … it's mostly cutting that I would generally think is that[30]. Erm … But it is

---

29 Self-harm
30 Self-harm

that physical self-harm, that is how I would think about it. *(S6 Headteacher)*

Extract 10.2
> S1. I would say it[31] is hurting the body in a way that is intentional. That's what I would say. It can be done is so many different ways. But I think it's intentionally causing physical damage to the body. *(S12 duel roles of Pastoral support officer and PE teacher)*

Extract 10.3
> It's[32] the physical marks. You are doing it intentionally in order to hurt yourself *(S17 Head of year)*

Extract 10.4
> When I think of it[33], I always think of them cutting themselves. *(S5 Head of year)*

School staff in this study therefore focused upon what they perceived as "harming behaviours" to define adolescent self-harm. Some staff also added a further qualifier within their physical harm descriptions centred upon intention - the harm injury was not an accidental injury as it was completed on purpose by pupils in order to cause physical damage to themselves. Hence the physical injury behaviour was staff's central focus, and the injury cause stemmed from pupils' own choice to hurt themselves. Unlike pupils, school staff did not include psychosocial factors nor pupils' strong negative emotions and feelings (such as unhappiness and distress) that stemmed from the psychosocial factors within this definition of harm. These dimensions appeared to be absent, as the focus was upon the physical injury and harm.

---

31 Self-harm

32 Self-harm

33 Self-harm

4.3.2 A Perception Of How Common Self-harm Was

Staff definitions of self-harm included descriptors of how common self-harm was, similar to pupils, but there were three descriptors (and not one like that of pupils): uncommon, more common or common.

Some senior-level school staff, who held pupil safeguarding and well-being leadership roles, defined self-harm as an uncommon behaviour, a definition which appeared to be gained from when these staff drew experientially upon the adolescent self-harm from within their own school setting. Therefore, similar to pupils, the descriptor was contextualised experientially by school staff, in regards to their own perceived contact with self-harm in their school context. In these instances the senior staff perceived self-harm as an uncommon behaviour in their own school setting, and also uncommon in general for youth in their community. Furthermore the actual number of pupils in their school who self-harmed were delineated, which for these staff was only a very few pupils *(see extracts 11)*. This pupil number given would mean that these senior staff had little contact with self-harm, and may give one explanation for their perceptions of self-harm being very uncommon in their school and also in the general youth population.

Extracts 11

Extract 11.1
> S14. I don't think it's[34] that common. We have a significant number of pupils with poor behaviour … but not that[35] … it isn't something we come across here … Oooh, dear … over the last ten years I would say that we are probably looking at 1% of our pupils. *(Head of year)*

Extract 11.2
> S11. We don't have … a culture of it[36] here. No we don't. We don't (*she strikes the table with her hand*) … touch wood … we don't have a massive issue here with it … I have about five children that I know of, in a school of 900 … it's just not an issue here. Most kids don't do it … *(Head of safeguarding and pastoral care)*

34 Self-harm

35 Self-harm

36 Self-harm

Hence some senior-level school staff, with pupil safeguarding and well-being leadership roles, appeared to not hold any perception of adolescent self-harm being a common health behaviour. Their perceptions differed significantly from those of pupils who defined adolescent self-harm as common *(as in extracts 3)*.

In staff's delineation of self-harm in this way, when they centred upon their perceptions of the actual numbers of pupils who self-harmed in their school, there was evidence of communication behaviours by these senior school professionals that expressed discomfort. These were expressed verbally and non-verbally *(see extract 11.1, "Oooh, dear", and also the long pauses within extracts 11)*. Chapter 6 provides further contextual details regarding these types of discomfort behaviours as they were representative of the school socio-cultural norms regarding adolescent self-harm found in this study.

Some school staff described adolescent self-harm as a "more common" behaviour *(extract 12)*, reflecting upon and modifying their first thoughts of it being an uncommon behaviour. They drew attention to the very small amount of self-harm that they came into contact with in their school, and they too delineated this with actual pupil numbers *(like the other staff in extracts 11 above)*. Hence these staff also had little contact with adolescent self-harm. However these staff qualified the small pupil numbers with the point that there would be "many more" that they did not know about, hence perceived that adolescent self-harm was a common health behaviour *(extract 12)*. These staff's perceptions of community-based self-harm aligned with the self-harm "iceberg" visibility model (Hawton et al. 2012a), with the greatest part of the "iceberg" submerged under the water and invisible to health services and support. Problems in the surveillance and visibility of adolescent self-harm are well documented in research, which lead to fundamental health support barriers for this population group (Hawton et al. 2012a; 2015b; World Health Organization 2016; Geulayov et al. 2018; Witt et al. 2021).

Extract 12

> Self-harm is more common in our school community than I would think actually. I think I would say I am quite naive in that I would think it was a rarity. We've probably come across two or three in year 12. So you are

looking at three I know out of 120 odd. And I would say there are probably many more. *(S5 Sixth form head)*

A minority of school staff highlighted self-harm as "common" because they had had a sudden increase in self-harm from 2016. This increase was delineated as "massive" and "epidemic" *(extracts 13)*. One consequence of this upon staff was that they themselves had much more contact with pupils' self-harm.

Extracts 13

Extract 13.1
> Over the years then I was finding the reasons for people to come and see me were becoming more and more complicated. And there was a massive increase in self-harm. I would say three years ago[37] we had an epidemic in school.   *(S12 Pastoral support officer and PE teacher)*

Extract 13.2
> Because I have been in this school, this has been my 6th year, and I think in the last three years[38] I've seen a massive increase in the amount[39] that we deal with. *(S1 Assistant head/well-being lead)*

School staff also drew attention to their lack of adolescent self-harm health training in school *(extracts 14)*. These may be explanatory factors why some school staff did not perceive self-harm as a common youth behaviour.

Extracts 14

Extract 14.1
> I haven't had any training on it[40]. Obviously I have had safeguarding training. *(S15 Welfare officer)*

---

37 I.e. 2016

38 I.e. since 2016

39 Self-harm

40 Self-harm

Extract 14.2

So I've not had training on it[41]. It's not something we've had here. We've had safeguarding training, and training on autism and all of that stuff. But nothing specifically on self-harm. *(S10 Health, social care and PE teacher)*

Extract 14.3

We have had no training on it[42]. I would love to have training. We do have safeguarding training and we have to do that. So all staff are trained generically. But I've also got a role now as well-being support. Well I've got a few who are self-harmers, but I don't see them for that. I see them for general well-being to talk about how they are, how they are today and whatever. So it[43] may come briefly up in the topic of conversation but I can't work with it. I'm not trained, I'm not qualified in that. When we had an epidemic in school, that's when I asked for extra support. Because I was getting pupils coming to see me about it and as a result I just felt then this is going beyond what I know. And I needed training. So I had spoken to the previous head, and she told me to look into it. But then nothing came of it. And then she left. *(S12 Pastoral support officer and PE teacher)*

Extract 14.4

We haven't had that much training about it[44]. I am dealing with this daily with our young people. I'm not a trained nurse. I'm not a trained medical professional. I'm only doing the best I can by a young person. And it's hard. Sometimes we get things right, and sometimes we don't. *(S7 School well-being support officer)*

Extract 14.5

I would like training … it[45] is not any easy discussion to have with a pupil. Some staff may find that very difficult to do. Other staff might be

---

41 Self-harm

42 Self-harm

43 Self-harm

44 Self-harm

45 Self-harm

fully prepared to have the conversation about the issue[46], but then find it very difficult to cope with the responses of some children … And either way those conversations can be very very challenging … Sometimes you have to admit it's challenging. *(S14 Head of year)*

The absence of any specific adolescent self-harm health education and training led some school staff to perceive themselves to have knowledge barriers, these being present due to the training issues. This included some staff in a pupil support role who wanted specific training due to their contact with pupils where at times self-harm arose as a pupil health concern *(extracts 14.3 and 14.4)*. This training had not been forthcoming. For one staff member this meant she felt she could not work with pupils' self-harm, perceiving herself as unqualified *(extract 14.3)*. Another continued to try to support her pupils who self-harmed as best that she could, in what she perceived to be a challenging situation, one facet of this being her perception of the limitations in her professional competencies *(extract 14.4)*. One member of staff noted the need for staff training due to his perceptions of the "very, very challenging nature" *(extract 14.5)* of providing support for adolescent self-harm, specifically in regards to discussing the self-harm with the pupil. Therefore points to highlight from within staff's perceptions here are: there may be some contextual-level barriers to staff's health education and knowledge regarding adolescent self-harm; for the majority of staff in this study their child safeguarding training had not included adolescent self-harm, nor had they had any specific health topic training for adolescent self-harm.

Drawing upon the results found within this section, staff's ability to recognise, understand and support pupils' health needs and address specific risks could be impaired by their health knowledge limitations and training needs issues (Welsh Government 2017; 2019a; 2021a; NICE 2022a). Furthermore, as already demonstrated in this chapter, pupils perceived the self-harm and suicide risk trajectory as being influenced by help options for pupils in a crisis situation – a lack of help, or support, or choices in the crisis increased the risks (*as in extract 5.2*). Staff's lack of adolescent self-harm health knowledge and training could limit pupils' range of help options and choices available at a crisis point.

───────────────

46 Self-harm

4.3.3 The Visibility Of Adolescent Self-harm

Visibility was a defining theme of adolescent self-harm held by school staff. A differentiation was made regarding whether self-harm was visible or not visible, specifically within the secondary school context. This definition theme included two domains, with a visibility distinction made between self-harm as characterised within the "private" domain, and that which was in the "public" domain *(extracts 15)*. This dichotomous framing of public and private self-harm within a central theme of visibility is recognised in research which also draws attention to it being present within wider linked system socio-cultural settings, as well as its importance and potential negative impact upon individual behaviour and health support (Scourfield et al. 2011; Taylor & Ibanez 2015; Chandler 2016; Steggals et al. 2020ab).

Extracts 15

Extract 15.1

> So we had no idea that child was self-harming. Because the child was self-harming in a discrete place. The stomach. I do think there are categories of self-harmers, between the open or discrete. And I think a self-harmer who is discrete, that doesn't want anyone to know, in my opinion I think they are maybe a little bit worse. Because it's not in the open domain. And I think the problem is, one, there's the risk of infections. But two, there is no support. So I think that is more of a worry than open self-harm. *(S12 Pastoral support officer and PE teacher)*

Extract 15.2

> For a lot of them, it[47] really is a private thing. And you don't find out about it. So I would say there are probably many more pupils that we just have no idea about. We find out because they become very ill, because they've got an infection because of it[48] or something, and they have often collapsed in front of us. *(S5 Sixth form head)*

Self-harm being visible and in the "public" domain was one route for some staff's contact with self-harm. A further gradation was perceived here by staff which centred

---

47 Self-harm

48 Self-harm

upon staff's perceptions of pupils' self-agency and choice in making their self-harm visible and public. Staff differentiated between pupils who "chose" to publicise their own self-harm and make it public to others, in contrast with those who "chose" to keep their self-harm private until this was only made visible and public due to a health crisis event *(extracts 15)*. Staff perceived that the latter group had not chosen to make their self-harm visible in the public domain as it took place through pupils' acute health needs within a crisis point and not prior to this. Staff highlighted the health risks to pupils in this situation *(extracts 15)*. Research delineates the multifactorial barriers that can impact pupils' choice and self-agency within their self-harm disclosure journeys (Fortune et al. 2008ab; Klineberg et al. 2013; Hasking et al. 2015b; Rosenrot & Lewis 2020), as well as the complexities that may surround pupils' health decision-making processes and in pupils being supported or deemed to have the capacity by professionals to undertake their own health decisions (WHO 2015ab). There may therefore be some tensions in applying the terminology of "choice" and self-agency to pupils within the context of these system-level barriers, which untrained school staff would most likely be unaware of.

Hence staff's self-harm definition theme of visibility had two domains of "public" and "private" self-harm, which were mediated by pupils' self-agency and choice. "Private" self-harm was viewed as being more severe and having more acute health needs than "public" self-harm. When this "private" self-harm came to the attention of staff this was due to a pupil's self-harm health crisis. Therefore a model of acute self-harm that is specific to the school context may be drawn from staff's information here. That is, within the school context there is some adolescent self-harm that is present which is invisible to school staff until a sudden and severe self-harm related health crisis occurs which brings the pupils' acute self-harm needs to the attention of staff – it is only at this acute crisis stage that pupils' self-harm becomes visible to staff due to pupils' need for urgent medical attention. This type of modelling can help to illustrate the characteristics of some pupils' self-harm needs within school for support planning purposes.

4.3.4 An Authenticity Assessment Of Self-harm, Being Dependent Upon Its Visibility.

School staff defined self-harm in regards to its authenticity, of it being authentic or not authentic *(extracts 16)*, differentiating between these two "types" of adolescent self-harm and making an assessment of the self harm's "authenticity". Additional negative attributes were assigned to "inauthentic" self-harm which led to pupils and their self-harm to become disparaged by school staff as being an act or for appearances sake only. Staff demarcated between the self-harm which was "real" and an authentic form of distress, and that which was "for attention" and therefore not valid *(extracts 16)*. The assessment of authenticity was dependent upon whether the self-harm was kept private or made public by a pupil, drawing upon staff's visibility theme definition of self-harm (*as presented in section 4.3.3*). This was also the same definition theme that pupils' held (*as presented in section 4.2.4*), where an authenticity assessment of adolescent self-harm was also made, being dependent upon its visibility, of whether the self-harm was made public by a pupil or kept private. Hence just like for staff, for pupils the assessment rested solely upon the actions of pupils who self-harmed, of whether their self-harm was disclosed to others or not, which led it to be deemed "attention-seeking" or not. Hence this authenticity assessment appeared to be an accepted norm held by both pupils and school staff about self-harm within their school context in this study. Chapter 6 provides further contextual details regarding this conceptualisation of adolescent self-harm, as it was representative of the school socio-cultural norms regarding adolescent self-harm found in this study.

This norm and its inherent tensions that centre upon disclosure, communication, silence and secrecy is recognised in sociological-informed research (Scourfield et al. 2011; Chandler 2016; Steggals et al. 2020ab), as well as the conceptualisation of self-harm through moral judgements that centre upon what is good and what is bad (Creswell 2020).

Extract 16.1

> I think there is intent to hurt themselves or possibly to give the
> appearance of this in whatever social situation they are in or within
> groups, to show there is some scar or scarring. *(S17 Head of year)*

Extract 16.2

> And I think there are two forms[49] now. One form happens to alleviate
> one's pain. But there is another form, much more so, that it is a public
> thing. And then it[50] is an attention-seeking protocol. And for this type of
> pupil who does this, she is getting the attention that she needs, but it's
> the wrong kind of attention. Because she only gets it if she self-harms.
> So you can argue that it becomes a self fulfilling prophecy. "I have to
> keep self-harming so I get the attention". *(S3 Headteacher)*

There are some potential support barriers that this type of negative definition of self-harm may risk for pupils who self-harm and who try to bring their needs forward through the use of disclosure. Pupils' help-seeking behaviours necessitate self-harm being disclosed to another person, which brings the self-harm from the "private" to the "public" domain. However if the "public" disclosure of self-harm in the school context renders it as "inauthentic" and not genuine, this could lead to pupils not disclosing their self-harm and consequently the self-harm getting worse. This is one explanation for why pupils may keep their self-harm private in schools and not disclose it to anyone. This may not be a choice by pupils, who may want to seek help, but it could be a forced privacy shaped by the negative contextual dynamics here that surround any disclosure of self-harm in the school context.

This negative definition of self-harm as inauthentic and attention-seeking has been highlighted in UK school-context research (Cooke & James 2009; Timson, Priest & Clark-Carter 2012; Evans & Hurrell 2016; Doyle et al. 2017). Wider system UK health-context research also demonstrates this same negative definition being present (Jeffery & Warm 2002; Friedman et al. 2006; Dickinson, Wright & Harrison 2009) and posits

---

49 Self-harm

50 Self-harm

that it could undermine professionals' support provision including in undertaking psychosocial assessment (Barr, Leitner & Thomas 2005) and wound treatment decisions (Rai, Shepherd & O' Boyle 2019). Hence this type of negative definition of self-harm is not isolated to schools but exists across the interrelated system. What is unique to this PhD study is that it delivers more detail about the school-context mechanisms here. It also means youths' fears of themselves being labelled "attention-seeking" if they bring their self-harm into the "public" domain and ask for support, as demonstrated in prior research (Rowe at al. 2014), may actually be well-founded fears, which could also lead to poor treatment and support. This may add further complexity to pupils through the negative impacts that may occur within a potential self-harm disclosure point. These school-based negative factors may impact pupils' self-harm trajectories, with worst case pupils being at risk of collapsing from their health needs and injuries (*as demonstrated in extracts 16*) due to this being the only point their needs can be made public and disclosed within the school context.

The lack of staff training highlighted in this chapter section may be a major explanatory factor for the main themes that staff held within their definitions of adolescent self-harm. Furthermore if staff viewed themselves as untrained and not qualified they perhaps would not feel confident in teaching this health topic to pupils, nor would they feel confident in providing support. They may not be able to provide health education and support to pupils at an individual support level but also at a whole-school level. There could be an absence of adolescent self-harm health topic education within the whole school community *(as illustrated in pupil extracts 4 and staff extracts 14)*. These may be explanations for why pupils might perceive they have had little or no contact with school staff about the topic of self-harm *(as in extracts 4)*. Further analysis surrounding these issues are presented within this study's grounded theory model in Chapter 6.

Wider research highlights that there is an urgent need to both recognise and take adolescent self-harm seriously due to the risks that are presented to adolescents and young adults if their self-harm is not treated as such (Mars et al. 2019; Townsend 2019). One of the specific risks stemming from the research findings in this section centred upon school staff's definitions of self-harm is that it could lead to increasingly desperate measures by young people to have their needs recognised. This may cause pupils to

change their self-harming behaviour method and increase its lethality, *as illustrated in extracts 17* where two young people have both done this as a way of communicating their distress, and also for their ongoing unmet needs to be recognised and taken seriously by professionals. As previously outlined in chapter 2 (*section 2.2.4*), research by Hawton et al. (2020) that explored a cohort of over 9,000 10 to 19 year olds over several years has demonstrated an increased risk of death for adolescents who self-harm from suicide and accidental death, a risk which lasts for a duration of consequent years. They raise the issue that changing the method of self-harm to more lethal methods is a factor within this increased risk of death.

Extracts 17

Extract 17.1

> And this boy had hanged himself on the back of a door with his phone charger cable … and we cut him down ... but when I took him to the psychiatrist they said he wasn't suicidal … And he was a prolific self-harmer. I mean every inch of his arms was covered … And … looking back now, I don't think he was suicidal … I think he genuinely was trying to say to us, you've seen all this self-harm, I am serious about this. *(W13 Trainer in self-harm support)*

Extract 17.2

> SUYP3. When I was 13, I used to do it[51] in the back of the classroom. And no-one would notice. *(Female 17yrs)*
>
> Researcher. If you don't mind me asking, when you self-harm in the class like that, what would you define it as?
>
> SUYP3. It's a cry for help. I've been trying to ask my GP for years for help. It was only, phew, March, April last year when I took an overdose, that he actually listened to me.

---

51 Self-harm

4.4 Chapter Conclusion

This chapter has gained an understanding of how pupils and school staff conceptualised adolescent self-harm within their secondary school context, through presenting the main themes in pupils' and school staff's definition of adolescent self-harm. It also denotes the absence of adolescent self-harm health education in the school context for pupils and for the majority of school staff, and some of the critical issues that stemmed from this.

The main themes of pupils' and school staff's definition of adolescent self-harm appeared to share some similarities which included: the dimensions of self-harm; how common self-harm was; and an authenticity assessment of self-harm. Additionally for pupils there was the theme of a self-harm and suicide risk correlation. For school staff a further theme was the "visibility" of self-harm, in which staff also perceived that adolescent self-harm that was kept private by some pupils risked severe self-harm needs and health crises. But within these themes, although there were some similarities and overlaps, there were also some critical differences between both groups in regards to the information contained within their themes, which the chapter elicits. Consequently the chapter presents some of the challenges and potential barriers upon the health education and knowledge of adolescent self-harm in schools, as perceived by pupils and school staff within this community-based study.

The chapter has demonstrated that pupils and the majority of school staff perceived that they had not received any quality health education about adolescent self-harm within their school context, which was a critical barrier to their knowledge. Staff wanted to receive school health education and training about adolescent self-harm for their pupil support needs. A further critical issue centred upon pupils' perceptions of having little or no contact with school staff about the behaviour of adolescent self-harm. This was mirrored by the majority of staff in this study, who perceived themselves to have little contact with pupils regarding their self-harm behaviours. Hence there were barriers within the organisational management practices for adolescent self-harm, as school staff had not received specific training regarding adolescent self-harm. This also led to

support barriers being present for pupils' self-harm needs, with staff perceiving themselves to be untrained and unqualified to provide this support.

An important key results finding in this chapter was that pupils in this community-based study perceived themselves to have common contact and lived experiences of self-harm (through their own self-harm, or their peers' self-harm), whereas the majority of school staff in this study did not. Pupils' knowledge of adolescent self-harm was drawn from their lived experiences, and not from school health education as there was none about adolescent self-harm in the school context. For pupils, having no health education and little contact with school staff when they may be having common contact lived experiences of self-harm, these could present many risks.

The chapter has also presented an example of an institutional norm, value and assumption in the school setting that was a negative school influence in regards to adolescent self-harm. This was the concept of authenticity, where a pupil's self-harm underwent scrutiny by others and an assessment was made of whether the pupil's self-harm was "authentic" or "inauthentic". Paradoxically, within this norm, the disclosure of self-harm by pupils rendered their self-harm to be assessed as inauthentic and pejoratively defined as "attention-seeking". This conceptualisation risked delivering negative impacts upon pupils who self-harmed, such as: pupils applying this concept to their own self-harm and judging themselves harshly as a consequence; the concept causing pupils to become confused about their own reasons for their self-harm; acting as a disclosure barrier for pupils, who kept their self-harm private and to themselves because the concept risked them being disparaged within any of their potential help-seeking points in school. As an institutional-level norm in the school context, chapter 6 provides further details regarding this conceptualisation of adolescent self-harm that has been demonstrated in the results of this chapter.

Due to this chapter's results findings of pupils perceiving themselves as having common contact with adolescent self-harm, and given their lack of health education and contact with school staff regarding adolescent self-harm, the next results chapter explores pupils' lived experiences of adolescent self-harm in their secondary school community context, and their health behaviours, needs and support within these experiences.

CHAPTER 5: UNDERSTANDING HOW ADOLESCENT SELF-HARM CAME TO BE PRESENT IN PUPILS' LIVES, & THE SCHOOL CONTEXT INFLUENCES

5.1 Chapter Introduction

The aim of this chapter is to understand the conceptualisation of adolescent self-harm and the school context influences, drawn from the youth research participants with lived experience of adolescent self-harm in their secondary school context. Through this approach pupils' health behaviours, needs and support in the school context can be explored. As Chapter 4 has demonstrated, pupils perceived themselves to have common contact and lived experiences of adolescent self-harm, through their own self-harm or their peers' self-harm. This chapter is therefore structured into two parts to present the main themes in youths' perspectives upon their lived experiences of adolescent self-harm in school and the school context influences. The first part centres upon the "own self-harm" lived experiences, the second part upon the "peer self-harm" lived experiences. The overarching conceptual theme within both types of lived experiences was of how adolescent self-harm came to be present in pupils' lives within their school context. However, how this came to be differed between the two types of lived experiences, which the chapter elicits, to present the conceptual differences.

The results demonstrated in this chapter are drawn from the youth research participants' perceptions. The results therefore provide information that contributes towards understanding the research questions in this study, from youths' perspectives, which includes: (RQ1) how youths with lived experience of adolescent self-harm in their secondary school conceptualised adolescent self-harm within the school context; (RQ2) what youths with lived experience of adolescent self-harm in their secondary school viewed were the organisational management practices for adolescent self-harm in the school context; (RQ3) what youths with lived experience of adolescent self-harm

in their secondary school thought were the institutional socio-cultural features in the school setting that influenced adolescent self-harm;(RQ4) the type of preventive intervention support in school that youths with lived experience of adolescent self-harm in their secondary school felt was viable for their support needs.

5.2 The Main Themes Within The "Own Self-Harm" Lived Experiences, Of How Adolescent Self-harm Came To Be Present In Pupils' Lives: The Circumstances In The School Context Which Were Perceived As Leading Pupils To Self-harm

The themes in this section present the school context circumstances and risk factors that the youth research participants perceived led them to self-harm, which was how adolescent self-harm came to be present in pupils' lives in school.

5.2.1 The School Context Circumstances: Peer Violence, Its Pervasive Nature, & Perceptions Of The Lack Of Help In School

For the youth in this study who disclosed their own self-harm behaviour, a main explanatory factor within their initial self-harm trajectories was their experiences of regular peer violence in school, and its negative impacts upon their well-being *(see extracts 1)*.

<u>Extracts 1</u>

Extract 1.1

> The bullying …[52] School was just … a horrible place for me … I moved from school X because of the bullying. And then half of the bullies moved from school X to school Y after I did … And I have been pushed under a school bus and injured … With you being in school, and with the daily bullying, you are still the school's responsibility. Like, the school needs to help you. That's what they are supposed to be there for. But they don't do this. I didn't get any help at school. The school bullying went on

_____

52 … denotes long pause

134

the entire time I was there and so I self-harmed. No-one would help.
(SUYP3 female 17yrs)

Extract 1.2
The bullying in school was horrendous. Absolutely horrendous and
school didn't do anything about it. The bullying varied from classmates
or the class teasing me, to the 6th form boys sexually harassing me. It
sort of varied. I would have things thrown at me, I would have items of
my personal possession broken, including my phone. It was just a range
of bullying each day. It was horrendous and the staff in school weren't
doing anything at all. I was so stressed I self-harmed. *(SUYP2 female
24yrs)*

Extract 1.3
During class it was name calling and being mean. But in between classes
and in break time, it would be hair pulling, punching, head butting. I had
my nose broken from being head butted. I had two girls hold me up
against the wall, while that happened. It used to be a bunch of girls
surrounding me, picking on me and stuff like that. It was really like hard
core. For a long time. For the whole time I was in school. And school
didn't do anything about it. I tried to ask for help, my teachers didn't do
anything about it, they seemed to be unaware of it, and so I was self-
harming because of all this. *(WYP8 female 22yrs)*

Extract 1.4
The school bullying, I was in a horrendous state. I mean it got to the
point that I was bullied in year 9. Someone held a knife to my throat in
school, in front of everyone. It just got to the point that I just wanted to
end it all. I was not in the right mindset. I just wanted them to please
stop bullying me. That's what I would call out, "please just stop". But no-
one answered to me. *(SUYP1 male 18yrs).*

These peer violence experiences were of a regular nature and relentless, which
participants endured *(see extracts 1)*. The ongoing and pervasive nature of the peer
violence led pupils who were victims of this to self-harm. These peer violence incidents

included physical violence and assault, one of which was corroborated by a parent, including its ongoing duration *(see extract 2)*.

<u>*Extract 2*</u>

> W2. With my daughter (*i.e. WYP8*), there was a lack of belief. School not believing what she said. Every day when she would come home, she would be crying. She would have pieces of scalp ripped out. She would have spit all over her clothes. I knew this was not normal childish behaviour in school. And it was a whole group of girls. Two of them pinned her against the wall, in the middle of the school grounds, and the other one head butted her, when we got her to the hospital they said her nose was broken. Another time they literally beat her and spat all over her. These are the things that happened … So this went on altogether for six or seven years. And school just couldn't deal with any of this. And through all this my daughter *(i.e. WYP8)* was self-harming. *(Community Youth Support Worker and parent)*

The extensive and perpetual nature of the peer violence for pupil victims, which includes victims being unable to escape and having to endure this long term, are characteristics that are recognised in research (Chrysanthou & Vasilakis 2020). Self-harm research also demonstrates the link between peer violence and self-harm (Andrews at al. 2014; Geel et al. 2015; Holt et al. 2015), including the characteristic of the peer violence's perpetual nature (due to these being repeated events within the school context) within pupils' self-harm (Barker et al. 2008).

In pupils' peer violence experiences, participants held expectations that support would be provided in school to help address the violence *(extracts 1)*. However in each case participants perceived this help did not occur, and that because the peer violence was not addressed it continued. It was therefore an ongoing and large part of their lives in school *(extracts 1)*. Participants felt that school had failed in their duty and responsibilities to protect them, and had given them no help *(extracts 1)*.

A critical risk that was present in these school context circumstances (i.e. peer violence, its pervasive nature, and the lack of help in school) was that of pupils' death by suicide *(extract 3)*.

<u>*Extract 3*</u>

> When people find out that bullying heads to where someone kills themselves, they will start to realise that a person is going through a lot. With my friend a lot of people took this girl to be small and a weirdo, and she was being bullied so much. Everyone thought she was fine. And the next minute, she wasn't. She was dead. She took a load of pills and everything. They need just to stop the bullying in school. It needs to stop. Because of the countless times of that happening[53]. I mean I've lost a lot of friends through bullying, from suicide. *(SUYP1 male 18yrs).*

This suicide risk appeared to be present when pupils in school thought that ongoing peer violence was a common and endemic factor in their school context *(extract 4.1)*. In these challenging circumstances, where pupils' perceived there to be no support or options available, these issues might place a young person in a hopeless situation with few support options *(extracts 4)*. This could risk suicide to be viewed as "the right way out" *(extract 4.1)*, because there was nowhere for these pupils to turn to and find different options other than that of suicide, placing pupils on a cliff edge *(extract 4.2)*.

<u>*Extracts 4*</u>

Extract 4.1
> With all of this bullying, the kids around here, they think suicide is the right way out. But honest to god, it's not. Because I've dealt with a lot of all that myself. With the bullying, I talked myself out of suicide. And other people. Me and my mate, we both stood on the bridge[54]. And then I was like, "No. I can't do this." And I stood off and grabbed him. Because he wanted to go. *(SUYP1 male 18yrs).*

---

53 Pupils' deaths by suicide

54 This high bridge was close to the secondary school. It had no safety barriers or any other safety measures in place.

Extract 4.2

> So … if your areas of support are cut off, it's like being on a road, and
> you haven't got anywhere to turn off. There is a cliff at the end, and you
> have no where to turn off. And that's it … and they could turn around
> and actually … (*coughs*) kill themselves. (*P10 male 18yrs*)

These findings mirror those found in wider research which demonstrates that being a victim of peer violence is a strong causal factor in suicide behaviours and ideation (Holt et al. 2015), as well as death by suicide (Klomek at al. 2010). The longer that pupil victims experience peer violence the more they are placed at risk in regards to adolescent suicide ideation and suicide attempts (Geoffroy et al. 2016), which is why the enduring nature of the peer violence in the school context found in the PhD results here presents a serious risk to pupils. A critical public health point to raise is that if there is a high bridge close to a school setting, with no safety barriers in place (as in extract 4.1), this safety risk should be urgently addressed (Public Health England 2015), due to the ease of access for pupils to a potentially lethal self-harm and suicide method. Hawton's (et al. 2012a) causal pathways in adolescent self-harm and suicide risk modelling exposit a range of underlying risk factors, which include: negative life events, of which peer violence is an example; psychological distress and hopelessness, which the pervasive nature of the peer violence and the lack of help in school could lead pupils to experience, these being negative and painful emotional states; the accessibility and lethality of the method that is chosen for the self-harm, with its lethality also bringing a risk of accidental death and also suicide for young people, of which a high bridge by a school with no safety barriers is a critical risk factor; also young people coming into contact with the behaviour of adolescent self-harm or suicide, a risk which the school community context presents. Hence the themes in this section centred upon peer violence mirror many aspects of Hawton's (et al. 2012a) model, providing illustrations from pupils' lived experiences in their secondary school context.

Placing the findings within this section alongside the results of two School Health Research Network studies (Hewitt et al. 2019; Page et al. 2021) which found that over a third of secondary school pupils in Wales stated they had been bullied in school (in the 8 weeks prior to both of these SHRN studies), these may warrant further research

investigation in order to gain further details about the peer violence in schools in Wales and pupils' safety, centred upon pupils' lived experiences within their school context. Pupil perceptions of a lack of support are highlighted as an important risk factor within pupil self-harm and suicide focused research (Andrews et al. 2014; Geel et al. 2015; Madjar et al. 2018). The results' findings in this section mirror these research findings, but give more details drawn from pupils' perceptions of the type and nature of the long-term school context negative circumstances pupils may be experiencing which risk them to self-harm.

5.2.2 The School Context Circumstances: Pupils' Help-seeking Behaviours For Their Self-harm Perceived As Being Ignored By School Staff

Pupils undertook help-seeking behaviours for their own self-harm which were directed to school staff. But they perceived that at this help-seeking juncture school staff closed down the topic of self-harm. They felt that no attention was given to their self-harm and that the topic was ignored by school staff, leading to no further discussion or support. They held the perspective that they were not given opportunities to discuss their self-harm and support needs *(extracts 5)*. These circumstances left pupils' self-harm support needs unmet and therefore pupils' self-harm continued, which was why adolescent self-harm became a long term health issue for these pupils during secondary school. This was a major factor in why pupils' initial self-harm behaviour continued and was present in their lives for a long period of time whilst they were in secondary school.

Extracts 5

Extract 5.1

There were some issues in secondary school, like if I brought up that I was doing self-harm, they would stop any support. They would be seriously concerned and get other people involved, and then they would stop the session. And that would be that. And I would never hear anything again. They said I was in danger and they needed to investigate, that sort of thing. My self-harm was closed down immediately whenever I brought it to the table for discussion, and help never came. *(SUYP2 female 24yrs)*

Extract 5.2

> There has been nothing about it[55], not in school. And I know like a lot of people with it, and they have nowhere to go. Because it's a topic not many people talk about much, I feel. And if you bring it up, like they say, it's not a problem, don't worry, you'll grow out of it, it's a phase. And then nothing more is said about it[56]. And so we never talked about it again. But honestly, for me it's just got worse since then. So it doesn't help when they do this in school. *(P29 female 17yrs)*

Extract 5.3

> Before, I had like a massive blow, and I wanted to end it all and tried to … to …[57] One thing I've found, but a lot of people, they might not mean to, but they disregard these things. In school I wish there was somebody exactly for self-harm that I could talk to. Not a school counsellor. Someone, if you were feeling really bad about it, or you are worried about someone else, you can talk to somebody. And they deal exactly with that. Because there are like, so many things about it. The school counselling just hasn't focussed on the self-harm. It hasn't done anything about it. I don't know what to do. *(P29 female 17yrs)*

Pupils therefore wished to discuss their self-harm needs with school staff, for help and support. They did engage in help-seeking for these purposes. In regards to the youth viewpoints that held that school staff closed the topic of adolescent self-harm down, excluding it from pupils' support needs, Chapter 6 provides further contextual details regarding this type of staff behaviour, as it was representative of the school socio-cultural norms regarding adolescent self-harm found in this study. Some examples that were perceived of how staff closed the topic of self-harm down at pupils' help-seeking points were as follows:

1. School staff became "seriously concerned" about the topic *(extract 5.1)*. Staff explained to the pupil that the pupil was in danger from their self-harm, which required further investigation. These staff subsequently told other school staff

---

55 Self-harm

56 Self-harm

57 The pupil is making a reference to their suicide attempt.

about the pupil's self-harm and their serious concerns about the pupil due to their fears that the pupil was in danger from their self-harm. The consequences were that there was no further discussion by staff with the pupil regarding the pupil's self-harm, and no help appeared to be provided for the pupil's self-harm support needs.

2. School staff minimised the pupil's self-harm and appeared to not view adolescent self-harm as a serious health topic. This meant that staff decided that support was not needed for the pupil's self-harm. The consequences were that no further discussion took place by staff with the pupil regarding the pupil's self-harm and support needs *(extract 5.2)*.

3. School staff ignored and excluded the topic of adolescent self-harm from pupils' health support. The consequences were that there was no discussion by staff with the pupil regarding the pupil's self-harm and support needs *(extract 5.3)*.

In these help-seeking points that were initiated by pupils for their self-harm support needs, school professionals were perceived as taking the lead. School staff directed the decision-making processes and subsequent actions. This is in contrast to a more participatory and person-centred approach of professionals working with pupils' perspectives upon their own health behaviours and needs. As a consequence, for the youth in this study who disclosed their own self-harm behaviour in school, they perceived there to be an absence of targeted support provision within the school context for their self-harm needs.

Within this type of school environment, if school staff closed the topic of self-harm down when pupils asked for help from them for their self-harm support needs, this could deliver critical risks for pupils in self-harm or suicide behaviour crises due their needs being unmet. There also could be increased risks here if pupils had already experienced ongoing peer violence and held perceptions of no support in school for their situation, given these are key risk factors that have been highlighted in the lived experiences in *Section 5.2.1*. For example, when factoring in the potential negative health impacts from the topic of self-harm being closed down at pupils' help-seeking points by staff (*such as*

in the examples illustrated in points 1 to 3 above), this may lead to pupils' perceiving their specific needs are neglected and that no pupil support is available. These could deliver a cascade of negative factors that risked pupil self-harm, suicide behaviours and suicide. Chapter 4 reveals staff's lack of training and the problematic issues that surrounded some staff's definitions about self-harm, which could be some explanatory factors within these circumstances. Hence at a critical support point when pupils' self-harm becomes clearly visible in the public domain of school, which necessitates school staff to take action and provide support, this may not take place due to these types of school context circumstances. Chapter 6 provides further contextual details upon this point.

The impact upon pupils' self initiated help-seeking behaviours could be profound. Help-seeking behaviours within a quality youth health orientated system-level support context (which includes access to wider support network resources) can be critical junctures in a young person's life, having the potential to facilitate unmet needs and support avenues to become visible and explored in a non-judgemental person-centred approach, focussed upon a young person's health and well-being (WHO 2010b: 2015ab; 2017; 2020b). The circumstances outlined in this section potentially risk any future help-seeking behaviours by pupils to become subdued or to cease. If due to these circumstances pupils hold perceptions of help and support being unavailable, this could have the potential to increase their psychological distress and hopelessness which are two key risk indicators in self-harm and suicide risk modelling (Hawton et al. 2012a). It would also mean that pupils' self-harming behaviours would continue for long periods of time whilst in school (*as in extracts 1, 2 and 5)*, presenting many health risks to pupils.

The findings in this chapter regarding the specific circumstances and risk factors which pupils perceived led them to self-harm, as well as their self-harm to continue, centre upon school context circumstances. These were the main factors in how adolescent self-harm was perceived to become present in pupils' lives within their secondary school context. In addition, a risk of pupils' death by suicide also emerged.   An important point to raise here was that school staff in this study did not make any reference to these types of school context circumstances and risk factors as conceptualised in the "own

self-harm" lived experiences in this chapter, nor the unmet support needs here for both pupils and their peers. This may mean that school staff are unaware of these issues and the risks that they present in pupils' self-harm and suicide trajectories. The lack of help and support in school for pupils regarding their experiences of peer violence and also within their help seeking points to school staff for their self-harm support needs are unexpected results findings, which warrant further research investigation.

These factors risked pupils to perceive the school as a negative environment. Public Health England's analysis of pupils' self-harm in the 2013/14 Health Behaviour in School-aged Children study found that those pupils who perceived the school environment as negative were more likely to have reported that they had self-harmed (Brooks et al. 2017; 2020). This same theme was also present in the ALSPAC self-harm and school self-reported experience study by Kidger (et al. 2015). Hence the school environment plays a critical role in pupils' health and well-being. The research findings in this chapter section delineate the perceptions from youth with experience of their own self-harm in the school context, from which the negative impacts and risks that can be present for adolescent self-harm within their secondary school environment are drawn. The findings depict the support barriers that may be present in school for pupils with lived experience of self-harm. These types of support barriers for adolescent self-harm are illustrative of pupils holding a disadvantaged group status, as well as the presence of health inequalities (Whitehead & Dahlgren 2007; WHO 2010a; Viner et al. 2012; Braveman 2014; Luchenski et al. 2018; National Collaborating Centre for Mental Health 2019). The health risks stemming from these issues are highlighted within wider research which demonstrates that it is the accumulative nature of these adverse experiences that are critical risk indicators of poor health outcomes (Bethell et al. 2017; Oh et al. 2018; Ports et al. 2020). Specifically, as perceived by the youth participants in this study with lived experience of their own self-harm, the poor health outcomes were self-harm, suicide ideation, suicide attempts and death by suicide.

5.3 The Main Themes Within The "Peer Self-Harm" Lived Experiences, Of How Adolescent Self-harm Came To Be Present In Pupils' Lives: The Circumstances In The School Context Which Were Perceived To Lead To Pupils' Initial Contact With Adolescent Self-harm, Through Their Peers' Self-harm

The themes in this section present the school-context circumstances and risk factors that the youth research participants perceived led to their initial contact with adolescent self-harm, which was how adolescent self-harm came to be present in the pupils' lives in school.

5.3.1 The School Context Circumstances: Peers' Self-harm Crisis Episodes

A major school context influence that first brought adolescent self-harm to become present in some pupils' lives in school was that of their peers' self-harm. The main theme in the lived experiences of "peer self-harm" was that adolescent self-harm first became visible to pupils through their peers' self-harm health crisis-incidents *(extracts 6)* within their secondary school community context. A health crisis is an emergency situation, where serious detrimental impacts are occurring (or have occurred) upon a person's health and well-being; health encompasses a person's mental health and another term that may also be used is that of a mental health crisis (NICE 2004; Gask & Morriss 2009; NICE 2011; Care Quality Commission 2015).

Extracts 6

Extract 6.1
> Friends, they would just bring it[58] up. It was never, "help this has happened". It was always, "I've done this[59], and then it could be bad. They would be bleeding. *(WYP10 male 21yrs)*

Extract 6.2
> And then when my friends did it[60], then they would always send a message to you and a graphic picture. In an individual message, not in a

---

58 Self-harm
59 Self-harm
60 Self-harm

group chat. And normally it was out of the blue, kind of thing. They don't say, "oh, this next picture is going to be me with slit wrists". It's "bang". Here's a picture of me with slit wrists and bleeding. *(WYP09 male 21yrs)*

Extract 6.3

We were in biology, and I saw X take a blade off his sharpener, and he then went to the toilet where he hurt himself. He was bleeding. *(P10 male 18yrs)*

Extract 6.4

At that end of year school party which school had arranged, my friend was drunk and cut himself with a razor blade in the toilet. He had an accident, the blade slipped and he was bleeding a lot. I found him bleeding in the toilet. He had collapsed on the floor. *(WYP09 male 21yrs)*

Extract 6.5

So they were like, "last night you know, I hurt myself". And then they would show us and it[61] was bad. And they would be injured. *(P3 female 16yrs)*

In the descriptions of peers' self-harm crises, these revealed the key junctures when peers' self-harm behaviours became visible to pupils, which was when pupils came into contact with their peers' self-harm. This occurred at two key points within peers' crisis episodes, the characteristics of which are outlined within points A and B as follows:

A. At a post-injury point, when peers had physically self-harmed themselves:

   I. either immediately after the physical harm behaviour had taken place *(extracts 6.1,6.2,6.4)*:

   II. or within a few hours after the self-harm injury *(extract 6.2)*, or

   III. or in the following morning at school *(extract 6.5)*;

---

61 Self-harm

B. At a point when peers were taking direct action to physically harm themselves *(extract 6.3)*.

For pupils therefore, their contact with their peers' crisis-incidents occurred through three visibility routes which included:

1. Peers choosing to reveal and show their self-harm injuries to pupils, after peers' physical harm behaviour had taken place *(extracts 6.1,6.2,6.5)*.

2. Peers undertaking preparatory action to physically self-harm themselves, which pupils noticed *(extract 6.3)*.

3. Pupils finding their peers alone and in an emergency situation due to their injuries from peers' physical harm behaviours *(extracts 6.3,6.4)*.

These visibility routes were also facilitated by pupils' community-based access, location, proximity and presence to their peers, within their peers' crisis-episodes. For example, some pupils were physically present in the school community-based location with their peers where a peer's community-based self-harm crisis episode took place, such as the school toilets *(extract 6.3)*, the school classroom *(extract 6.3)* and the school social setting *(extract 6.4)*. Therefore, by pupils being present in the school community with their peers, and by pupils having community-based contact with their peers due to the school context, these were key factors why peers' self-harm crises became visible, as well as the emergency nature of the crises. This could mean there is the potential for any pupil in a school community-based setting to have contact with their peers' self-harm crisis episodes, like the pupils within this study.

The visibility of peers' self-harm through their crises episodes also meant that pupils were brought into contact with detail about the methods of self-harm that their peers' used. Pupils' perceptions were that the majority of peers in the self-harm crisis episodes captured in this study cut themselves *(extracts 6)*, and that razor blades were used for the harm injury method *(extracts 6.3,6.4)*. The razor blades were gained from an everyday object that all pupils carry in school, that of a pencil sharpener. These sharpeners have razor blades within them that can be dismantled to gain access in the

school setting to a razor blade, as extract 6.3 demonstrates. Furthermore this dismantling process may also not necessarily be an easy thing to achieve, and may risk pupil injury in this process, particularly if this dismantling takes place when a pupil is in distress. This information was corroborated by one school staff member in this study who also recognised that pupils used pencil sharpener blades for the purpose of cutting themselves, highlighting the risks of the type of wound and subsequent infections *(extract 7)*. Use of a raw razor blade means that a person's control of the blade may be difficult, as well as the blade's ability to inflict deep wounds, leading to risk of heavy bleeding and potentially lethal injuries (characteristics which are potentially captured in *extracts 6 and 7*). Therefore an everyday school context item that all pupils carry in their school presents a risk for some pupils when it is used by pupils as a way of carrying and gaining access to a razor blade for their self-harm behaviour.

<u>*Extract 7*</u>

> And with the cutting, by pupils taking razor blades out of pencil sharpeners, you can see the deep scars and the infections that can cause. *(S7 school well-being support officer)*

School-based adolescent self-harm research recognises that the majority of pupils who self-harm do not access health services support, but that some pupils may undertake help-seeking behaviours which are mainly directed to their friends (Fortune, Sinclair & Hawton 2008b; Rowe at al. 2014). The results in this section therefore add some further details upon the type and nature of pupils' help-seeking, such as that which occurs through some pupils' self-harm crisis episodes. These crisis episodes can act as catalysts in bringing pupils' self-harm into the visibility of other pupils, who then may try to provide support, as the next section demonstrates.

5.3.2 *The School Context Circumstances: Pupils' Support Provision In Their Peers' Self-harm Crisis Episodes*

In conjunction with the main theme of pupils' first contact with adolescent self-harm being through their peers' self-harm crisis episodes *(in 5.3.1),* another theme in the lived experiences of "peer self-harm" was the support that pupils attempted to provide within

these crisis episodes. This crisis support role brought pupils into close contact with adolescent self-harm in their school context. This support provision took place due to pupils' perceptions of their peers' crisis needs and self-harm injuries which required urgent support (*as in extracts 6 above and extracts 8 below*). For pupils who were immediately present to their peers' self-harm injuries, these pupils perceived the harm injuries as being serious due to the severity of the cut, and in the majority of cases the level of bleeding that was taking place at this same time *(extracts 6 and 8)*. For pupils where there was a delay before their peers revealed their self-harm injury to them (i.e. in the following morning at school), these pupils also perceived their peers' self-harm injury as a significant wound *(extract 6.5)*. As well as the nature of the injuries described, pupils also captured their peers' symptoms of shock (Doerschug & Schmidt 2016; Standl et al. 2018) and the consequences of these in peers' crises (i.e. ongoing bleeding, blood loss, pale appearance, shaking, physical collapse – *extracts 6.1,6.2,6.3,6.4 and extracts 8*). Any treatment delay in this type of situation may lead to serious harm.

Extracts 8

Extract 8.1

> WYP10. Like one friend, she would just say, "oh I've done this[62]". And then I was like, "oh shit, OK". Because it was bad and bleeding. And she would be white, and like shaking. *(Male 21yrs)*
>
> Researcher. Sorry, just for the recording notes here, WYP10 has just looked at his wrist and made a large slash gesture.
>
> WYP10. Well, it's not exactly a nice thing to say, is it really? People don't like saying it[63]. People don't like saying "slitting wrists". And so I talk with her. I talk with her for about half an hour. But I dealt with it[64] all the time, and I don't have any training. I'm guessing.

---

62 Self-harm

63 Self-harm

64 Self-harm

Extract 8.2

And it[65] can be at anytime during the day or night. So you try and give help, but like, what can you do if they send you a message and you are then seeing someone with slit wrists and bleeding? (*distressed tone*) Like there is nothing that you can do (*very distressed tone*). So you go, 'poor you', and you talk and you try and be supportive as possible. *(WYP09 male 21yrs)*

Extract 8.3

And when I saw him take the pencil sharpener blade and leave the classroom to go to the toilet, I followed him. And I had to try, I wanted to get the blade off him. So I was talking and talking to him, and he had hurt himself badly, and so I was ready to kick down the door. This was in year 11. I just talked to him, and then he did slide it under the door to me. And there was a lot of blood. And if I told someone, they[66] wouldn't trust me. And then, when they got into a bigger situation, I wouldn't have been there to help them. So you just stay by them. That's all you can do in these difficult situations. *(P10 male 18yrs)*

Extract 8.4

My friend was bleeding and I couldn't find any teachers[67]. There were supposed to be teachers there. Oh my God (*distressed tone*). And so they didn't do anything to help. So I was talking to him. But he wouldn't go to the hospital, wouldn't call his parents. He still wouldn't go to hospital, even though he was bleeding. He didn't want any help. I had to get the razor blade off him. And now that I am thinking looking back, now I am 21, where were the teachers? He was in serious danger, especially by being drunk and bleeding. There could have been an accident. And there was an accident. I didn't know what to do. *(WYP09 male 21yrs)*

---

65 Peers' self-harm

66 I.e. the peer in the self-harm crisis

67 This was an end of year 11 school celebration for pupils organised by the school (pupils were 16 years old at the end of year 11) where teachers were apparently supposed to be present but appeared not to be.

Pupils provided their physical presence and empathetic "talking" support to their peers *(extracts 8)*, both of which are invaluable in crisis episodes (Mental Health Foundation 2007; Care Quality Commission 2015; Samaritans 2020; Young Minds 2021). However pupils highlighted that they "didn't know what to do" *(extract 8.4)*, that they were "guessing" *(extract 8.1)* during a self-harm crisis incident, that they perceived there was nothing that you could do in these emergencies except be present and try to talk supportively *(extracts 8)*. Even with their lack of knowledge and training, pupils did try to provide support through these methods. But their lack of knowledge negatively impacted their use and efficacy of these, within the demanding and challenging situation they were placed within. Furthermore the majority of the pupils did not take any first aid action to address their peers' physical harm injuries. Some pupils also placed themselves and their peers at risk of further physical harm by attempting to get a raw razor blade off their peers themselves, when peers were in crisis *(extract 8.3)* and also intoxicated *(extract 8.4)*. Critically therefore, pupils did not choose to or were unable to gain access to any crisis or first aid health support for their peers' injuries. Pupils remained physically (or virtually) present with their peers in these situations and perceived themselves to be the only source of support. This also meant that pupils spent periods of their time with their peers for the duration of these complex incidents, the majority without accessing any further support for their peers' needs.

Underpinning pupils' perceptions of not knowing what to do in these situations were also a number of perceived factors that centred upon no support being available for them to access, which acted as barriers to pupils' help-seeking to health services or school staff on behalf of their peers. These perceived factors included: the disclosure of the peer's self-harm crisis through social media *(i.e. when a pupil was "virtually" present, as in extract 8.2)*; school staff not being able to be found in the setting the pupil was in *(as in extract 8.4)*; the situation being a regular occurrence that an individual experienced with their peers which potentially normalised it *(as in extract 8.1)*; pupils not wanting to break the trust of their friends when peers had asked them to keep it private *(extract 8.3 and extracts 9)*.

Extract 9.1

It was a big shock because I had never experienced that[68] before … I have never gone through it. I didn't really know what to do. You want to be a good friend and be there for that person, and keep their trust. So it is difficult. So that was about 2 years ago. And it impacts me because it is someone I am close to. I've found … from friends who've like …yes *(upset tone and voice trails off shakily)* … So I've got a number of people that are close to me with this[69]. And you don't know what's going on all the time, and how to get help. And this eats away at the trust. And it's then difficult for you … I think it's such a sensitive position to be in, to have that information. You want people to be trustworthy. Often people will say, "I don't want anyone to know". But it's when do you disclose about it? It's hard for people to know. At what stage do you do this? Obviously, it's an impossible question. When does it become too much for you to deal with? *(P27 female 17yrs)*

Extract 9.2

And I didn't want to "out them". For me, I considered it[70] quite a private matter. So they say, "can you keep this a secret". And like I would not betray their trust. I would definitely not do that. Even if … well … it … it can be really hard *(upset tone)* … because it[71] carries on, and because I also don't think anyone can help. And well, they might be angry at you if you go for help. And it might make them end up being in a worse state. Because you've, looking for a better word, betrayed them. So they will feel like "that's another person I can't trust". *(P19 male 17yrs)*

Extract 9.3

And because they don't want anyone else to know about it[72], then it can just very easily end up with one person carrying it. Which I would say is

---

68 Self-harm

69 Self-harm

70 Self-harm

71 Self-harm

72 Self-harm

pretty tough (*upset tone*). And that's draining. Especially if it's for long periods of time. So you feel like you are constantly looking after them. If it's like one conversation about it[73], that's not necessarily draining. But if you've gone two months of carrying someone though that, that's when it's draining. And if you are there for someone each time they do this over a two or three or four year period, then that's hugely draining. Like it was for me with my friend in school. *(WYP09 male 21yrs)*

For the majority of youth in this study with experience of their peers' self-harm in secondary school, keeping the trust of their friends who self-harmed was of paramount importance, and they viewed this trust to be integral to their friendship relationship, which if betrayed would change and damage the friendship *(extracts 8.3, 9.1 and 9.2)*. One consequence that these pupils feared regarding this friendship breakdown was that it could place their friend in an isolated position, and at more risk of emotional and physical harm. Hence most of these pupils did not want to betray their friends' trust, and also perceived themselves to be in a position of being the only support for their friends' self-harm needs.

This carer and support role brought pupils into close and regular contact with peers' self-harm within their secondary school community-based setting *(extracts 8 and 9)*, a support role that pupils could be placed in for long periods of time, sometimes for years *(extracts 9.1 and 9.3)*. Providing care to their friends in these circumstances was perceived as challenging and difficult for themselves *(extract 8.3 and extracts 9)*, and there was also some evidence of their distress regarding these incidents when they spoke about them (as in the distressed tones that occurred within *extracts 8.2, 8.4 and 9)*. There were also complex ethical health dilemmas for these pupils to have to navigate on their own, with no prior information, knowledge or training to draw upon to help manage these. For example NHS guidance acknowledges the complexity of providing support within self-harm crises and has a range of specific protocols in place for health and care professionals in order for them to navigate the challenges that may arise, such as within the informed consent process in order to support a young person to gain treatment access for their physical harm injuries (National Collaborating Centre

---

73 Self-harm

for Mental Health 2004; NICE 2004). Some pupils in this study highlighted how they had taken the hard decision to "betray" their friends' trust in order to try to get help from school staff due to their perceived severity of their friends' self-harm, but unfortunately this was viewed by the pupils as unsuccessful due to staff's inaction *(extract 10),* which was a response that appeared to happen a number of times to pupils' help seeking to school staff regarding these issues. This negatively impacted any future help seeking by these pupils for their peers' self-harm needs.

Extract 10

P1. I went to a teacher about one of my friends cos they would do it[74] all the time. And I went to the teacher. But I totally regretted that, because they did nothing. It just made it worse. *(Female 17yrs)*

Researcher. Can you outline how it made it worse?

P1. Because we had her trust in telling us, and we made the decision, me and another friend, because we both knew about it[75]. And we were so nervous. And we discussed it. So we went to a member of staff, 'cos we thought it was for the best because it[76] was getting out of control. And they did nothing about it. So we ruined the trust for nothing.

Researcher. Were you able to go for help again to anybody else?

P1. We didn't try after that. That's why I wouldn't go to a member of staff again, because nothing happened. And that's happened a lot with me when I've gone for help from teachers.

P2. The same for me. *(Female 16yrs)*

P3. They are kind of just marking, or too busy. Or tell you to go and find help elsewhere. *(Female 16yrs)*

P2. I just wouldn't go to them.

P1. It wouldn't even be an option for me any more.

Hence within youths' perceptions upon their lived experiences of these issues, the complexities and challenges emerged *(extracts 8 and 9)* that pupils had to try to manage and carry all by themselves in the school context *(extract 11)*. This was felt by

---

74 Self-harm

75 Self-harm

76 Self-harm

some pupils as an almost impossible situation to know how to manage *(extract 9.1)* for the specific support needs that were present. An important point to raise (which was the same point made for the "own self-harm" lived experiences in section 5.3.2) was that school staff in this study did not make any reference to these types of school context circumstances as conceptualised in the "peer self-harm" lived experiences, nor the unmet support needs here for both pupils and their peers, raising the potential of school staff being unaware of these issues and the risks they present for pupils and their peers. The health surveillance barriers that surround community-based adolescent self-harm are well documented, as demonstrated in Chapter 2. One consequence would be that the details regarding the self-harm crisis incidents would not be captured within the health surveillance systems of the local community, such as within local councils' well-being needs assessments (Social Services and Well-being (Wales) Act 2014, s14.1) or the linked wider health systems monitoring processes, with these incidents being invisible to them. This would maintain the status quo regarding the issues captured from within pupils' lived experiences of adolescent self-harm in school and their support needs.

Extract 11

> WYP09. I now would say self-harm is happening. It's widespread. It's common. Adults need to understand this. The pupils, these are kids who are the ones who are dealing with it, with this issue in school. And no-one is helping them. I know the 16 year olds and 15 year olds in my school and there are a lot of them there who are self-harming. The people who are dealing with that and carrying that are kids. Like we had to. It is still the same teachers there, the same headteacher. You are basically leaving it to kids to help other kids, to also deal with the fact they are self-harming or potentially suicidal. And so for self-harm we need something very different, considering the current system at the moment. It just doesn't work for self-harm. It needs to be ripped out and a new one needs to be put in. *(Male 21yrs)*
> WYP10. And the kids in schools they just accept it. They don't complain. They just try to help their friends, with no support. And for pupils,

nothing about any of this[77] is an obvious thing to do. Adults would struggle to do that. A friend shouldn't have to do all of this or have to carry it all by themselves.*(Male 21yrs)*

WYP09. What's harsh is giving that burden to a pupil to carry on their own. Because it is a burden, and it takes a massive toll. And even now, thinking about all this, it's still a punch to the guts. Damn (*he sighs and exhales strongly*).

Research exposits that friends are an important source of informal support to peers who self-harm (Fortune, Sinclair & Hawton 2008b; Rowe at al. 2014; Holland et al. 2020), but does not provide details regarding the specific needs of these pupils who provide this type of informal support. Given adolescent self-harm is common this could also mean that pupils may be supporting more than one friend at a time. The findings within this section therefore present important detail in regards to the characteristics of the "informal" support that pupils may be providing to their peers, which could be pupils providing emergency support for their peers within a self-harm crisis. The results findings in this chapter which demonstrate that pupils had contact with their peers' acute self-harm crises, and also attempted to provide support for their peers within these crises, these are unexpected results findings. The emergency nature of the crises, their complexity, the fact that pupils are trying to provide crisis support, the lack of pupils' adolescent self-harm health education, these present critical risks within these crises to pupils and their peers. These warrant further research investigation. Recent Welsh Government support guidance for professional adults in youth settings responding to adolescent self-harm highlights the emotional impact on adults, as well as it potentially being "difficult, exhausting and distressing, … risk(ing) stress and burnout" (Welsh Government 2019a, p.34). This would be the same for pupils in the school context providing support to their peers within the self-harm crises, but with more risks for pupils given they are not adult professionals, do not have a professional support network to draw upon, are not perceived by professionals as providing this type of support, and do not receive professional training due to their pupil role and age.

---

77 I.e. trying to provide support in peers' self-harm crisis episodes

5.4 Chapter Conclusion

This chapter has gained an understanding of the conceptualisation of adolescent self-harm and the school context influences, drawn from the youth research participants with lived experience of adolescent self-harm in their secondary school context. This has been achieved by presenting the main themes in the two types of lived experiences found in this study, that of pupils' own self-harm and that of their peers' self-harm.

The main conceptualisation of adolescent self-harm found within both types of lived experiences was of how adolescent self-harm came to be present in pupils' lives in school. However, this differed for each type. Within the lived experience of pupils' own self-harm, the school context circumstances and risk factors that led them to self-harm were: peer violence, its pervasive nature, and the lack of help for the peer violence in school. Also pupils' help-seeking behaviours to school staff for their self-harm were perceived as being ignored, which was a factor in why their self-harm continued to be present whilst they were in school. The lack of help and support in school within pupils' experiences of peer violence and also within their help seeking points to school staff for their self-harm support needs, these are unexpected results findings. Within the lived experiences of peers' self-harm, the school context circumstances and risk factors that led adolescent self-harm to first become visible to pupils was due to their peers' self-harm health crisis episodes. This led pupils to attempt to provide their support to peers within these crises, a crisis support role which brought these pupils into close contact with adolescent self-harm in their school context, sometimes for many years. Pupils' contact with their peers' acute self-harm crises, the support that they provided within these crises, and the lack of school support available for them in this complex crisis carer role (which could be a long term support role that pupils provided for their peers in school) are unexpected results findings.

A critical school support barrier therefore found within both types of lived experiences was the perceptions of the lack of support in school from school staff regarding these school circumstances and risk factors. An issue to highlight is that school staff in this study did not make any reference to these types of school context circumstances and risk factors as conceptualised in this chapter by the youth research participants with

lived experience of adolescent self-harm. Therefore, at a school organisational and management level, these school context circumstances and risk factors for pupils may be unknown. Within the lived experiences of own self-harm, pupils' perceptions were that in their help seeking to school staff, the topic of adolescent self-harm was excluded from being discussed by school staff and also an excluded topic from pupils' support needs. This exclusion was representative of the school socio-cultural norms regarding adolescent self-harm found in this study, of which further details are provided in Chapter 6.

Some pupils with long term lived experience of their own self-harm wanted to be able to talk about their self-harm and discuss their self-harm support needs in school. They wished to have targeted help and specific support regarding self-harm to be in place in school so that they could have someone they could go to in order to discuss their own self-harm when needed, and also discuss that of their peers' self-harm if they were worried about them. Within the peer self-harm lived experiences, due to their peers' self-harm crises this brought pupils into close contact with adolescent self-harm. Within these circumstances first aid and health crisis support for peers' injuries did not occur; pupils felt they did not know what to do, drawing attention to their lack of knowledge and health training to inform their actions and support within these complex self-harm crises. Pupils were also presented with a complex ethical dilemma of not breaking their friends' trust whilst providing support in their peers' acute self-harm crisis points. These circumstances were perceived as difficult and challenging, which led to pupils feeling burdened, under pressure and in distress. Attention was drawn to the fact that these pupils carried this support burden on their own in the school context, with no help being available for them in their school, or for their peers who self-harmed, and that this was inappropriate. It was therefore deemed by youth in this study who provided support for their peers' self-harm in school that the current system in the secondary school context for adolescent self-harm was fundamentally inadequate and a new one needed to be put in place.

Following on from the results findings in this chapter and Chapter 4, the next chapter presents the results of the grounded theory analysis of the main institutional, socio-cultural level influence upon adolescent self-harm in the school context that was found

within this study, drawn from the the research participants' perspectives, which offers a theoretical framework within which the results findings of Chapters 4 and 5 can be further contextualised.

CHAPTER 6: UNDERSTANDING THE CORE INSTITUTIONAL, SOCIO-CULTURAL LEVEL INFLUENCE UPON ADOLESCENT SELF-HARM IN THE SECONDARY SCHOOL CONTEXT

6.1 Chapter Introduction

The aim of this chapter is to understand the main institutional, socio-cultural level influence upon adolescent self-harm in the secondary school context, and how this was grounded in the multiple stakeholder perspectives of youth with lived experience of adolescent self-harm in their secondary school, school staff, and wider support network professionals within the broader school-linked system with knowledge and experience of adolescent self-harm. This is demonstrated through the theoretical model presented in this chapter, which conceptualises the core institutional, socio-cultural level influence upon adolescent self-harm in the secondary school context, for the purposes of preventive intervention support design, drawn from the perceptions of the key stakeholders within this study. The chapter is therefore structured to present the grounded theory model with its main categories and subcategories. There are six categories in total. Data extract evidence is provided to illustrate each subcategory. The data extract evidence is a small sample of selected extracts which are representatives of a much larger evidence sample for each category and subcategory. Each category of the model is a conceptual domain with no hierarchy or numerical order, and the categories have been numbered purely for chapter structure clarity.

The results in this chapter answer the main research aim of this study, which was to theorise schools' influence on adolescent self-harm, presenting the overarching socio-culturally informed theory from the grounded theory analysis. The chapter also provides information that contributes towards understanding the research questions in this study, revealing how this pivotal institutional, socio-cultural level influence: shaped how pupils

and staff conceptualised adolescent self-harm in the school context (RQ1); impacted the existing organisational management practices for adolescent self-harm (RQ2); structured the institutional norms, values and assumptions in the school setting in regards to adolescent self-harm (RQ3); affected the type of preventive intervention support that pupils and staff thought was viable within the secondary school context for adolescent self-harm (RQ4) .

6.2 Introduction To The Grounded Theory Model Of Stigma

The systematic grounded theory analytical method, with its emergent and abductive logic, led to a cohesive set of interlinked concepts, generating this study's model (Corbin & Strauss 1990; Tavory & Timmermans 2019) which was informed by the research participants' perspectives. This analysis revealed that stigma was a dominant and pervasive institutional, socio-cultural level influence upon adolescent self-harm within the school context. A summary overview of the grounded theory model of stigma is presented in *Table 12*, with its main categories and subcategories. Stigma was consistently present within the qualitative data, being both dominant and widespread. Stigma was viewed by wider support network professionals as the fundamental issue that negatively impacted adolescent self-harm in schools (for two examples, *see extracts 1*). These professionals perceived that stigma acted as a mechanism for discrimination, as well as for school to become an adverse environment for pupils and their self-harm health support needs. For these professionals it was of paramount importance that the issue of adolescent self-harm stigma in the school context was brought to the forefront, in order to begin to try to address it.

Extracts 1

Extract 1.1
> The stigma in schools is without a doubt the biggest barrier with self-harm. But if we don't talk about it, it is never going to go away. So we need to just put stigma up front and central, and keep on going trying to address it. Stigma is huge, and the discriminatory aspects are huge too.
> *(W1 Children's charity manager)*

Extract 1.2

> The issue in school is the stigma. Young people spend so much time there … for young people school is their life. The school context is really important for modelling behaviours. Between peers and teachers with self-harm. Teachers have spoken to me in the work I do about how much they struggle with self-harm. They also don't know what to say or do. So I think there is a lot of work to do in school for self-harm. *(W23 Senior academic, health professional and government advisor)*

Table 12: The grounded theory model of stigma – the stigma categories & their subcategories

THE STIGMA CATEGORIES	CATEGORY SUMMARY OVERVIEW AND THEIR SUBCATEGORIES
1.Word Tabooing	**CATEGORY SUMMARY:** This category was the avoidance of the use of the word "self-harm" in the interviews. The word "self-harm" was positioned as being under a taboo, which acted as a barrier through restricting the use of the word. **SUBCATEGORIES SUMMARY:** (A) The use of physical gestures to denote adolescent self-harm, as a non-verbal replacement. (B) Euphemisms. Substitution words or expressions were used as a replacement for adolescent self-harm. (C) Long pauses that were used prior to the physical gestures, replacement words, or the actual use of the word "self-harm". (D) Discomfort behaviours which occurred in communication centred upon self-harm.
2. Exclusion	**CATEGORY SUMMARY:** The was the perceived exclusion of adolescent self-harm from the established social, educational and physical boundary norms in school, with self-harm being positioned as outside of these norms and excluded. The topic of self-harm and pupils who self-harmed were excluded from: a school's public discourse; a school staff member's professional role and responsibility (i.e. of providing pupil support and safeguarding) norms; the school-pupil group norms as held by school staff or the pupil group; the school public service norms. **SUBCATEGORIES SUMMARY:** (A) School public discourse exclusion. The topic of adolescent self-harm being perceived as being barred from a school's public

THE STIGMA CATEGORIES	CATEGORY SUMMARY OVERVIEW AND THEIR SUBCATEGORIES
	discourse, excluding adolescent self-harm from this.
	(B) School staff duties exclusion. The topic and behaviour of adolescent self-harm was perceived as being removed from staff's duties and professional roles, excluding self-harm from these.
	(C) School-pupil group norms exclusion. Distinctions/differentiation were made about adolescent self-harm which placed adolescent self-harm outside the conceptions of the school-pupil group "normality"[78] that were held regarding pupils in school (either by school staff or other pupils). Adolescent self-harm was perceived as being excluded from these school-pupil group established norms.
	(D) School public service norms exclusion. Pupils with adolescent self-harm behaviours were perceived as being excluded and restricted from having access to some of the public service norms in school that centred upon promoting pupils' education and welfare that other pupils automatically had access to.
3. Negative judgements	*CATEGORY SUMMARY:* This category was the negative judgement held about self-harm, where stereotypical depreciations were made that meant that the topic and behaviour of adolescent self-harm was belittled. *SUBCATEGORIES SUMMARY:* (A) Adolescent self-harm was judged as immature or foolish and ridiculed. (B) Adolescent self-harm was judged as a superficial trend and fashion that was for an outward show or appearance's sake only. (C) Adolescent self-harm was judged as inauthentic and attention seeking, as when it was disclosed to others in the school context it was deemed as being of a publicising nature. (D) Fault finding and blame, where adolescent self-harm was judged as a form of weakness or failure.
4. Contact fears of acute danger & complexity	*CATEGORY SUMMARY:* This category was the perceived beliefs that were held about the danger and complexity of pupils and staff coming into contact with adolescent self-harm as a health education topic or in support provision. These were of an accentuated nature, hence representations of fears. *SUBCATEGORIES SUMMARY:*

78 This conception of "normality" was established by the wider and majority consensus in school, or wider society, with self-harm being excluded from these.

THE STIGMA CATEGORIES	CATEGORY SUMMARY OVERVIEW AND THEIR SUBCATEGORIES
	(A) The perceptions of the fear of the acute danger to pupils being brought into contact with the health topic of adolescent self-harm, of adolescent self-harm being a dangerous topic. (B) The perceptions of the fear of adolescent self-harm being highly problematic and too complex for school staff to work with.
5. Public Concealment	*CATEGORY SUMMARY:* This category was the perception of a school's concealment of adolescent self-harm from the public domain or view, leading to adolescent self-harm being made to become an invisible topic and behaviour from within a school's public domain or public discourse. *SUBCATEGORIES SUMMARY:* (A) At an institutional level, the topic and behaviour of adolescent self-harm in the school context was perceived as being hidden from public view. (B) At an institutional level, the existence or reality of adolescent self-harm within the school context was perceived as being publicly denied.
6. The construction of adolescent self-harm as deviance (in need of correction) eliciting pupil sanctions	*CATEGORY SUMMARY:* This category was the perceived construction of adolescent self-harm as a form of deviant pupil behaviour that was against school behaviour standards, eliciting the use of pupil discipline strategies in order to correct the perceived deviant behaviour of adolescent self-harm. This was perceived as risking the mistreatment of pupils who self-harmed, with perceptions of pupils being sanctioned, ignored, admonished and angrily reprimanded for their adolescent self-harm needs. *SUBCATEGORIES SUMMARY:* The construction of adolescent self-harm as being a deviant behaviour (in need of correction) which elicited the use of: (A) sanctions to correct the behaviour, against pupils who self-harmed; (B) the tactical classroom discipline response of giving no attention to pupils' self-harm behaviours and needs, to correct the behaviour; (C) admonishment to correct the behaviour, including pupils being angrily reprimanded for causing trouble due to their self-harm.

6.3 The Stigma Model's Categories & Subcategories

6.3.1 Word-tabooing

This category was the avoidance of the use of the word "self-harm" in the interviews. The word "self-harm" was positioned as being under a taboo in the research interviews, which acted as a barrier through restricting the use of the word. "Word-tabooing" was specifically situated, in that it occurred upon certain words in this study. In the majority of cases this was for the word "self-harm" because that was the main subject of the interview study, but it also occurred for the words "suicide ideation", "suicide attempts" and "suicide" which this study was not investigating. These findings stemmed from within the initial data transcription process and subsequent grounded theory analysis, where an emerging pattern was recognised which in turn revealed that there was a fundamental contextual influence that surrounded the speaking of the word "self-harm", restricting its usage. The "word-tabooing" restriction indicated that there was a marked differentiation occurring within the research interviews in regards to the research participants' use of these words. This is illustrative of the sensitive and difficult nature of these topics. But most importantly this stigma category illustrated that there were strong and negative barriers present, restricting the research participants' use of these actual terms, with differentiation taking place which led to the avoidance of their usage. Word-tabooing was prevalent, pervasive and common, these being characteristics of a socio-cultural norm.

The subcategories of "word-tabooing" for adolescent self-harm included: (A) use of a physical gesture to denote self-harm (as a non-verbal replacement to represent the word "self-harm"); (B) euphemisms; (C) long pauses (that were immediately prior to the physical gestures, replacement words, or the actual use of the word "self-harm"); (D) discomfort behaviours (that occurred in the context of points A to C, as well as at other times when participants were talking specifically about self-harm). There were therefore some barriers upon speaking the term self-harm (and the other related terms as outlined in the paragraph above) within the interview conversation, as evidenced by the use of physical gestures, euphemisms, long pauses and discomfort behaviours. Further details regarding (A) to (D) are outlined below.

(A) The use of a physical gesture to denote self-harm (as a non-verbal replacement to represent the word "self-harm") involved a research participant making an action to represent the adolescent self-harm behaviour. In all cases this was a mime action of cutting behaviour. This mime action took place upon the arm, in specific areas that depicted actual examples of adolescent self-harm that the research participant had come into contact with *(extract 2)*.

Extract 2

> S10. I knew we had the one pupil[79], and it's taken her three years to finish her course here. And that was in a rush, because she spent a lot of time in counselling and dealing with things. But then thinking about all this …[80] hers[81] were (*she mimes cutting*) … hers were higher up. *(Health, social care & PE Teacher)*
>
> Researcher. So just for the recording, S10 is making cutting gestures at the top of her arms.
>
> S10. Yes, so they were at the top. It makes me feel a bit guilty now that I didn't spot these things[82] with the kids. Could I have done something to help her on the way? But since you've been here, you've focussed my mind, and I've been looking. There are more kids that seem to have the marks on the arms than I'd thought about. But up until this point I haven't had any training with this and I didn't know about it.

(B) Euphemisms were substituted for the word "self-harm", instead of its direct usage. These comprised of: the pronouns "it"; the turn of phrase "you know". These euphemisms encapsulated the dual attributes of self-harm, due to their interchangeable use as: a noun to represent the name or descriptive categorisation/labelling of self-harm; a verb to denote the behaviour of self-harm. Consequently the descriptive labelling of self-harm and the action of self-harm were enmeshed together. This is representative of the entity of self-harm, which is a descriptive label that classifies a behaviour, as the abstract term self-harm embodies harm behaviours. Euphemisms

---

79 A pupil who self-harmed

80 … denotes a long pause within the interview

81 Self-harm injuries

82 Pupils' self-harm

were also present for pupil suicide. Euphemisms are often used when a word is deemed offensive or harsh or unpleasant (OED 2022a), which is one explanation for their occurrence here regarding adolescent self-harm and pupil suicide.

Extract 3

> WYP9. I would never … it never triggers in my head so that I want to … you know[83]. *(Male 21yrs)*
>
> WYP10. I've been depressed. But I have never ever felt the pressure to do that[84]. *(Male 21yrs)*
>
> WYP9. No, I am too squeamish (*laughs nervously*). I would be more inclined to … like … you know … err … rather than the idea of that[85], be like… err … you know[86] …. you are …err … you are on a cliff looking out and going … ohhhhh[87]. You know those kind of thoughts[88].
>
> WYP10. I find that easier to understand that idea, jumping off a building[89] with the idea to release yourself from pain[90].

(C) Long pauses were immediately prior to physical gestures, replacement words, or the actual use of the word "self-harm". Hence these pauses occurred in the context of participants' verbal or non-verbal communication about adolescent self-harm. Furthermore these long pauses were also present when participants were focussed upon pupil suicide behaviours and suicide .

Extracts 4

Extract 4.1
> A family member of mine who first … because obviously I don't share my experiences in school. So when this particular family member first

---

83 Self-harm

84 Self-harm

85 Self-harm

86 Suicide ideation

87 Example of suicide ideation, with a specific method of suicide thought about (i.e. jumping off a cliff)

88 Suicide ideation

89 Specific method of suicide thought about (i.e. jumping off a building)

90 Euphemism for suicide

experienced that that[91] was something which happened in their peer group, it was quite traumatic, in that they were very shocked that this[92] sort of thing goes on. And so that was due to the whole sense of it being a taboo subject. *(S7 Sixth form school well-being support officer)*

Extract 4.2

In some instances in our past unfortunately we have had students, current school students … erm … ummm … (*he then takes a deep breath after the long pause here*) commit suicide. *(S14 Head of sixth form)*

(D) Discomfort behaviours occurred in the context of points A to C above (i.e. when a participant used physical gestures to denote adolescent self-harm, or in the euphemisms or long pauses that were part of participants' self-harm communication), as well as at other times when participants were talking specifically about adolescent self-harm. These behaviours included coughing, taking very deep breaths, as well as expressions of alarm such as "oof" or "oh dear". Similar discomfort behaviours were also present for suicide behaviours and suicide *(extract 5.3)*, but these also included facial expressions of grimaces.

Extracts 5

Extract 5.1

Researcher. So I'm going to draw the interview more to self-harm now. Could I just ask what your definition of adolescent self-harm is?

S14. Oof … (*he takes a very deep breath here*) oh dear me. *(Head of sixth form)*

Extract 5.2

P28. You know, some people self-harm because they don't … they have … they mentally sort of … they hurt mentally but … (*coughs to clear throat*) … in a lot of those (*voice begins to sound shaky and she tails off, and coughs again*) … OK … (*she takes a big intake of breath here*). *(Female 17yrs)*

---

91 Self-harm

92 Self-harm

Researcher: *Begins to initiate first stage of interview safety protoco*l.

P.28. I am OK . What was I wanting to say? Right[93].

Extract 5.3

> S8. I think I can speak for all the school nurses, because we are all general trained, we haven't got a mental health nurse working in our team. We were worried about that we would be asking the wrong questions[94]. You know, like, why have you done it[95]? And especially when … when we all found it very difficult to ask the question, "did you want to die?" But we have just had some CAMHS training on this, and so as we are doing it more and more, it has become slightly easier. I can't say it's a question I like doing. And it's hard to do this. It's horrible. Patching the wound up is the easier bit. Because if something happened … God, I don't think I could forgive myself. *(School nurse)*
>
> Researcher: I'm just capturing for the interview that you were grimacing when you spoke about asking about suicide risk and the intent to die.
>
> S8: Oh god yes. You need training and practice, like drip-feeding. It is a horrible subject.

Discomfort behaviours were representative of the taboo that was present in schools for talking about adolescent self-harm, suicide ideation, suicide attempts and suicide. For example a school nurse felt that the wound treatment of a self-harm injury was easier for her to cope with than her exploring and asking questions to pupils about their self-harm, which included asking questions to assess pupils' suicide intent. Her discomfort behaviour of grimacing demonstrated the presence of strong emotions. She was the only member of school staff in this study who had received specialist CAMHS practice-based training. Due to this CAMHS practice-based training (which as health professional training would also incorporate the training practice of supervision), she felt this type of training could help to begin to address the taboo for some school professionals. However her strong emotions still remained (*as demonstrated by extract*

---

93 Her physical posture had relaxed at this point, she regained her composure and confidence, enabling her to share her perspectives throughout the rest of the interview. This is an example of the positive impact of the interview safety protocol.

94 About pupils' self-harm

95 Self-harm

5.3). This could be one explanation why the staff member highlighted the characteristic of a regular "drip-feeding" training and practice approach was needed, which might be one consequence of staff's accentuated emotions and strong discomfort about the topic. Similar themes regarding staff finding self-harm as being very emotional and challenging to work with has been found in other health settings (Karman et al. 2015; O'Reilly, Kiyimba & Karim 2016; Carter et al. 2018), so these points are not just isolated to school nurses but occur throughout the wider health system. Within health settings, quality self-harm staff training has also been put forward as one important strand in helping to build staff's confidence and skills in working with adolescent self-harm (Nixon 2011; National Collaborating Centre for Mental Health 2012; Timson et al. 2012; NICE 2022a), with the gaining of practical experience in working with self-harm also being an important part of this (McCann et al. 2006), however more research is needed to evidence the efficacy of this type of training intervention. Also in regards to the issue that the school context may be perceived as an educational context, rather than a health context. School may not typically have the health training practice of supervision available for school staff who are deemed to be educational professionals. This differs to the experiences of that of health professionals in the school, such as school nurses, who will have received supervision due to them being statutory health professionals. The new NICE guidance (2022a) highlights that the practice of supervision to support school staff to work with adolescent self-harm is now to be utilised in the school context. These may be explanatory factors for why only one member of school staff in this study, who was also a health professional, had received specialist CAMHS practice-based training in adolescent self-harm.

Word-tabooing demonstrated that adolescent self-harm was perceived as a challenging, difficult, unpleasant and uncomfortable topic in school. Hence the word-tabooing reflected the taboo upon adolescent self-harm in the school context. A lack of school-based discussion could maintain the topic's unfamiliarity and restriction. Pupils felt that making it more common and more comfortable to talk about adolescent self-harm in school (in the context of trying to provide health education, help and support) was an important step to take. Pupils perceived this would enable them to have more knowledge about adolescent self-harm, and would also bring the topic of self-harm out into the open for discussion, help and support. When some staff and pupils were given

opportunities to safely talk about, reflect upon and understand self-harm in their school context, such as within this research project, they came forward to do this.

Extract 6

> P17. It[96] is a difficult topic. *(Female 17yrs)*
>
> P16. Definitely. *(Female 17yrs)*
>
> P17. I guess because a lot of the time you don't talk about it face to face with people, because it can be quite a taboo subject.
>
> P17. Because not a lot of people want to talk about it.
>
> P16. I suppose because it is something that is not really talked about. So when the opportunity comes up to try and help it[97], I wanted to try and help that. This is why I came to the interview. I think you kind of need to do this.
>
> P17. I think it[98] needs to become more common to talk about, and also to make it[99] more comfortable to talk about.

Wider support network professionals recognised the taboo upon any discussion of adolescent self-harm in the school context and the support challenges this presented for pupils' needs. The topics of adolescent self-harm as well as pupil suicide were perceived as being closed down and restricted due to their sensitive nature. Providing staff as well as pupils with training in adolescent self-harm and suicide was deemed by the wider support network professionals as fundamental in addressing this taboo and changing the school culture.

Extracts 7

Extract 7.1
> You need to talk about it[100]. I know the new school curriculum is going to hopefully give a platform where this[101] perhaps can be discussed. But

---

96 Self-harm

97 To help address the taboo in the school context about self-harm

98 Self-harm

99 Self-harm

100 Self-harm

101 Self-harm

then you are going to have to think who is to deliver this? And is it going to be those same school staff who shy away from all the conversations, who aren't particularly confident, who have all sorts of "taboo-ey" sorts of ideas. You would be horrified as a teacher having to deliver this. It's about having the right culture about all this, that school just doesn't have. *(W6 Youth charity director)*

Extract 7.2

Well I have been told by some schools that self-harm is just too sensitive a topic to talk about. I go on to schools to talk about children's rights, but in some schools, if I mention self-harm, especially if I raise the issues of pupil suicide, everything is locked down. I would say the worst thing a school could do is make suicide a taboo subject, or self-harm. Because then if someone is feeling suicidal or wanting to self-harm themselves, who on earth are they going to talk to? Because they are subjects you are not supposed to talk about? So support the teachers and support staff, so they are trained up, but also how to support the pupils themselves. So look, we are talking about self-harm. And we are talking about suicide. These aren't easy subjects. But they are also critical subjects. *(W13 nation-wide trainer in self-harm support)*

Word-tabooing was representative of the institutional, socio-cultural level influence that shaped the public discourse at a fundamental level, in that there were barriers in place that restricted the ability to use the term self-harm in the school setting and also that it was uncomfortable and difficult for research participants to do so. Word-tabooing was also potentially illustrative of structural-level stigma being present due to the word-tabooing being a socio-cultural norm and practice which was maintained within the secondary school context (Hatzenbuehler & Link 2014; Hatzenbuehler 2016). This type of stigma, which can occur when a health topic is deemed taboo and is maintained at a system-level within typical societal community contexts that youth are part of, is recognised in wider adolescent health centred research that has focused upon the impact of taboo perceptions and behaviours that occur within stigmatised health topics, demonstrating the detrimental impacts of a health topic taboo upon youth health needs

and support (Veenema et al. 2015; WHO 2015ab; Ivanova et al. 2016; Maclean et al. 2020; Nesamoney et al. 2022; Davies et al. 2022).

6.3.2 Exclusion

This category was the perceptions of the exclusion or debarring of adolescent self-harm from the established social, educational and physical boundary norms in school. These norms were maintained by the wider and majority consensus in school, with self-harm being perceived as positioned as outside these norms. This was an "othering treatment", which accentuated boundaries and dichotomy, leading to the expulsion of adolescent self-harm from the boundary norms.

The subcategories of exclusion included: (A) School public discourse exclusion. The topic of self-harm was perceived as being barred from a school's public discourse, excluding self-harm from this; (B) School staff's duties exclusion. The topic and behaviour of self-harm was perceived as being removed from staff's duties and professional roles, excluding self-harm from these; (C) School-pupil group norms exclusion, with self-harm perceived as being ejected by school staff and pupils from the school-pupil group norms that were held (by school staff and pupils) about school-pupils in school. (D) School public service norms exclusions. Pupils with self-harm behaviours were perceived as excluded and restricted from having access to some of the public service norms in school that centred upon promoting pupils' education and welfare, which other pupils automatically had access to. Further details regarding (A) to (D) are outlined below.

(A) School public discourse exclusion. The topic of adolescent self-harm was perceived as being barred from a school's public discourse which meant that there was no health education or information about the topic of self-harm in the whole-school public context. This was due to there being an embargo placed upon the topic which was actively maintained by the school. This embargo would continue to act as a strong barrier against any adolescent self-harm health education or information being brought into the whole-school public context. This was due to schools' fears that publicising adolescent

self-harm within their whole-school environment would both advertise and promote it to their pupils.

Extracts 8

Extract 8.1
> I would love to educate kids. I may be naive in saying that. But I wanted to do assemblies about it[102], because we did have an epidemic at one point. I mean it was horrific. But it was like, no you can't. You can't do an assembly. This was the previous head. You can't do an assembly because it is going to highlight it. It's also going to make pupils want to do it. *(S12 Pastoral support officer & PE teacher)*

Extract 8.2
> We don't cover it[103] as a whole school. We don't. I am … very cautious about … talking too openly about it. So we don't try to advertise it. *(S11 Head of safeguarding & pastoral support)*

A point to highlight here is that as part of the informed consent process and partnership work with schools that took place during this research project, three schools out of the five in this study did put aside their embargo to permit adolescent self-harm research participation information to be shared with their sixth form pupils within a sixth form assembly in their school, or to a small selected group of their sixth formers.

(B) School staff duties exclusion. The topic and behaviour of adolescent self-harm was perceived as being removed from some staff's duties and professional roles, excluding self-harm from these. Some school staff did not view adolescent self-harm as part of their job, which led to it being excluded from their statutory safeguarding duties. Some staff chose to not get involved with pupils' self-harm needs, nor follow the school safeguarding protocols. For example a senior staff member who was head of year and responsible for sixth form pastoral support felt that many pupils who self-harmed were in crisis in their lives, which drained staff, especially at pupils' help-seeking points when pupils had many needs to be addressed. This staff member said they immediately

---

102 Self-harm
103 Self-harm

signposted the pupils to other sources of external help that the pupil would need to access themselves, and did not follow up on this, viewing it as outside of their pastoral school support role. There was an expectation that pupils take care of and be responsible for their own self-harm crises and support needs, outside of the school context, especially sixth form pupils. Adolescent self-harm was therefore ejected from the school's support parameters, placed as a topic that was beyond its remit.

Extract 9

> I think for staff, this issue[104] is probably quite draining. When you come to school you have these little individuals in front of you in their own crises. I think that can be tiring. Erm … and when a pupil with this[105] … erm … reaches out for help, they tend to want or be quite needy. Yes. I mean only last week I handed a child a kooth.com card for this[106]. I can just see his face. Do you know what I mean? They don't want to talk to someone online. They wanted to talk to me. But I am quite out of my depth with this[107]. It is far too complex. So it's trying to tell them, I know miss is nice, and you like us, but this is far beyond my abilities. And it's not my role, especially with the older pupils who are adults. They need to be finding their own support route with all this. It is beyond my skills and abilities to support them. *(S9 Head of sixth form)*

This approach was at odds with what some pupils wanted, who wished to talk to a trusted adult in school about their self-harm needs and gain school-based support *(as demonstrated in* Chapter *5, Section 5.2.2)*. It could also create a situation where a pupil might feel rejected at a help-seeking point, with one consequence of this being a pupil not asking for support again. This approach could risk no pupil safeguarding protocols being initiated, which may be one available route within the school context to help understand pupils' support needs and risk of harm. For the youth in this study, leaving a pupil in the school context to cope on their own with their self-harm needs was deemed inappropriate *(extract 10)*. They drew attention to the point that children had specific

---

104 Self-harm

105 Self-harm

106 Self-harm

107 Self-harm

age-related factors that needed to be met in order to help them access health information and support – children were not mini-adults. They felt this could be facilitated by knowledgeable and trained school staff, as part of their safeguarding role. Young people also recognised the complexity of health issues and the need for facilitating health information and access to health support during these times, at whatever age a person was when they experienced them, and that pupils would need additional measures in place to achieve this.

Extract 10

> WYP10. Teachers should be able to identify and look out for issues going on with pupils. It's not an easy job for pupils to self diagnose themselves, recognise it's a problem, and then go and fix it. You are just trying to even cope with the problem, let alone then actively go out and fix it. That's asking too much, especially of a child. *(Male 21yrs)*
> WYP9. Surely it's part of the teacher's job to be trained to do so, as part of their safeguarding? So to spot those signs that things are going on, like self-harm? So for the teachers in our school, they felt it was not their job to do this for self-harm. *(Male 21yrs)*

C) School-pupil group norms exclusion. Distinctions or differentiations were perceived as being made that led to adolescent self-harm being placed outside the conceptions of "normality"[108] held in school regarding the school-pupil group norms. Hence some pupils who self-harmed were separated and excluded from being within the school-pupil group norms that were maintained in school. One distinction or differentiation method was of adolescent self-harm being labelled as being beyond the bounds and outside of the category of "normal" comprehension. For some staff it was beyond their capacity for understanding, beyond their reasoning or logic – hence it was believed to be incomprehensible and nonsensical.

---

108 "Normality" as established by the wider and majority consensus held in school or the wider society, with self-harm being excluded from these

I would be very interested in going on a course for that[109] because I still don't really know what to do with these pupils. I refer them to other health professionals. But do I understand it[110]? Will I ever understand it? I … I don't know. I can't imagine it as something you do. Why hurting yourself leads to relief. I just don't get it. It's a very difficult concept. Yes. But some training would help me understand what to do as opposed to … perhaps I'll never understand it. *(S5 Head of sixth form)*

This aspect of adolescent self-harm being placed outside the boundaries of established societal norms, through the shared consensus of others, which could lead to adolescent self-harm being differentiated as unusual or extreme, was recognised in the wider system. This was perceived by wider support network professionals as being due to societal factors, such as many adults lack of knowledge which was also exacerbated by their lack of contact with adolescent self-harm. They felt this would place many adults in the position of having no lived experiences of self-harm themselves, in direct contrast to the common contact with adolescent self-harm in youths' lived experiences. Hence a lack of knowledge and contact with adolescent self-harm risked the stigma behaviour of stereotyping.

Extracts 12

Extract 12.1

In schools and also in the general public I think that actually there is a danger that it[111] will be seen as an extreme … an extreme situation as opposed to something that a young person may be managing well. With the adults that I speak to it's still talked about as something most people don't quite understand. And it's … it's unusual, quite different, like it's a new phenomenon. Young people perhaps may not see it as a safe behaviour. But they see it as a behaviour that they see around them. *(W21 Public health professional)*

---

109 Self-harm

110 Self-harm

111 Self-harm

Extracts 12.2

A lot of people just don't understand it[112], especially in the general public. They don't come across it. So they make assumptions about it. That it is extreme. *(W18 Teacher in charge of pupil education centre for specialist service provision)*

Another distinction or differentiation method was of "us" versus "them" group labelling. Distinctions were made between the group norms as perceived by the participants within the interview, in opposition to the "others" who self-harmed who weren't within these group norms, who were placed outside of them *(extracts 13)*. A delineation was made between the pupils in the interview group who had the skills to be calm, logical and use a problem-solving approach to adversity, who could manage their own emotions, versus the "other" group of pupils who self-harmed that could not think in this "logical" way to self manage their emotions. Some pupils highlighted their difficulties in relating to these "other" pupils, viewing them as having extreme or perfectionist ways of thinking that could then risk self-harm or suicide behaviours. One pupil drew attention to the level of pain that could stem from a person experiencing strong emotions, but felt that if these could not be managed by a logical, emotional regulation approach, this would lead to self-harm being used instead by this "other" group of pupils.

Extracts 13

Extract 13.1

P19. I mean I try and be quite calm about most things. Because people who get really "grrrrr" (*mimics an anger noise*) about things, they confuse me, because I don't understand it. Because you can just look at it as, "if a bad thing happens, I will deal with it this way". "If the good thing happens, I will deal with it this way". So I am fine, so I don't need any of this. But people who can't do that, and are like, "if I don't get in to Cardiff University, I am going to kill myself". *(Male 17yrs)*
[*Pupils in the interview group laugh*.]
P19. They are obviously going to be having a very nasty time.

---

112 Self-harm

Extract 13.2

> I have had to talk people through it[113]. I've never gone to an adult about
> it. I've always just talked them through it. And I've said, if you need to go
> to them, you can go. If you need me to talk to you, I will talk to you. I've
> given them advice from what I thought, and then I've said, but I might be
> wrong so go to this person to find out more, because they are qualified. I
> feel like you need someone who understands the psychology behind it.
> And can … you know, talk people through it in the right manner. Because
> I can talk to them, but my ways of thinking are so different to them. So
> it's very hard to relate to them in a way. Because I have learned to be
> objective. And also thinking logically. They are very useful skills. I do
> trial and error. I figure out something that works for me to help manage
> my emotions. Emotions, they are just so turbulent. And then because
> they have so much emotional pain they use the physical pain to distract
> themselves. *(P12 male 16yrs)*

(D) School public service norms exclusions. Schools provide important public services within their Local Authority service support frameworks, which include the education, care and support of pupils to ensure their welfare (Education Act 2002; Social Services and Well-being (Wales) Act 2014; Welsh Government 2015ab; Additional Learning Needs and Educational Tribunal (Wales) Act 2018; Welsh Government 2022e). In this subcategory, some pupils who self-harmed were perceived as being restricted and excluded from having access to some of the public service norms in school that other pupils automatically had access to.

Some pupils with self-harm behaviours were isolated from taking part in the every day student routines and interactions of the whole-school school setting, placing them outside of these and excluding them. For example, *as in extract 14.1* where a pupil perceived they were physically barred from entry to the classroom and excluded from being taught within the lesson, with no other provision being made for them. One youth perceived that they were regularly placed in an isolation room in school, which was a physical as well as a social exclusion from other pupils or staff members *(extract 14.2)*. This youth viewed themselves as being excluded from participating in the pupil and

---

113 Self-harm

school norms within their school community, as well as being restricted in accessing educational support from teachers. Some pupils had needed to take time off from school due to their self-harm needs *(extract 14.3)*, however the school setting was viewed as being unable to provide the same educational provision for them as for other pupils, that it could not provide additional educational support targeted to these pupils' needs or make reasonable adjustments. The school's educational services were highlighted as being inflexible and unable to accommodate these pupils' individual needs, placing these pupils at a disadvantage to other pupils *(extract 14.3)*. One pupil with self-harm behaviours was perceived as being excluded from gaining assessment and support regarding their learning difficulties – in a subsequent further educational setting to which this same pupil moved, this establishment did complete this service for the pupil who was found to be severely dyslexic *(extract 14.4)*. Pupils, school staff and other linked-system setting staff described the negative impacts that stemmed from these school public service exclusions *(extracts 14)*. One pupil highlighted that this type of treatment was as if they were a piece of rubbish, of them having no value and being discarded *(extract 14.1)*; another young person stated how distressing this treatment was for them *(extract 14.2)*.

Extracts 14

Extract 14.1

> I mean no-one really resolves it[114]. They just threw me away. They would be like, you are not coming in the class. So you are on your own, waiting outside for the whole lesson. *(P1 female 17yrs)*

Extract 14.2

> With my self-harm, they felt that I was a danger to myself and others. They then thought that I would get violent within the school community. So they took me away from all that and kept me away. But I was never violent in school. I just wanted to pass my exams, do my work, have friends. And so they would then put me in X room, which was isolation. I was put there on a regular basis, kept away from all the other students and not allowed any time with teachers. I just had to have one member of staff that worked as like a pastoral or inclusion officer. So I was doing

114 Self-harm

all my work on my own, I wasn't allowed to ask for help with my school work. I was kept away from everyone and everything. It was just an awful experience. They took me away from the school community and kept me away … I failed most of my exams … but I'm now redoing those exams here at the youth centre. *(SUYP2 female 24yrs)*

Extract 14.3

If pupils miss more than 10% of lessons, it can equate to a grade at GCSE. There is a lot of information and research out there to suggest attendance has a huge impact. So if someone is taking a lot of time off, like for this[115], the school schedule just can't accommodate the different pacing for different needs, or for individual needs. What they can do at times, and what ends up happening, normally people end up withdrawing from a subject or topic. That is the only way to build in that flexibility. So they look at what subjects are optional. But then that reduces their opportunities doesn't it? *(S9 Head of sixth form)*

Extract 14.4

A pupil, she had failed her GCSEs completely. Her mother had been going up to the school saying, my daughter has got learning issues, please screen her for these. They didn't do it. She failed her GCSEs. So because she was 16, she went to a summer school, it was a training college. They picked up that she was severely dyslexic. So young people who may have learning needs are slipping through the net in school. So this young person, because she had found it so hard in school she self-harmed. And the school just wasn't interested. And this is the group that a lot of the young people I work with come in to. *(W22 Youth self-harm support project manager)*

A final example to bring into this category, as a brief note, was that this type of exclusion could also fall upon some school staff within the school context if they had their own self-harm behaviours and this was known to other staff members. Staff with self-harm behaviours could be excluded and restricted from the social, educational and also professional norms that other staff automatically had access to and who were able to

---

115 Self-harm

participate within these norms. One pastoral school staff member who wanted to take part in the research interviews (who had completed the informed consent process) was subsequently excluded from doing so by the school leadership staff. The reasons given by school leadership staff to the researcher was that the historical self-harm behaviour of the staff member rendered this person as too vulnerable to talk about adolescent self-harm in a research interview. This reason was never shared with the pastoral staff member and they remained unaware it. The lack of transparency and treatment differentiation, as well as the unauthorised disclosure of a staff member's confidential information, are illustrative of discrimination in the secondary school context[116].

Wider UK school-based research has captured similar exclusion themes, for example, in regards to the school public discourse exclusion (Simm et al. 2010; Coombes et al. 2013; Evans & Hurrell 2016; Parker 2018ab) and school staff's duties exclusion (McAndrew & Warne 2014; Evans & Hurrell 2016). The exclusion stigma category illustrates the risk of negative consequences for some pupils (and staff) with self-harm needs due to them being treated differently from the school socio-cultural group norms, their negative treatment stemming from the "othering" process which placed them within a stigmatised group. Within some of these exclusion practices there were some possible indications of a caricatured portrayal of self-harm, for example that a person with self-harm is potentially dangerous and violent to others (*as in extract 14.2)* or too vulnerable to participate in self-harm research (as in the staff member outlined above who was excluded from the research due to her self-harm). The exclusion category was representative of the key descriptor in public stigma theory of discrimination (Corrigan & Watson 2002; Bos et al. 2013), with distinctions being made due to adolescent self-harm, and where prejudicial actions and treatment took place that centred upon self-harm. The differing and negative treatment was a consequence of the disqualification process from the group or school prevailing "norms" - public stigma research deems this devaluation or loss of status as being a main risk factor for discriminatory practices (Link & Phelan 2001). The exclusion category stigma practices capture the segregation that took place within the school socio-cultural context for adolescent self-harm, and is aligned with structural-level focused stigma research that

---

116 This example took place in a school that did not give their consent for pupils' research participation.

centres upon the socio-cultural characteristics of an institutional setting within structural discrimination (Hatzenbuehler 2016).

6.3.3 Negative Judgement

This category was the negative judgement held about adolescent self-harm where stereotypical depreciations were made that meant that the topic and behaviour of self-harm was belittled. This category was representative of the public stigma theory key descriptor of stereotyping due to the negative beliefs that were held about self-harm. The subcategories of "negative judgement" included: (A) self-harm being judged as a form of immaturity or foolishness; (B) self-harm being judged as a superficial trend and fashion that was for an outward show and appearance's sake only; (C) fault finding and blame, with self-harm being judged as a form of weakness or failure; (D) the public disclosure of adolescent self-harm being judged as inauthentic and attention seeking. Further details regarding (A) to (D) are outlined below.

(A) Self-harm was perceived as being judged as immature, foolish, demonstrating a lack of judgement or capacity. This led to adolescent self-harm being ridiculed at times, with some pupils who self-harmed being ridiculed for lacking in intelligence, or for acting immaturely, or by joking behaviours. In the first instance some pupils were viewed as not using their intelligence to inform their actions – acts of self-harm were viewed as a form of stupidity.

Extract 15

> Like … some of my friends, they think it's[117] like the stupidest thing. But then they don't know like that I have done it. So then I don't say to anybody. There is a lot of people I know, saying like "ohhh, stupid, it's not a good way out". *(P29 female 17yrs)*

In the second instance adolescent self-harm could be framed as being immature, due to some pupils and staff perceiving it as a development phase which took place within younger aged pupils. This included perceptions that a pupil's increasing developmental

---

117 Self-harm

stages and the associated gains in maturity would automatically eradicate the pupil's self-harm: pupils would "grow up and out" of their self-harm. Hence pupils who self-harmed were seen as demonstrating their lack of capacity and maturity, their "childishness", which the self-harm represented. Pupils' self-harm was thus viewed as them being "silly". One pupil felt that this approach had belied the seriousness of her long-term and still current self-harm, leaving her in a very distressed and isolated position. Another pupil felt that this type of framing delivered unhelpful and toxic gender stereotyping comments that were particularly directed to males who self-harmed. A member of staff challenged the simplistic developmental framing of adolescent self-harm within the school context, which she felt could minimise the seriousness and complexity of pupils' self-harm, leading to staff not understanding or recognising the health risks.

Extracts 16

Extract 16.1

> P2. And I think a lot of people at that younger age were like that[118]. I heard a lot about it[119] then. But now when you are older it's different. Like, you just grow out of it. *(Female 16yrs)*
>
> P1. You [just grow up] *(Female 17yrs)*
>
> P3. [You grow up really.] *(Female 16yrs)*
>
> P2. It's kind of like a kid thing.
>
> P3. And you grow out of it.

Extract 16.2

> Most people thought self-harm was a cry for attention. I remember how widespread this thinking was in friends, teachers, the media. So it was against the norm to think otherwise. So the thought was, they will just grow up out of it. So like, "man up". *(WYP09 male 21yrs)*

---

118 These pupils were self-harming

119 Self-harm

Extract 16.3

I need someone to actually understand what I am going through. Because people were just like, "oh no, you will grow out of it"[120]. A lot of people have said to me, "oh no, you haven't got any mental health problems. It's just your age. It's just like your hormones doing it to you". But I don't think it's like this, it's more serious. I was supposed to go to CAMHS when I was about 13. And then people convinced me it was just a phase in my life. So I was like, I don't need to go, it's just a phase. But honestly, it's just got worse since then. And saying this type of stuff doesn't help. It's like the worse thing you can say to somebody like just because they are younger. Obviously, they are growing up. But if they are feeling that way, you have to take it into consideration. Listen to them. And try and understand. *(P29 female 17yrs)*

Extract 16.4

I would say it's the older generation that can't say it[121]. They are saying as their response, "for god's sake, just get on with your life. Don't be so silly". They don't understand. *(S8 School nurse)*

Extract 16.5

One of the other teachers here just thought of it[122] as, "what a silly thing to do". I think it's recognising that self-harm isn't always what you think about it, and that it isn't simple, and it is serious. *(S15 Pupil welfare officer)*

In the third area within the theme of foolishness, some pupils were perceived as being ridiculed through the use of joking behaviours that centred upon the topic and behaviour self-harm. There were also in vivo instances of self-harm being belittled through joking behaviours that occurred in the research interviews *(extracts 13.1, 18.3)*.

---

120 Self-harm

121 Self-harm

122 Self-harm

P29. I think I need a safe space to talk about it[123] to somebody. A safe space. That's like definitely. It's needed. Because I know like a lot of people with it, they have nowhere to go. Because it's a topic not many people talk about much, I feel. Or it's like humoured. People don't realise how serious it can be. And it's seen as something to laugh about.

Researcher: How would you like self-harm talked about?

P29. Not like straight into it. But like, just make people more aware. Let them know if they are struggling where they can get help and such. And like, it's not something to joke about. Let those people know that it is actually something serious. It's really bad when people make jokes. The jokes can be taken too far. It just makes you feel so like shit. Because they look down on you, like you are gross. And if you are really feeling like that … *(sighs heavily)* … I feel like if someone is proper struggling with it, and somebody cracks like a joke about it. Like it could affect them worse. I feel like schools don't speak about it, for people to understand. *(Female 17yrs)*

(B) The second subcategory of negative judgement was the perceptions of self-harm being judged as a trend, as a fashionable behaviour that was for an outward show or appearance's sake only. This subcategory was informed by a child development perspective, as in the previous subcategory. Some pupils were perceived as being at a developmental stage where they were easily influenced by their peers, which meant there was a risk of them following any trends within their school community. Self-harm was viewed as being one of these trend-like behaviours. These descriptions portrayed self-harm as a "popular" behaviour for certain pupils and pupil groups, that took place purely because of it being deemed fashionable. Social media and pupils' access to its self-harm content were also highlighted as strong peer trend influences within the school community. This could mean that self-harm was assigned as being for the purposes of copying peers' behaviour in the school community, to fit in with pupils' peer groups.

---

123 Self-harm

Extracts 18

Extract 18.1

I mean in the sixth form I am only aware of one pupil[124] at the moment out of the 135. And they have been referred to services. And sometimes it[125] is a trend. Sometimes. I know that sounds ... I know it's probably a terrible way to think of it, but it reminds me of in the 80s when suicide was on trend due to movies like Heathers. You know what I mean? And now it seems to be all over Instagram and Facebook. And there seems to be these weird clubs about it. So for me most times it just seems attention seeking and a trend because of this. *(S9 Head of sixth form)*

Extract 18.2

W6. I would like to say about social media here. *(Youth services charity director)*

W5. Yes, social media is a worry. *(School counselling services manager)*

W6. There have been occasions where ... it's[126] shared amongst groups, and that can lead to sometimes an effect that it ... it's like ... the word escapes me...

W5. It becomes the trend and the "fashionable thing".

Extract 18.3

W15. Maybe it[127] has become fashionable. *(Youth charity director)*

W14. Yes, it's fashionable. And my girls have said that to me about their school. They have said that people do it because they are in "that group" at school. They all dress like that in that group. And they don't really want to do it. But they just do it because they think it sounds cool. *(Youth charity manager)*

W15. Because it is different. (*Laughter*)

W14. It's the opposite of cool. (*Laughter*)

---

124 In regards to self-harm

125 Self-harm

126 Self-harm

127 Self-harm

(C) The third subcategory of negative judgement was of adolescent self-harm being judged as inauthentic and attention seeking. Adolescent self-harm was viewed as an inauthentic behaviour that was undertaken by a pupil for the purpose of drawing public attention to themselves to others within the school context. The term "attention seeking" was therefore used pejoratively and critically in regards to adolescent self-harm, to denote self-harm as being a negative socially orientated behaviour which pupils undertook to ensure public attention was given to them. This conceptualisation presented a risk that any adolescent self-harm that became public in the school context would be viewed as superficial, contrived or insincere behaviour. Adolescent self-harm was thus deemed to have a "public" nature, of being only a public presentation, for an outward appearance sake only ("for show" only), for the purposes of attracting and coming to the attention of others within the school context. Adolescent self-harm was judged as inauthentic and attention seeking when it was disclosed to other pupils and school staff in school, as this act of disclosure within the school context characterised the self-harm to be of a publicising nature *(extracts 19.1, 19.2, 19.5, also as illustrated in Chapter 2, Sections 4.2.4 and 4.3.4).*

Extracts 19

Extract 19.1

> I think there is an attention seeking purpose. They hurt themselves to show others their scars. So it's only for appearance sake, to show others in school. *(S17 Head of year)*

Extract 19.2

> When it[128] becomes a public thing, when they share it with others, it's attention seeking. *(S3 Headteacher)*

Extract 19.3

> So in school they think we are pretending. They say we are doing it[129] to get attention, that it's not real. So you don't say anything about it in school. *(P19 male 17yrs)*

---

128 Self-harm
129 Self-harm

Extract 19.4
> A lot of people in school think that people who self-harm do it for attention, that it isn't genuine. *(P8 male 17yrs)*

Extract 19.5
> If they are telling you about their self-harm, they don't have any problems. They are just looking for attention *(P10 male 18yrs)*

A professional in the wider support network highlighted that this was a dominant and pervasive perspective held by school staff, and how problematic it was. This professional took an active stance to address the stereotyping behaviour in their presence, by directly rebuffing the viewpoint and having "a real conversation about self-harm" *(extract 19.6)* with school staff.

Extract 19.6
> In all schools we need to get teaching professionals away from their view that self-harm is attention-seeking. That pupils are doing it just "to get attention" in their school. I always say to them, "my god, what a way to get attention", and have a real conversation with them about self-harm. *(W11 Manager CAMHS primary care team)*

(D) Fault finding and blame was a fourth subcategory of the negative judgement applied to self-harm. Some pupils who self-harmed were judged as having faults which were blameable qualities that they were assigned and censured for. Hence some pupils who self-harmed were judged and blamed as being weak or failures due to characterising them as: "a bunch of losers" *(extract 20.1)*; over-privileged; "mothered and overprotected" *(extract 20.2)*; unable to face challenges, "folding in" and "shying away" from problems *(extract 20.3)*; controlling "perfectionists" *(extract 20.3)*.

Extracts 20

Extract 20.1
> My sister, she is in the lower school, she says literally everyone has problems, they are depressed and sad and they are self harming. It's like, "what a bunch of losers". *(P19 male 17yrs)*

Extract 20.2

> S17.Yes. I don't want to come across all right wing, because, I am not right wing, but these kids[130] are kind of somehow protected until they hit the secondary school. Probably mothered and over-protected, so they have a growing sense of entitlement. And so maybe it hits them a bit harder because they are then confronted with their own errors and mistakes which they have been protected from. *(Head of year)*
>
> S19. Pupils need to interact with the pressures around them in a way which is positive, instead of self-harming and folding in and looking for the nearest support to go to. *(PE teacher)*
>
> S18. Cope with what is being thrown at them. *(Assistant head with responsibility for well-being)*
>
> S17. Not just shy away from things and self-harm.

Extract 20.3

> What you find in fact I think with things like self-harm, these can be your high achieving pupils. But it's because they are such perfectionists. *(S9 Head of sixth form)*

The negative judgement captured in this category section that was applied to self-harm could invalidate and minimise pupils' own self-harm experiences. It could lead to pupils being made to feel ashamed about their self-harm, which risked pupils hiding their self-harm needs from others. Pupils wanted self-harm to be talked about in school in the right way, for it to be taken seriously, for self-harm not to be judged negatively and talked about in such stigmatising ways in the school context as outlined in this category, including explaining to others about the negative consequences for pupils' who self-harmed. Some pupils also perceived the wide-scale nature of these negative judgements about self-harm, as they were present in their school but also in the wider society. The belittlement of self-harm that occurred due to the negative judgements, as well as pupils' fears of being negatively judged if they self-harmed, these were help-seeking and disclosure barriers for pupils.

---

130 Pupils who self-harm

<u>*Extracts 21*</u>

Extract 21.1

> I think people find self-harm a difficult topic, and they also find it difficult
> to open up about it. And after you have done it, then you tend to look
> down and go, "oh my God how am I going to cover this?". And we wear
> bracelets, bangles, anything to just cover up the scars. But I feel that
> people shouldn't have to cover up the scars. I feel that we should be able
> to speak about it. And not be judged about it. 'Cos at the end of the day,
> a lot of people take me for someone different. Someone they think I am.
> But I have my own personal story that makes me the person I am now.
> *(SUYP1 male 18yrs)*

Extract 21.2

> So they all judge you on it[131]. And that is done by the general population
> as well as in school. I think the people who know about it understand,
> and wouldn't judge you on it. But because they are being judged like
> this they will feel uncomfortable about talking about it, and be ashamed
> about it. If they are ashamed of it, then they won't be able to get their
> brain around it, to go for help. *(P12 male 16yrs)*

Extract 21.3

> You have got to make people not ashamed of it[132]. So you have to
> normalise it. So that you can tell friends, and for them not to just make it
> a joke. We don't tell them because of this. *(P19 male 17yrs)*

Extract 21.4

> P17. You want to have support if you are doing it[133], but then also you
> kind of want to keep it hidden. If you want help, you don't want to be
> judged. *(Female 17yrs)*
> Researcher. Is that what everyone else would do, hide your self-harm
> because of a fear of being judged? Everyone is nodding (*i.e. all the
> pupils in this group, P12 to P18*), every single one of you.

---

131 Self-harm

132 Self-harm

133 Self-harm

The negative judgements in this stigma category and its subcategories were representative of criticism and negative generalised assumptions, demonstrating stereotyping and prejudice that are core concepts in public stigma theorising (Link & Phelan 2001; Corrigan & Watson 2002; Bos et al. 2013). The belittlement of adolescent self-harm also risked pupils with self-harm needs to be disparaged through the group-based characteristics and associations that pupils were consequently labelled with. The stigma practices of negative judgement occurred within the socio-cultural school context and are illustrative of a consensus that was held regarding adolescent self-harm, hence the institutional setting amplified these stigma practices due to this consensus being present which risked garnering agreement and shaping the whole-school public opinion about adolescent self-harm. This is representative of structural stigma research frameworks which focus upon the potency of institutional settings to shape the consensus which may risk the amplification and prevalence of stereotyping and prejudice within the institutional setting, thus playing an aggravating role as well as both maintaining and extending the stigma practices (Bos et al. 2013).

6.3.4 *Contact Fears Of Acute Danger & Complexity*

This category was the perceived beliefs that were held about the danger and complexity of pupils and staff coming into contact with adolescent self-harm as a health education topic or in support provision in school. They appeared to be of an accentuated nature, in that adolescent self-harm was deemed as very dangerous and complicated. This meant that due to these perceived characteristics, it was felt that adolescent self-harm could not be safely managed in the school context. Hence these acute beliefs were representations of fears. The fears centred upon the dangerousness to pupils in having health education regarding adolescent self-harm, because this education could risk promoting self-harm as a new negative behaviour to pupils. Also in regards to staff being unable to provide support, due to the highly problematic and complicated nature of adolescent self-harm. The subcategories of "contact fears of acute danger and complexity " included: (A) The fear of the acute danger to pupils being brought into contact with health education or information about adolescent self-harm, of self-harm being a dangerous topic; (B) The fear of adolescent self-harm being highly problematic and too complex for school staff to work with.

(A) The fear of the acute danger to pupils being brought into contact with health education or information about self-harm, of self-harm being a dangerous topic. In all the schools in this study adolescent self-harm was perceived as being a very dangerous topic and behaviour. Many school staff felt that there was no safe way that pupils could have contact with the topic of adolescent self-harm, due to the risk of danger from promoting self-harm or bringing it to pupils' attention which could cause pupils to self-harm. In regards to this fear, staff did not appear to perceive that many pupils were likely to have come into contact with adolescent self-harm previously through their own lived experiences, either through that of their own self-harm behaviour or that of their peers' self-harm. Hence staff's fears were focussed upon the point that it would be the first time pupils would be brought into contact with adolescent self-harm, through any health education or information about adolescent self-harm that took place in school.

Extracts 22

Extract 22.1
> I don't think we would ever focus on self-harm, because of the risk from promoting it to pupils. I am thinking also of the worry we have, about them being interested in it. *(S5 Head of sixth form)*

Extract 22.2
> I wouldn't want it[134] to be taught about to pupils because you don't want to put ideas into the young people's minds about it. *(S8 School nurse)*

Extract 22.3
> With teaching pupils about self-harm, what you don't want to do is to encourage pupils to try it. They may have not known about it before. So we wouldn't be able to do this in our school. *(S12 Pastoral support officer and PE teacher)*

School staff therefore felt that there was no safe way that pupils could have contact with the topic of self-harm. They viewed that any discussion or health education regarding adolescent self-harm with pupils could risk pupils to begin to self-harm. This same fear was also acknowledged in the wider support network system too, but it was recognised

---

134 Self-harm

that secondary school pupils were likely to already have come into contact with self-harm, so they needed to be given protection through adolescent self-harm health education, with pupils being educated about self-harm in a safe way.

Extract 23

> Having an open conversation about self-harm, that's a tricky one. It's a difficult one because you don't want to put ideas into young people's heads. You don't want to be subjecting them to things that they weren't even thinking of. But I know that it's happening at younger and younger ages. So they are being exposed to it a lot more. So they need to have the tools to deal with it. Because when you are exposed to something, you need to have the tools. So they need to be taught about it in a safe way. *(W2 Youth support worker and counsellor)*

One consequence of this fear was that there was no appetite for any whole school health education about adolescent self-harm in the school context to be delivered to pupils. This point is reflective of the findings in Chapter 4 of there being no education in schools for pupils about adolescent self-harm. Chapter 4 has also demonstrated that the view of adolescent self-harm being a common behaviour in school was not a widely held belief by school staff, which was in direct contrast to pupils' experiences of self-harm as it was a common behaviour for them in their school community. Hence school staff may have been unaware of pupils' common contact with self-harm, and pupils' lived experiences of self-harm.

Within this background context as outlined above, school staff's fears about providing adolescent self-harm health education to pupils as being dangerous because of the risk of putting "ideas into the young people's minds about it" *(extract 22.2)* may be problematic, given pupils may already have their own knowledge and lived experiences of self-harm. Another tension which a wider support network professional drew attention to was that much younger aged children were now experiencing self-harm than previously thought *(extract 23)*. This could mean many more young pupils coming into contact with self-harm, at much earlier ages, with little support to mitigate this. Research demonstrates that adolescent self-harm is common health issue for UK pupils

and that also younger age pupils are self-harming (Stallard et al. 2013b; Witt et al. 2021).

A government representative in this study acknowledged the strength and prevalence of the fear that was present in many schools in Wales about adolescent self-harm, which it was perceived as being due to stigma. It was highlighted how important it was for school staff "to be equipped with the skills and the sensitivities to talk about self-harm and suicide in an appropriate way" *(extract 24)*, given these negative circumstances. It was also felt that stigma would lead to support barriers, such as limiting the uptake by schools of the Welsh Government school-based adolescent self-harm support resources (2019a) that had been recently designed.

Extract 24

> Teachers need to be equipped with the skills and the sensitivities to talk about self-harm and suicide in an appropriate way. There is a new government resource going to be in place for this. I know that many teachers are terrified if a young person has been self-harming. I know that there are schools where they are, where some are afraid to talk about this. For some schools, it is the stigma. For other schools, "it's not the kind of thing that happens in our school because we are such a great school so kids couldn't possibly feel like that in our school". Self-harm happens in all young people's schools. So we can't have teachers or school leaders picking and choosing about this new self-harm resource. We have got to have that universal role out of it. It will also need monitoring in schools, to ensure its uptake. *(W17 National Assembly Committee Member)*

(B) The fear of adolescent self-harm being highly problematic and too complex for school staff to work with. This fear was encapsulated by two analogies made by school staff, that support contact regarding pupils' self-harm risked opening up "a can of worms" *(extract 25.1)* or "Pandora's box" *(extract 25.2)*. "A can of worms" is an analogy used to represent an extremely complicated problem that has not previously been looked at or had any input, and where the examination of the issue is likely to create a lot of problems (OED 2022b). "Pandora's box" is an analogy used to represent

something that is very problematic, complicated and negative, which should not be brought into the open and discussed, as this is deemed to be a very foolish approach due to the complexity and risks that are present (OED 2022c). These two analogies also captured the characteristics of closing down the topic and behaviour of self-harm, of not opening the "can of worms", or "Pandora's box", of keeping the lid firmly closed so as not to work with adolescent self-harm due to its complexity and difficulty. Consequently this fear acted as a support barrier, limiting staff's contact with the topic and behaviour of adolescent self-harm. This could lead to staff feeling that it was not part of their professional duties because of these issues, with pupils' self-harm support needs not being viewed as school staff's professional remit, duties and responsibilities.

Extracts 25

Extract 25.1
> With self-harm you are opening up a can of worms. So do we even tackle it as a school? Because I think it can be very, very challenging and worrying for staff. *(S5 Head of sixth form)*

Extract 25.2
> So it's[135] the Pandora's Box. So you don't open it because you don't think you can manage it in any shape or form. *(S3 Head Teacher)*

Extract 25.3
> With self-harm teachers will be thinking, "Oh God I don't want to go down that road[136]. Because of all of the problems and difficulties. They can be thinking this from lack of confidence, lack of knowledge. But also in them thinking, "it's not my area, I'm a teacher". I know we have staff here thinking this, that "it's not my domain". *(S12 Pastoral support officer and PE teacher)*

In regards to school staff's contact fears of acute danger and complexity, wider support network professionals highlighted the prevalence and strength of these types of fear that were present in school staff regarding adolescent self-harm. They viewed these

---

135 Self-harm
136 Self-harm

fears as stemming from staff's lack of knowledge, skills and training. These professionals also noted that the accentuated negative emotion of fear could act as a major barrier to school staff being able to be taught and learn new skills in understanding and working with the topic and behaviour of adolescent self-harm in the school context. It could lead to school staff closing down the topic of adolescent self-harm with pupils, especially when pupils came to them for support at help-seeking junctures *(as illustrated in extract 26.1 and also in Chapter 5, Section 5.2.2).* It was felt that there was an urgent need to address these types of fears to enable adolescent self-harm to be safely "talked about in the right way in schools" *(extract 26.3)* to support pupils' needs.

Extracts 26

Extract 26.1

> W5. I think self-harm still causes an element of alarm in schools. *(School counselling services manager)*
>
> W6. Yes, and panic in schools and school staff. Because they don't know what to do. They would not have the conversation with the young person. *(Youth services charity director)*
>
> W5. Anything so as to not talk about it.
>
> W6. A child has come to that person because they feel comfortable with that person. The person needs to feel confident that they can discuss what the problem or issue is, in a way that is helpful, and not shutting it down because the adult feels alarmed and is uncomfortable about it.

Extract 26.2

> There are all sorts of myths about self-harm. "If I talk about it, that will it make it worse." With the work I do, I think teachers want information about self-harm because they feel like they are not equipped. I think they will feel safer having a clearer idea. I do think awareness may have got better but it's still not what we'd hoped for. I think these are difficult things for people to understand and they find them frightening. And that creates a strong barrier to learning about something. *(W23 Senior academic, health professional and government advisor)*

Extract 26.3

> You need to be talking about self-harm. Stop being fearful of it. Anything
> you can do to remove the fear of the adult to enable them to actually
> have an empathetic conversation, rather than go, "oh my God, they are
> self-harming!". With self-harm, there is such a fear element to it from an
> adult perspective, not necessarily from a child perspective. So peer to
> peer there isn't. But in the adult perspective there is a real fear. And
> unless we address that fear actually nothing is going to improve. Within
> the schools they fear if they talk about these things, it makes it worse.
> Well actually, it doesn't. It normalises it. It makes it common. But also,
> let's get it talked about in the right way in schools. *(W1 Children's
> charity manager)*

Hence the fear-based beliefs in this section encapsulated strong negative emotional responses as well as the labelling of self-harm as highly dangerous and complex. Prior UK school based research has also reported similar findings of staff's fear-based beliefs (Best 2006 in Evans & Hurrell 2016; Parker 2018ab; Evans et al. 2019), and in the exclusion stigma category *(Section 6.3.2)* attention has already been drawn to the wider research theme regarding adolescent self-harm health education being absent from the school context (Evans & Hurrell 2016; Parker 2018ab). The negative labelling shares the characteristic of stereotyping, and the strongly held negative emotions that stem from the stereotyping behaviours are characteristic of prejudice, both of which are recognised as core stigma descriptors within public stigma theory research (Bos et al. 2013). They are also illustrative of being a social mechanism for avoidance, as the extracts in this stigma category evidence, which within the public stigma model is a form of discriminatory behaviour (Link & Phelan 2001). They may also be a mechanism for exclusion, which is also a a form of discriminatory behaviour. For example, in the exclusion stigma category *(Section 6.3.2)*, fear-based beliefs of adolescent self-harm being dangerous and complex were present in some of the exclusion stigma behaviours as defined within this category *(as in extracts 8.1, 9, 11, 14.2)*.These fear-based beliefs might also therefore lead to widespread exclusion practices within the secondary school context, which are further examples of discrimination. When exclusion and discrimination occur from system-level institutional practices, such as those that were perceived as taking place in the school context as outlined in this stigma category, this

is also illustrative of structural stigma (Link & Phelan 2001; Corrigan et al. 2004; Bos et al. 2013; Hatzenbuehler & Link 2014; Hatzenbuehler 2016; 2017).

6.3.5 *Public Concealment*

This category was the perception of the school institutional-level concealment of adolescent self-harm from the public domain or view, which was perceived as leading to adolescent self-harm being made to become an invisible topic and behaviour from within a school's public domain or public discourse. Hence the topic of adolescent self-harm was perceived as being treated negatively in the school public context, with school actions at the institutional-level taking to place to obscure and conceal it. These negative distinctions were characteristic of discriminatory actions, which were underpinned by the negative beliefs about adolescent self-harm. The subcategories of public concealment included two subcategories: (A) At a school institutional-level, the topic and behaviour of adolescent self-harm in the school context was perceived as being hidden from public view; (B) At a school institutional-level, the existence or reality of adolescent self-harm within the school context was perceived as being publicly denied.

(A) At a school institutional-level, adolescent self-harm was perceived as being concealed through keeping or hiding the topic and behaviour away from the public view in the school context. Analogies described how adolescent self-harm was perceived as being "brushed under the carpet in school" *(extract 27.1)*, or "kept underground" *(extract 27.2)*, away from the public discourse in school, and as a consequence there was no discussion about self-harm in the whole-school context. In this way the topic of adolescent self-harm was made invisible in the school context. This approach in school was perceived to risk pupils with self-harm to also be hidden from public view and the whole-school context in school. For example, two young people recalled it as being strange when it appeared to them that some pupils who self-harmed were being hidden or kept away from the rest of the school and removed from the whole-school environment. Another young person *(as previously noted in extract 14.2)* captured this process in their perceptions, of the school's removal of them from the whole school

public context and in them being kept away from it through being placed in social isolation.

Extracts 27

Extract 27.1
> I think it is damaging when self-harm is brushed under the carpet in the school. They[137] don't want it highlighted. I think they are probably worrying that it will make our school look bad. We are under special measures anyway. *(S12 Pastoral support officer and PE teacher)*

Extract 27.2
> I think self-harm is a very uncomfortable topic for school. Most schools find it very hard to admit that this is going on in their school. So it's all kept underground, and so there is no conversation happening about it. So my daughter could have died during her time of crisis[138] in school. We need to break this type of cycle. And my daughter, she came though a very dark period in school. She's happy now. But it's the school culture, where my daughter was. So it's institutional. *(W2 Youth charity support worker and counsellor)*

Extract 27.3
> WYP10. For some of those pupils who self-harmed, school did take them out of the environment and kind of just hid them from the rest of us. I think they were seen as acting out in school. *(Male 21yrs)*
> WYP9. I guess that's why some pupils keep it all hidden away, if they want to be in school. But just to remove them from out of the school environment so they don't become an issue. I thought that was a bit weird. *(Male 21yrs)*

In some schools when there had been pupils who had died by suicide these tragedies were perceived as also being hidden or kept away from the public view. It was felt that these schools would not permit any public discourse about the topics of adolescent self-harm or suicide within their setting. A wider support network professional viewed this as

---

137 The school leadership team

138 Crisis incident in school (*see extract 33.2 for more details*)

an attempt to erase the reality of the situation from the school context, of pupils' death by suicide *(extract 28.1)*. He felt this was a misguided approach, as to him a pupil's death by suicide could never be erased, and that this type of approach presented serious risk to pupils in a school where this had occurred. His concerns are illustrated in pupils' lived experiences in *extract 28.2*, which shows how seven pupils in a secondary school in Wales were trying to make sense of their friend's suicide, how to mourn their friend, and how cope on the anniversaries of their friend's death by suicide, in a school where pupils felt that they had been strictly prohibited to talk about any of these issues and their friend's death by suicide in their school. One negative impact of this was that it led to these pupils not being able to discuss the topic of adolescent self-harm in their research interview in school, perceiving "there is a barrier, we can't talk" (*extract 28.2*). This barrier was one consequence of their experiences in school and the institutional-level practices that surrounded the topic of pupil suicide when there had been pupils' deaths by suicide within the school. These types of circumstances illustrated here could present serious risks to bereaved pupils for their recovery and well-being, as well the risks of suicide ideation, suicide attempts and suicide that close contact with a friend's death by suicide brings (Hawton et al. 2012a; Cerel et al. 2017; Rodway et al. 2022).

Extracts 28

Extract 28.1

> And in some schools where there have been pupil suicides, they won't
> talk about suicide or self-harm or anything to do with it. But you can't
> erase memory. You can't erase this stuff from society. It would be like us
> trying to erase the memory of people we love who have died. That's the
> worst thing we could do. And if someone is feeling suicidal who can they
> talk to? Because it's a subject you are not supposed to talk about? In
> terms about that worry about copycats and what have you, you look at
> your pupils, and you look at who are vulnerable to that. At an
> anniversary, you check out which pupils are going to be the ones who
> are vulnerable. It's going to be their siblings who are going to be
> vulnerable to it, or their best friends. Well you know who they are. So
> you target them in terms of the support and stuff. As a whole school

approach, not talking about it is the worst thing we do. *(W13 Nation-wide trainer in self-harm support)*

Extract 28.2

Researcher. So I am just double checking everyone is OK, as it feels like to me that it's got a bit difficult to talk at this point in the interview, now we are talking about self-harm.

All pupils (P12 to P18) in strong tones. [Yes].

Researcher. Is there any reason for this, do you think?

Pupils (P12 to P15) talk over each other. [It's sensitive] [There's been] [I don't][Yes]

P17. Well, there was like a … a thing[139] happened in school … And then when it was the year afterwards, and they[140] said that no-one could talk about it in school. We also wanted to do like a thing … like to celebrate our friend's life … kind of … and they said that we couldn't do it, because it would bring it back up. *(Female 17yrs)*

P18. Yes, they shut it down completely. *(Female 17yrs)*

Researcher. So this is impacting talking about self-harm in this interview?

P18. Yes.

P17. There is a barrier, we can't talk.

(B) At an institutional level, the existence or reality of adolescent self-harm within the school context was perceived as being publicly denied. There were perceptions that in some schools the existence of the adolescence self-harm that was taking place in their school context was not able to be admitted within their public discourse or community. It was perceived that schools would deny its existence as well as publicly denying that they had any problems with adolescent self-harm in their school.

---

139 A pupil's death by suicide

140 School staff

Extract 29.1
> Some are afraid to talk about this[141]. For some schools, it is the stigma. For other schools, "it's not the kind of thing that happens in our school because we are such a great school so kids couldn't possibly feel like that in our school". Self-harm happens in all young people's schools.
> *(W17 National Assembly Committee Member)*

Extract 29.2
> So some schools are saying they haven't got a problem with it[142]. But I would rather these schools say the truth to me. That they have a problem with this, and this is how they are dealing with it. So when they say to me, "we haven't got any problems here with self-harm, or pupil suicide", they do have these problems. They have had pupil deaths. So I know they have these problems. *(W13 Nation-wide trainer in self-harm support)*

One explanatory factor given for this public concealment was the need for schools to uphold a good public image of the school and this not becoming tarnished through their fears of being associated with the negative social problem of adolescent self-harm. It was perceived that at a school governance level there could be challenges in accepting that adolescent self-harm was present in the school, hence public concealment occurred due schools protecting their public image. Another factor that was felt to explain this was that schools were in fierce competition with each other which impacted how they promoted themselves publicly. Some pupils perceived that a large amount of school resources was being directed to the appearance of pupils and the school building, in order to create a positive public image of the school to parents and school inspectors. Pupils felt this approach to be superficial, where the public image goals of school leadership staff were prioritised over pupils' well-being and support needs. This approach was also viewed by pupils as being present due to school leadership staff's

---

141 Self-harm

142 Self-harm

lack of knowledge and training about pupils' mental health and well-being, being critical negative factors for the absence of these within a school's culture *(extract 30.3)*.

<u>*Extracts 30*</u>

Extract 30.1

It has to have a whole system approach with this[143] in Wales. It has to be the systems and the whole school culture. That's the impression I had when I … OK I am not going to name schools here. But one school I went to recently they wouldn't allow the topic of adolescent self-harm. And we get this with lots of schools in Wales. Because schools are governed locally, they are not necessarily governed by the local authority. So local parent-governors, they make the decisions. So they might be very concerned about self-harm. We have talked about professionals being scared off by self-harm. Well parent-governors, they are not very happy to admit to there being self-harm in the school. So they will either deny that it is happening. Or put obstacles in the way. Or not encourage people to come in and talk about it. So that's what I mean by a cultural thing. That's where I suppose leadership through the head and the chair of governors is really important in terms of how that influences what goes on in a school. And then I suppose it's what the local authority can do as a facilitator to bring schools or the professionals in the schools together. So it's layered and systems, but it's also culture. I think. *(W15 Youth charity director)*

Extract 30.2

What is most important is schools saying how they are dealing with pupils' self-harm and suicide. But they are saying that they don't have these problems. Because schools watch each other. You see it with head teachers, "My school is bigger and better than your school". That's what they do. So until we get to a point where schools are saying, look we've got this great programme that deals with self-harm, have you got it? That's brilliant, do you know what it's done for the kids in our school? Until you can boast that pupils' well-being in school means that your

_____

143 Self-harm

marks or your grades are better, then it is not going to happen. *(W13 Nation-wide trainer in self-harm support)*

Extract 30.3

WYP10. The headmaster, he would have had no real concept of mental health. So he wouldn't be able to spot it[144] or know how to deal with it if it became a problem. He was always concentrating on rules that didn't matter. Pushing uniform is the obvious one to pick up, but let's be honest, uniform isn't having an impact on how well you are doing in your grades, nor is it going to help you with self-harm. The amount of effort they put in to trying to enforce school uniform. If they put the same effort into trying to help pupils in school I think a lot of people would have benefited from that. But the school uniform I think it's a very easy, obvious tick of the box. I think if you have inspectors coming in, or if you have parents. It's about image. It's a very easy one to push that image with. *(Male 21yrs)*

WYP9. Yes, it's very superficial. He was concerned with, "are the hallways painted?". Not with pupils' well-being. *(Male 21yrs)*

A systems-level and joined up approach was therefore perceived as paramount in addressing these types of institutional-level challenges. Key factors in this approach included: the ethos of the school leadership team; the school support and resources of the local authority; bringing the diverse school stakeholders together. All of these were viewed as helping to proactively shape the culture of a school and its decision making so that the public concealment of adolescent self-harm did not take place, and that is could be prioritised within the school. It was felt that this approach would enable the societal issue of adolescent self-harm to be made public so it could be more openly addressed within the school context. One example given was to create a whole system-level change in order to prioritise pupils' well-being in school above everything else, which would enable schools' public image and school culture to be targeted to pupils' well-being. This was viewed as being able to facilitate schools to publicly celebrate and promote the pupil well-being programmes they delivered, as well as bringing positive benefits to pupils' well-being *(extract 30.2)*. An important point to raise

_____

144 Self-harm

is that this system-level change called for here has begun to take place within the new system-level school well-being curriculum developments in Wales (Welsh Government 2021a).

The stigma category of public concealment could therefore act as a barrier to publicly sharing any information about the prevalence of adolescent self-harm in a school context. Prior UK school-based research has highlighted that there may be a risk from the institutional endowment and mechanisms that could maintain the status quo of adolescent self-harm being "rendered invisible" (Evans & Hurrell 2016, p.8) in schools, viewing stigma as being a factor within these types of institutional practices. The public concealment stigma category is illustrative of public stigma, in that at a school leadership level adolescent self-harm was negatively labelled (i.e. stereotyping), there was professional consensus regarding this label (i.e. prejudice), which led to the discriminatory behaviour (Corrigan & Watson 2002).   The public concealment of adolescent self-harm was perceived as taking place at an institutional level, within the school leadership and their local community school governance structures *(extracts 29, 30.1)*, and thus was characteristic of structural stigma (Link & Phelan 2001; Corrigan et al. 2004; Bos et al. 2013; Hatzenbuehler & Link 2014; Hatzenbuehler 2016; 2017).

6.3.6 *A Construction Of Adolescent Self-harm As Deviance (in Need Of Correction), Eliciting Pupil Sanctions*

This category was the perceptions that were present regarding the construction of adolescent self-harm as a form of deviant pupil behaviour that was against school behaviour standards, eliciting the use of pupil discipline strategies in order to correct the perceived deviant behaviour of adolescent self-harm. This was perceived as risking the mistreatment of pupils who self-harmed, with perceptions of pupils being sanctioned, ignored, admonished and angrily reprimanded for their adolescent self-harm needs. Due to this construction, pupils' self-harm was held to account within the school rules and norms regarding pupils' good conduct and behaviour, instead of it being placed within a health support or disability needs approach, an approach which could have elicited care and support. The subcategories within the category of the construction of adolescent self-harm as deviance (in need of correction) included: (A) the use of

sanctions to correct the behaviour, against pupils who self-harmed (as well as against these pupils' parents and/or carers); (B) the use of the tactical classroom discipline response of giving no attention to pupils' self-harm behaviours and needs, to correct the behaviour; (C) the use of admonishment to correct the behaviour, which included pupils being angrily reprimanded for causing trouble due to their self-harm.

(A) This subcategory was the perceived construction of adolescent self-harm as being a deviant behaviour, which elicited the use of sanctions to correct the behaviour, against pupils who self-harmed. For some pupils with self-harm, at times they were unable to attend school due to their health needs. It was perceived that these types of school absences risked sanctions being delivered upon pupils as well as their parents and carers. Pupils' self-harm and their support needs appeared to be framed within the school discipline approach, within the school attendance rules, instead of within the school health support and care structures for pupils' needs. Pupils and their families/carers received the school and local authority consequences for poor attendance. Pupils' adolescent self-harm health needs appeared to not be recognised, nor were pupils able to gain an authorised absence from their school for their self-harm health needs. Pupils' unauthorised school attendance led to letters, penality notices, risking worst case court attendance (Welsh Government 2013). These circumstances also positioned pupils' self-harm behaviour and their needs as a form of delinquency, due to the use of legal action to address them and pupils being under the age of 18 years (Sampson 2001).   All of these circumstances placed additional stressors upon pupils with adolescent self-harm support needs, as well as their parents or carers who would need to manage and balance the tensions and challenges from the statutory protocols surrounding pupils' school attendance *(extracts 31)*.

Extracts 31

Extract 31.1
> P19. Don't you get fined if you don't attend, if you get below 75% (i.e.
> attendance rate)? *(Male 17yrs)*
> P22. I find this really stressful, it was one of my worse issues with my
> self-harm. So I got to a percentage because of this, and they sent
> lessons home. Then I was like in school, and then I would take one day

off. But I would have consistent letters. And I was like, give me a chance. It put me under a lot of pressure. And then home was difficult, because they didn't want to get those letters. *(Female 17yrs)*

Extract 31.2

Teacher X, head of 6th form, sent quite an angry letter, saying that I needed to come to school. It said that if I don't spend enough hours in school, that I could be barred from sitting my exams and be kicked out of school. Really threatening me. It was infuriating to have to deal with all that stress they were putting on me … It wasn't supportive at all, it was the opposite of supportive … Looking back, it's easy to understand why I was hurting myself at that time during school. *(SUYP4 male 22yrs)*

Extract 31.3

So when I am meeting with the parents it is about the school attendance needing to get better in these specific ways. And we make a plan. Or we have to go down a legal route. We are now going to let the courts decide whether or not that is satisfactory. So we are being a bit more hard nosed. But we are also being much more serious in saying, if you don't do that we are seeing this as neglect. And our issue then is to take that to court to say we are not failing that child. So normally, if a young person discloses they are self-harming, it becomes child protection automatically. Because we don't have capacity to work with the self-harm, and we haven't had training. So at that point it goes into the legal and safeguarding routes. *(W19 Pupil attendance support manager)*

Extract 31.3 illustrates that the unauthorised school attendance that could occur due to pupils' self-harm needs was also a criteria for child neglect. This in turn would activate statutory child safeguarding team involvement upon the family/carers, such as the statutory participation and assessment of the family/carers. This procedure would be the case even if the school context was where the problem for pupils' needs resided and not the family. Any disclosure of pupils' self-harm was also managed by these child protection services, activating a statutory safeguarding assessment procedure. These could be very stressful experiences for a pupil and their parents and carers, not least due to the threat of the court process that underlines statutory services involvement.

(B) This subcategory was the perceived construction of adolescent self-harm as being a deviant behaviour, which elicited the use of the tactical classroom discipline response of giving no attention to pupils' self-harm behaviours and needs, to correct the behaviour. In schools in Wales the tactical strategy of ignoring a pupil's misbehaviour is used as a behaviour management technique for decreasing the "unwanted behaviour" (Welsh Government 2012, p.33). School staff are taught the need to be selective about which type of pupil behaviours they give their attention to and not to "reward poor behaviour by paying attention to the pupil who is misbehaving and being disruptive" (Welsh Government 2010, p. 34). Wider support system professionals perceived that adolescent self-harm was being misconceived in schools by school staff, as a form of deviant behaviour that needed to be corrected through teachers using the tactical discipline approach of withholding their attention from pupils' self-harm behaviour. This was viewed by wider support network professionals as being pervasive and prevalent throughout the whole school context.

Extracts 32

Extract 32.1
> In schools they say there is nothing wrong with that pupil[145]. They will say they are just doing the self-harm for attention. And they will say if you give them attention about it, then it will just perpetuate it. *(W14 Child and young person helpline advisor)*

Extract 32.2
> W16. I mean there was that whole thing in school about self-harm, about children being naughty and "acting up". It was like, "ohh, they are just looking for attention" (*spoken in a negative tone*). So don't give attention to them. But it's like, yes they are looking for attention. But the question to ask is why? *(Youth charity manager)*
> W14. Exactly yes. *(Child and young person helpline advisor)*

Extract 32.3
> Schools think self-harm is attention-seeking. And I say about attention. I'm an adult. I can say to you, can I speak to you? That's how I get your

_____

145 A pupil who is self-harming

attention. If a child's way of seeking attention is to cut themselves, I would suggest that they are trying to tell us something. Give your attention, you know? And that's not wasting your time, because that is what you are employed to do. So in some schools, they don't want to do that, because they think it's a bad thing to give any attention to self-harm. They think not giving attention makes it stop. It doesn't. I have worked with marginalised and vulnerable young people, where self-harm is part of their life. There are two things that I consistently say on our self-harm training across the board. Listen to the voice of the child. And think what it is like for that child in that child's life. And that's all it is. One of the biggest things we can do for children and young people who self-harm is to listen to them. They are trying to cope with life. The ones who show you their self-harm are trying to send you a message, that they are not coping. And just having these type of insights, that doesn't take an awful lot of time to learn them. *(W13 Nation-wide trainer in self-harm support)*

Hence school staff were perceived as ignoring adolescent self-harm due to it being depicted as an unacceptable form of behaviour in the school context that was in breach of school conduct standards and norms. The wider support network professionals highlighted the impact of the dominant and pervasive stereotyping of adolescent self-harm as "attention-seeking" in the school context (which was also demonstrated in *Section 6.3.3, subcategory C*), and it being a reason why school staff viewed pupils' self-harm as a form of deviance in need of correction. The in vivo phrase "acting up" *(extract 32.2)* was used by wider support network professionals to suggest that pupils who self-harmed were viewed in schools as them putting on a dramatic show or a performance, for the purposes of misbehaving, which was therefore of a public orientated nature, inauthentic and for attention-seeking purposes only. If self-harm was perceived as a negative and deviant pupil behaviour in this way, as being a transgression of the school rules, this was viewed as the explanation for why school staff might choose to give no attention to pupils' self-harm, as a misplaced pupil discipline strategy.

School staff's lack of training about adolescent self-harm has been demonstrated in Chapter 4 which may be important explanatory factors. A wider support network professional (who delivered adolescent self-harm training throughout the whole of Wales) offered advice for schools and their school staff, to help address the construction of adolescent self-harm as being a deviant behaviour in school that is in need of discipline, the use of the misplaced discipline strategy of withdrawing attention from pupils' self-harm, as well as the stigma conceptualisation of adolescent self-harm as attention-seeking *(extract 32.3).* This advice is presented in points 1 to 5 as follows:

1. If a pupil is self-harming, and they bring their self-harm behaviour to the attention of a member of school staff, they may be trying to send a message that they want and need help, that they may not be coping with some problems in their life.

2. A pupil who self-harms may not be able to articulate their need for help verbally, only through their action of showing their self-harm to a member of school staff. It may therefore be a pupil help-seeking action.

3. Hence when pupils bring their self-harm to the attention of school staff, school staff need to give their full attention to a pupil who is self-harming, and not withdraw their attention, in order to try to understand the pupil's specific needs.

4. School staff should try to provide a supportive space so that the pupil can talk about their self-harm experiences and needs.

5. School staff should try to be sympathetic and empathetic regarding what a pupil might be experiencing in their life, when pupils are self-harming to try and cope with their life circumstances.

(C) This subcategory was the perceived construction of adolescent self-harm as being a deviant behaviour, which elicited the use of admonishment to correct the behaviour, that included pupils being angrily reprimanded for causing trouble due to their self-harm. Similar to the other subcategories in this category, the pupil discipline approach of admonishment was perceived as being applied for pupils' self-harm needs within their

school context, that appeared to be due to school staff viewing pupils' self-harm as inappropriate pupil behaviour that needed correction. The discipline response in this subcategory was perceived as being disproportionate, critical and harsh, with very detrimental impacts upon pupils due to it taking place during pupils' help-seeking episodes for their self-harm needs, but also when they were in crisis. It was perceived that in these situations pupils were being blamed for their self-harm needs, and that they were shouted at because staff felt pupils were causing trouble through their self-harm behaviour. Hence the admonishment through the use of shouting was viewed as being of an accentuated nature and also inappropriate due to the specific situations it was used within when pupils were seeking help or in crisis. Extracts 33.1 and 33.2 illustrate the perceptions of the very detrimental impacts upon pupils that stemmed from this.

Extracts 33

Extract 33.1

> I was regularly disciplined for my self-harm. I was too scared to approach the heads of the school. I was too nervous because I was always being shouted at by the heads of the school and disciplined. So I was too nervous to take any problem I had to them. So I would go home crying and hurt my wrists. Whilst I was in school I used to self-harm an awful lot. I would end up in a lot of trouble basically. I would end up in a lot of pain. I perceived it in school that I was going to get into a load of trouble for my self-harm. That it was all my fault. That I shouldn't really exist. I felt like I wasn't treated like a human basically. *(SUYP2 female 24yrs)*

Extract 33.2

> One of my other daughters, she was also getting bullied, this was in a different school setting. And it got so bad, and … erm ... that she … erm … took … two packets of paracetamol … erm … in school. And one of the other pupils told a teacher. So they phoned me and I went down. I walked into the headmistress in her study, just as she was shouting, "you stupid girl, look at all the trouble you've caused". She was there waiting for the ambulance to come. And this teacher just said that. So she was

211

disciplined in that crisis situation. Young people won't be opening up about their self-harm, because of adults saying things like, "look at all the trouble you have caused". *(W2 Youth charity support worker and counsellor)*

Extract 33.3

I've been told by many young people who we work with here for their self-harm that teachers "lose it" with them. Like really lose it. And that they are in trouble for their self-harm in school. I mean what on earth? Possibly they are shouting because they are under pressure, but they shouldn't be around young people. *(W22 Youth self-harm support project manager)*

Extract 33.4

With self-harm in Wales we still need to step up. We get many cases of young people here where they say, I tried to talk about my issues and my self-harm in school, but I was shouted at and told to shut up and get on with my work. It's the school environment as much as anything. *(W12 Youth self-harm support project director)*

Two additional characteristics of the shouting were illustrated, in that it was perceived to be at a level: (1) where staff appeared to have "lost it" with their pupils, which is suggestive of staff not being fully in control of themselves; (2) where pupils were frightened. Wider support network professionals viewed these characteristics to be demonstrative of a person's unsuitability for working with children, adolescents and young adults. Wider support network professionals also recognised that school staff were under some pressure in school, but they felt that this did not explain why staff would choose to direct a shouting response to vulnerable pupils in crisis and in need. Hence the stigma subcategory here offers an explanatory factor to this question the wider support network professionals posed, in that school staff may perceive pupils as causing trouble by their self-harm which could lead them to admonish pupils through the use of shouting. The use of shouting appeared to be a discipline technique that was customary in schools, but its pervasive use and the level/pitch of the shouting that school staff used could risk some pupils feeling too frightened to approach these

teachers for help, especially if the school staff that had been shouting in this way were the designated school staff that pupils were supposed to go to for help in their school *(extract 33.1 and 34)*.

<u>*Extracts 34*</u>

> P1. Teachers need to talk normal to you, not shout at you. You can hear other classrooms and the teachers screaming. *(Female 17yrs)*
> P2. It shocked me when this first happened. Now I'm used to being like jumpy in school. *(Female 16yrs)*
> P3. I just assumed that everyone will be used to that … But that's just what we have gone on with for five years here
> P1. Sometimes I am scared of a teacher because of this.
> P3. Especially because one of the health like professional teachers we have is a scary teacher that I just wouldn't go to for help. Because of the amount of times I am walking past in the corridor and they are screaming.
> P2. Yes, like the deputy head, all those people we are meant to go to for help, like the protection officers or whatever, they are the scariest people in the school.

A school-based systematic review has previously highlighted the problematic issue of adolescent self-harm being deemed as a transgression of the school-context pupil behaviour standards and norms, thus eliciting a disciplinary response, which also meant that pupils were excluded from receiving support (Evans & Hurrell 2016). The findings from this category, of the perceived construction of adolescent self-harm as a form of deviant pupil behaviour that elicited the use of pupil discipline strategies in order to correct the behaviour, these are also reflective of sociological-centred research that has presented deviance as an important concept in self-harm research, in order to understand self-harm within its social and community contexts (Taylor & Ibañez 2015; Adler & Adler 2022). This research highlights that deviance engenders stigma due to social processes that are inherent within any given social context. From a sociological perspective, deviance is therefore socially defined and embedded within structural power dynamics in specific contexts (Lauderdale et al. 2022). Deviance is the

divergence from the societally held norms that shape societal behavioural standards, and the school context is structured by both societal and institutional norms.

Within this category, the negative labelling of difference and denigration occurred, with adolescent self-harm being framed as a form of deviance within the school-context, which led to pupils being unfairly treated through the use of school discipline strategies. The distinctions that were made due to adolescent self-harm, the negative beliefs held about adolescent self-harm, the negative emotional reaction of anger due to the negative beliefs held, and the subsequent unfair treatment of pupils with self-harm needs within this category, these are illustrative of stereotyping, prejudice and discrimination within public stigma theory. (Link & Phelan 2001; Corrigan & Watson 2002; Bos et al. 2013). Due to these being institutionally operationalised within the school context through the pupil discipline procedures they are also an example of structural stigma (Hatzenbuehler 2017).

6.4 Chapter Conclusion

This chapter has demonstrated that a main institutional, socio-cultural level influence upon adolescent self-harm in the secondary school context is that of stigma. This stigma is conceptualised through the grounded theory model of stigma, drawn from the multiple stakeholder perspectives of youth with lived experience of adolescent self-harm in their secondary school, school staff, and wider support network professionals. In this way, school's influence upon adolescent self-harm has been theorised, which was the main research aim of this study. Through the stigma model's categories and subcategories, the chapter provides illustrations of how stigma: shaped pupils' and school staff's conceptualisation of adolescent self-harm in the school context; impacted the existing organisational management practices for adolescent self-harm; and structured the institutional norms, values and assumptions in the school setting in regards to adolescent self-harm. *Table 12* in this chapter has presented the summary of the categories and subcategories of the stigma model.

The categories and subcategories within the grounded theory model illustrate the pervasive, prevalent and ubiquitous nature of stigma that structured adolescent self-harm within the secondary school context. This aligns with wider stigma research that also draws attention to these characteristics as being why stigma may have such a negative impact upon health trajectories (Hatzenbuehler et al. 2013; 2017; Major et al. 2018; Stangl et al. 2019). As the grounded theory stigma model captures a main institutional, socio-cultural level influence in the school context, it is a representation of structural stigma (Hatzenbuehler & Link 2014; Hatzenbuehler 2016; 2017). The stigma model also delineates the unfair and avoidable differences within the school context that adolescent self-harm engendered, which are characteristic of health inequalities being present (Galobardes et al. 2013; Hatzenbuehler et al. 2013) for the adolescent self-harm population group. The model captures the differentiation in the school context that adolescent self-harm appeared to elicit, which stemmed from negative distinctions, negative responses and behaviours towards adolescent self-harm. These were illustrative of the socio-cultural influenced processes of stereotyping, prejudice and discrimination, which are pivotal descriptors of stigma within public stigma theorising (Corrigan & Watson 2002; Bos et al. 2013), and as such the grounded theory model in this study aligns with public stigma theory.

The stigma model captures the potential of there being a cascade of negative impacts for pupils' self-harm in the school context. This is due to the pervasive, prevalent and ubiquitous nature of the stigma which the categories and their subcategories demonstrate. This risks an adverse school environment for pupils with self-harm support needs. Each of the stigma categories help in the theorisation of what causes and sustains adolescent self-harm within the secondary school context, eliciting specific and important detail that enables the stigma in the school context to be clearly delineated and closely examined, for the purposes of adolescent self-harm preventive intervention support design. In this way the stigma that structures adolescent self-harm in the school context can be made visible and brought to the forefront, in order to begin to try to address it. Consequently the next chapter will discuss the main research findings in this study and the implications for research, policy and practice.

CHAPTER 7: DISCUSSION

7.1 Chapter Introduction

This thesis has explored schools' influence upon pupils' experiences of adolescent self-harm, for the purpose of system-level preventive intervention support design. This thesis contributes new knowledge regarding the school context and adolescent self-harm. It furthers our understanding of the institutional-level conditions that can risk accumulative negative impacts at an individual-level for adolescent self-harm. These new findings can now be taken into account within system-level adolescent self-harm preventive intervention design for secondary schools in Wales.

The chapter considers the findings presented in Chapters 4 to 6, to ascertain how the findings have addressed the research questions explored within this thesis.

The chapter begins by situating the results within the research aims, to show how this study has made a contribution to understanding schools' influence upon pupils' experiences of adolescent self-harm in Wales. This is followed by an overview of the study's strengths and limitations. After this the implications for research, policy and practice are made, drawn from the key insights gained in this study, for the purpose of system-level preventive intervention support design. The chapter then concludes.

7.2 Situating The Results: Gaining An Understanding Of Schools' Influence Upon Pupils' Experiences Of Adolescent Self-harm In Schools In Wales

The main aim of this thesis was to understand and develop socio-culturally-situated theory regarding schools' influence on adolescent self-harm. This theorising was targeted to the purpose of adolescent self-harm preventive intervention support in the

school context in Wales. The project's aim and study design was drawn from a number of elements which were presented in Chapters 2 and 3 of this thesis. Chapter 2 presented the key research knowledge that the project was both informed by and aimed to make a contribution towards. Chapter 3 described the research methodology and methods that underpinned the study's grounded theory analysis of the qualitative research data, which was gained from the differing stakeholder groups in the study. Section 3.9 in Chapter 3 gave an overview of how the results chapters were structured to present the research findings.

The results in Chapters 4 to 6 gained an understanding of the study's research questions, which enabled the main research aim to be achieved. There were multiple perspectives from the key stakeholder groups upon the study's research questions, which were captured and demonstrated in each of the results chapters. This complexity and multiplicity were key facets within the overarching socio-culturally-situated theory.

In the introduction to Chapters 4 *(Section 4.1)* and 5 *(Section 5.1)*, an overview was given regarding the type of information that each chapter contained, which stakeholder perspectives the information was drawn from, and the contribution that it would make towards gaining an understanding of the research questions. Each of the chapter's findings in regards to the research questions were summarised in the chapter conclusions *(Chapter 4 Section 4.4, Chapter 5 Section 5.4)*. Chapter 6 answered the main research aim of the thesis, to theorise the main institutional, socio-cultural level influence upon adolescent self-harm in the secondary school context, from the multiple stakeholder perspectives in this study. A summary of the theory was presented (*table 12*).

For adolescent self-harm preventive intervention purposes, a main finding in Chapter 4 was the absence of adolescent self-harm health education in the school context for pupils and the majority of school staff, and the chapter presented some of the critical issues that stemmed from this. Another important finding was that pupils had common contact and lived experiences of self-harm (through their own self-harm, or their peers' self-harm), whereas the majority of school staff in this study did not. Given these findings, in Chapter 5 youth perspectives upon their lived experience of adolescent self-

harm in their secondary school context were explored, which revealed how adolescent self-harm came to be present in pupils' lives through the school context influences. The key differences within the two types of lived experiences (i.e. own self-harm, peers' self-harm) were elicited, in regards to the school context circumstances and risk factors. Peer violence, its pervasive nature and the lack of help in school were the main factors for why pupils began to self-harm themselves. For other pupils, the first time that they came into contact with adolescent self-harm in their school context was due to their peers' self-harm crises, where they attempted to provide crisis support – these were acute and emergency situations, and no first aid or other support was able to be gained within them. In both types of lived experiences, no help appeared to be available in the school context, such as from school staff. In pupils' help-seeking for their own self-harm, staff were perceived to close the topic down and no further support appeared to be offered. This led to pupils' self-harm to continue. In their peers' self-harm crises, pupils did not know what to do, and felt there was no school support they were able to access, either because of the complex ethical dilemma which centred upon their peers asking them to keep the self-harm crises private, or because peers could not gain help and support from staff in school. This placed pupils in a carer role for their peers' self-harm crisis support needs, sometimes for years whilst they were in school.

Chapter 6 provided a school system-level analysis, in which the results of Chapters 4 and 5 could be further contextualised. It demonstrated that the main institutional, socio-cultural level influence upon adolescent self-harm in the secondary school context was that of stigma. This was presented within the chapter's grounded theory model of stigma. This model illustrated the pervasive nature of the stigma in the school context through its 6 categories and 19 subcategories, which revealed how adolescent self-harm was structured by stigma. The model captured the potential for a cascade of negative impacts and accumulative stressors upon pupils within their lived experiences of adolescent self-harm in their school, risking an adverse school environment for pupils with self-harm support needs. In this way, the stigma that structured adolescent self-harm in the school context was rendered visible and brought to the forefront for preventive intervention purposes, as was called for by the stakeholder group of wider support network professionals who viewed stigma as the fundamental issue that negatively impacted adolescent self-harm in schools in Wales.

The theoretical model therefore illustrates how stigma can negatively shape the conceptualisation of self-harm within the secondary school context, acting as a strong barrier to adolescent self-harm support needs and prevention intervention for adolescent self-harm in the school context. The theory can also be situated within the study's critical realist paradigm *(as described in Chapter 3, within Sections 3.3.4 and 3.8.1)* that incorporates the socially situated nature and construction of knowledge, where causal mechanisms can be understood through its Context, Mechanisms and Outcomes (CMOs) configuration (Bhaskar 1989; Sayer 2000; Danermark et al. 2002; De Souza 2013; Fletcher et al. 2016; Yucel 2018): for adolescent self-harm, the school context (C) may give rise to stigma (M) which can lead to negative outcomes (O) that are barriers to adolescent self-harm support and prevention intervention.

7.3 An Overview Of Some Of The Study's Strengths & Limitations

The research access barriers that took place within this study strongly restricted the access to secondary schools and local authorities, limiting the number and availability of purposefully sampled schools and their local authorities for this study sample *(Chapter 3 Section 3.7.3 provides details of the research access barriers)*. This limitation means that the results findings should be treated with some caution. Specifically in regards to the potential transferability of findings drawn from data gained from 3 to 5 secondary schools in Wales, which means that any generalised statements in this thesis centred upon schools, school staff and pupils may be limited by this point. However the schools in this study were purposefully sampled, varying in socio-deprivation indicators, academic attainment, language medium, school size, and also in the National School Categorisation quality indicators (*see Table 11 for the characteristics of the purposefully sampled schools in this study*), which is a strength that can help to address some of the consequences that stem from the study's potential limitation of only a small number of schools in Wales taking part in the study.

One reflection point that may be raised here at the outset, in order to contextualise the study's potential limitations in regards to the quality of the study's findings, is that this project is a critical realist grounded theory qualitative research study, and not a

quantitative study. Qualitative research standards inform the research quality evaluation (Seale 1999; Malterud 2001; O'Brien et al. 2014; Flick 2018), of which reflexivity and transparency are key quality criteria (Seale 1999; Malterud 2001; O'Brien et al. 2014; Flick 2018). This is the reason why chapter 3 in this thesis delivers a reflexive-informed detailed account of the research project's methods and methodology, to meet qualitative evaluation criteria and help demonstrate the research quality and external validity of this study (Seale 1999; Malterud 2001; O'Brien et al. 2014; Flick 2018). In addition, one further example that I can give here regarding chapter 3 and the use of its reflexivity and transparency to demonstrate the strength of this study for the purpose of meeting key quality criteria, is the point that Birks and Mills (2015, p.15) have provided an overview of grounded theory which includes a summary of the common core criteria of the grounded theory method - this is why a summary account is presented in chapter 3 (*Sections 3.8.1 and 3.8.2*) regarding the grounded theory method in this study, such as: the concurrent data generation, collection and analysis; the constant comparative analysis using induction and abduction; and theoretical sensitivity. Theoretical sampling also occurred within this study, which in grounded theory is when more information is needed to be gained to saturate the developing categories during the analysis (Birks & Mills 2015). This was one reason why a new second wave of participants from new organisational groups (i.e. community centre youth participants and third sector community organisations) was subsequently accessed that had not originally been planned for – this occurred after 4 months from the start of the original data collection period. This decision of a new second wave of participants was also informed by the study's research access barriers (*this information is presented in Section 3.7.3*), and so the study's research barriers also facilitated the grounded theory method in regards to theoretical sampling. Hence the grounded theory method in this study mirrors that of the summary criteria of Birks and Mills. The information in this paragraph helps to demonstrate the strength of the study and its findings, where reflexivity and transparency were undertaken for quality purposes.

The purposeful sampling to gain access to wider support network professionals with knowledge or expertise regarding adolescent self-harm was limited by the research access barriers. This restricted the breadth of the sample from within the linked school system and wider support network, which means this study gained little information from

professionals who were part of child and adolescent health and social care settings, such as CAMHS (for example, only one senior CAMHS professional took part). The health service has its own system in regards to engagement and collaboration in health research projects with partners (Health and Care Research Wales 2023; NHS Health Research Authority 2023) which is a point that would need to be considered within the design of any future study that wished to incorporate linked school system and wider support network perspectives. For example, to work closely with these types of organisations (such as CAMHS and social services) to gain senior-level key stakeholders that could help to address the potential research barriers in community-based adolescent self-harm preventive intervention research. However given the majority of children and adolescents who self-harm do not access health service settings (Hawton et al. 2012a), which mirrored the experiences of the youth within the PhD study, the lack of information from child and adolescent health settings and their local authorities had limited impact upon some of the research findings, as these were not settings that the majority of youth in this study had engaged with (or had been able to gain access to for support). Furthermore stigma has been shown to be present in health setting research (National Collaborating Centre for Mental Health 2004; Nixon 2011; Timson et al. 2012; Manning et al. 2017; Rai et al. 2019), so as it is a known risk factor this could have made some contribution to the research access barriers. Further work would need to explore the reasons for the research access barriers found within this study regarding wider support network professionals and local authorities' research engagement with the topic of adolescent self-harm.

The accentuated research access barriers also restricted sixth form pupils' access to the study which means that the results findings may be limited and not representative. Furthermore, due to the ethical issues and considerations of this project (*see Chapter 3 Section 3.6.1, also Appendix 2A*), all pupil participants were of the ages 16 to 18 years in order that they held the legal status of Gillick competence (Griffiths 2016) to ensure they had the legal capacity to take informed decisions for themselves – pupils under 16 years would have required a Gillick assessment to demonstrate this capacity. This is why pupils aged under 16 did not participate in this study. However this may present a limitation upon the study's findings being representative in regards to pupils under the age of 16 years.

Another potential limitation in regards to representativeness is that all the youth in this study had common contact with adolescent self-harm in their school context, and there were no examples of youth with no contact with adolescent self-harm. This means that the data is drawn from youth with lived experience of adolescent self-harm in their school context, and is not representative of those who do not have these types of lived experiences. However if this point is situated within a health inequalities research lens it is a strength of the study that it has facilitated the views from youth with lived experience of adolescent self-harm, who may be marginalised, who therefore may have different experiences and outcomes than that of pupils who do not have experience of adolescent self-harm, illustrating some of the health risks and inequalities that may be present.   Gaining this evidence contributes to health equity for adolescent self-harm, as the collection of this type of data from marginalised youth through participatory qualitative research and its analysis are each fundamental measures that help the achievement of health equity (WHO 2010a; Public Health Wales 2016; 2019). Additionally, for health equity purposes for adolescent self-harm, the study identified multilevel factors through its socio-culturally-situated approach which demonstrated some of the health and support interactions between the individual and the school-system setting. This multilevel analysis is a strength in addressing health disparities as these occur at an individual-level within the context of a whole system-level dynamic and are likely to remain entrenched without system-level intervention (Moore & Evans 2017; Agurs-Collins et al. 2019).

A strength of this study was in regards to its data collection design and methods. These were focussed upon the issue of adolescent self-harm being a potentially sensitive research topic, and ethics being at the forefront of this research project design, especially for the youth research participants. This focus shaped the way that I undertook this project to help ensure participants' safety, but also to help participants to feel safe, comfortable, in control and at ease in the interview setting environment. This is one reason why a participatory approach was utilised (*as outlined in Chapter 3 Sections 3.4.2 and 3.4.3)*, which was successful in achieving these goals – the principles embedded within Participatory Appraisal *(see Chapter 3 Section 3.4.3)* were

key factors here, and they also enabled me to establish a trusting relationship with the potential and actual research participants that I came into contact with in schools (*see Chapter 3 section 3.4.4*), as well as in the other organisational settings. One reflection to consider here is that the trustworthiness of qualitative research is a key quality indicator, but also how the research is carried out and how the information is gained are also critical quality issues as they are to do with ethics (O'Brien et al. 2014), which the principles of Participatory Appraisal (PA) also concern themselves with. PA highlights and promotes the ethical conduct of the researcher, as the foundation principles of PA centre upon: the researcher establishing trust and rapport with their research participants; how research participants are to be treated by the researcher; and the way that a researcher facilitates the research data collection within an interview, for example in the way that the information is gained from the research participants. PA is therefore a valuable approach in qualitative research in enabling the ethical conduct of a researcher, particularly when a researcher is undertaking an outreach approach (as in this study). For example, it enabled me to take actions centred upon demonstrating my integrity as a researcher to key stakeholders and within the organisations that I visited, establishing people's trust and confidence in me as a researcher, and treating them with respect and dignity, as well as showing how much their views and opinions were valued by me in the role of the researcher (*see Chapter 3 Section 3.4.4*).

Hence a strength of this study in regards to its data collection design and methods, was of helping participants to feel safe, comfortable, in control and at ease in their interview setting environment. Further examples to highlight here that were particularly successful included the welcoming and supportive ethos that I was able to generate within the actual interview setting through the "interview welcome" resources (*as outlined in Chapter 3 Sections 3.7.3 and in Appendix 2A regarding the mini risk assessment details*). Also, in the study's informed consent resources for pupils (s*ee Appendix 5A*), pupils were encouraged to bring a friend if they wanted to, so that they would feel more comfortable and at ease in the interview. This was very successful, as in all of the focus groups with pupils in this study these were groups of friends. Another example was the research participants being offered flexibility in their interview method (*see Appendix 5A*), of them being able to choose for themselves whether they wanted to have a one-to-one interview with the researcher, or be part of a focus group (*a summary is*

presented in Chapter 3 Section 3.9 regarding participants and the interview method that the participants' chose and took place).

A potential study limitation centres upon the different dynamics between the 2 types of interview method utilised within this study, between the use of one-to-one interviews and that of focus groups. For example, a focus group could limit disclosure of sensitive information (which a one-to-one interview might not), and also influence the participants' perspectives due to the group dynamic - group participants might therefore be influenced by the social norms held within a group, and the group social context might limit or restrict the focus group participants' perspectives (Fern 2001; Hollander 2004). This is why within this research project the characteristics of the individual research participants and the type of relationships between the individuals who chose to participate in the focus groups were important factors within the focus group social dynamic and in addressing its potential limitations (Fern 2001). For example, in regards to the youth participants, an individual characteristic of the youth participants was that each one of them had lived experience of adolescent self-harm (*the details are provided in Appendix 6 – see 6A and 6B*). Also in regards to the youth participants within the research project's focus groups, their relationship with the other focus group members was that of them being close friends. With the focus groups, these individual and group social characteristics acted as a positive dynamic, as these friendship groups openly discussed the sensitive research topic due to their trust and confidence in each other. Also, the size of the focus groups were small, ranging from 2 to 6 participants only, which is a factor that is also supportive of research participants' personal discussion and disclosure within a focus group interview approach (Birks & Mills 2022). The majority of youth in this study chose to participate in focus group interviews (*see Chapter 3 Section 3.9*) and the focus groups that they were part of consisted of their close friends. This friendship relationship dynamic within the youth focus groups, which helped to address the potential social dynamic limitations within a focus group, was facilitated through youth being encouraged to bring friends with them to the research interview (*as outlined in the previous paragraph*). Hence in this study rich data was gained from within both of the interview methods, from the one-to-one interviews as well as the focus groups.

Another potential study limitation is that the interview results data was collected in 2019. Also some of the young people provided school context information regarding their experiences from years prior to 2019 (for example, the non-school sample of young people). There is therefore the issue of the age of the data and its themes still being current, particularly in the context of the major events that have occurred within the intervening period, such as the COVID-19 pandemic, the system-level curriculum overhaul in schools in Wales which is centred upon pupil well-being (Welsh Government 2022d), and the recent self-harm policy guidance (Welsh Government 2019a & 2021a; NICE 2023a) that positions schools as central support sites for adolescent self-harm.

This limitation can be partly addressed and contextualised within the following points:

1. The strong research access barriers found in this study, which strongly limited the access to gaining pupil interview data, may mean that there are significant challenges in gaining this type of data in Wales. This same issue also occurred in a prior 2017 study centred upon schools in Wales (Parker 2018). Further research is needed to address the strong research barriers that appear to be present in schools in Wales, with specific focus on enabling pupils research participation, to gain current research data and evidence – there has been no adolescent self-harm research with pupils in schools in Wales since 2019.

2. The major school context circumstances and themes as outlined in chapters 4, 5 and 6 may still be present. One example being the issue of peer violence still being present in schools in Wales. For example, as demonstrated in thesis section 5.2.1, where two School Health Research Network studies by Hewitt et al. 2019 and Page et al. 2021 found that over a third of secondary school pupils in Wales stated they had been bullied in school in the 8 weeks prior to both of these SHRN studies. The most recent SHRN study by Page et al. 2023 also captured similar data, that of a third of secondary school pupils in Wales perceiving themselves to have been bullied in school in the prior 8 weeks to the SHRN study.

3. Some of the issues during and since the COVID-19 pandemic include a potential increase in pupils' emotional and mental health problems (Carr et al. 2021; Michaud et al. 2022; Page et al. 2023) and school non-attendance (Welsh Government 2022h; Senedd Research 2023; Long & Roberts 2024), which can be risk factors in the onset and duration of adolescent self-harm (Hawton et al. 2012a; John et al. 2021). There is also the potential for their still being large numbers of pupils not gaining access to any health support for their self-harm needs (Geulayov 2022b).

4. In a subsequent consultation meeting that took place in DECIPHer in June 2023 (that I was part of) with Welsh Government representatives, these representatives highlighted that a review and targeted work was needed regarding the implementation of the recent adolescent self-harm government school guidance. For example, to help understand schools' needs in Wales in order to help and enable them to implement the recent school-context support frameworks for adolescent self-harm.

Points 1 to 4 mean that the results in this thesis may still have some relevance for informing adolescent self-harm policy and practice centred upon schools in Wales. However these points also mean that further research to gain current research data centred upon secondary schools in Wales is now warranted. It could also mean that some of the results themes in this thesis might still be found to be present in some schools in Wales if the same research was undertaken in the current year of 2024.

A strength of the study is in gaining the evidence of the access barriers that surround community-based adolescent self-harm research in Wales, and the design of an approach to directly target them to help successfully address some of them *(details are provided in Chapter 3, Sections 3.7.2 and 3.7.3)*. An important component within this approach was the overarching applied ethical research framework of the study, which had been designed to ensure participants' safety, manage the ethical complexities that could arise within this project, and to help address the potential research access barriers *(details are provided in Chapter 3, Section 3.6.1)*. Through the use of the overarching applied ethical research framework of the study, by prioritising the potential

risk of harm to the youth participants yet also balancing this within the Welsh context of youth participation rights to have their voices heard upon complex and sensitive youth health topics that concerned them, this approach led the way forward in the project's decision making to help manage the complex ethical issues as well as the research access barriers for youth participation in this adolescent self-harm research project.

My prior CAMHS consultant professional role working with adolescent self-harm was pivotal in enabling this qualitative research project to take place successfully and safely (*as outlined in Chapter 3 Sections 3.4.4, 3.6.1, 3.7.3*). My CAMHS knowledge and professional experience also meant that there were very few barriers or limitations for me in regards to safely interacting and discussing the topic of adolescent self-harm with any of the research participants, or any of the individuals or organisations I came into contact with as part of this qualitative research project. I am an experienced professional in safely working with the complexities that can arise with adolescent self-harm, which was gained from my front-line CAMHS experiences and through my wider system support work to build capacity and improve county-level service support provision for adolescent self-harm (*as outlined in Chapter 2 section 2.4.5 and Chapter 3 Section 3.5.1*). This brought extensive benefits as a qualitative researcher, such as in facilitating pupils' perspectives, as I was used to safely and confidently discussing adolescent self-harm with young people – to me this was "business as usual", being a CAMHS health topic and behaviour that I had worked with on a daily basis for over 3 decades. I also held a set of therapeutic communication and relationship skills (Morrissey & Callaghan 2011; Roth et al. 2011; National Collaborating Centre for Mental Health 2018; Hartley et al. 2022; Sharma & Gupta 2023; Yao & Kabir 2023) gained from CAMHS which had helped me as a CAMHS consultant to establish immediate trust and rapport with CAMHS clients and their parents/carers – these skills were also invaluable in my qualitative researcher role when coming into contact with potential research participants and members of their organisations, and in the qualitative research interviews.

As such, my CAMHS professional skills and knowledge, as well as my attitude to adolescent self-harm, these were key components in enabling this qualitative research project to be achieved. However, one reflection to briefly raise here, that could have

acted as a limitation upon this study, and one that I experienced at times, is that I was undertaking qualitative adolescent self-harm research whilst not being part of (or having close professional contact with) a CAMHS setting (or any another NHS or social care organisational setting). This meant that at specific times in this qualitative research project I did not have access to the targeted supervision, resources and support that would have been useful and available for me in a CAMHS setting or from a more senior CAMHS experienced professional who had knowledge and expertise in working with adolescent self-harm – these aspects ensure safe and ethical practice in CAMHS, as they are embedded at an organisational-level, where practitioners work within a multidisciplinary team where support can be elicited, and they do not work in an isolated position from their team (Partridge et al. 2010; Dogra et al. 2017; Laver-Bradbury et al. 2021). In this research project, as a sole adolescent self-harm qualitative researcher who had no access or contact to the aforementioned resources, even though I am an experienced and senior CAMHS consultant, very intensive and additional demands were present (*as outlined in Chapter 3 Section 3.6.1*). These demands were due to the major ethical and safeguarding responsibilities and complexities that I had to plan, carry out and manage as the PhD researcher responsible for this project - for example, during the ethical planning stage and also the data collection stage of this qualitative research project. Some safeguarding risk examples that I needed to address and manage included: the study's "in vivo" nature with the research participants being in their social setting; the participants having lived experiences of adolescent self-harm; the researcher being external to the organisational community setting. These points (including the limited support and guidance for researchers completing qualitative research upon this topic) have been raised and acknowledged in wider research (Lakeman & Fitzgerald 2009b; Lloyd-Richardson et al. 2015; Barnard et al. 2021), as well as their potential for them being qualitative research barriers and limitations which must be addressed to support future qualitative adolescent self-harm research – this also includes the point that a much stronger support focus is necessary to meet the needs of the researchers who are to undertake this type of research work. I managed these issues strategically, drawing upon my prior system-level CAMHS consultant work with adolescent self-harm (Parker 2015; Parker 2017ab), as well as my front-line CAMHS adolescent self-harm professional practice skills, in order to address them,

such as by a focus upon ethics and drawing upon the resources in the organisational settings that I completed the research within (*as outlined in Chapter 3 Section 3.6.1*).

The approach in this study enabled 76 research participants from differing key stakeholder groups from within the school context and wider support network in Wales to take part: sixth form pupils (30), young people from a community youth centre (7), school staff (19) and wider support network professionals (20). This is a large sample for qualitative research. The data triangulation and validity quality methods (Kisely & Kendall 2011; Morris 2017; Campbell et al. 2018) within the approach in this study facilitated rich and quality data to be gathered, achieving the project's aim due to the breadth, depth, diversity and multiplicity of the 76 perspectives upon the topic under study, enabling some (but not all) of the study research access barriers to be addressed. This approach in this study could therefore be utilised to continue to help try to address the adolescent self-harm research access barriers that are present in the secondary school context in Wales, to build the confidence of schools in Wales and equip them with the skills and support to participate in adolescent self-harm research.

7.4 Implications For Research, Policy & Practice

7.4.1 Research Implications

The critical issues that surround adolescent self-harm which mean that it is a serious public health concern, as well as the central role of the school community context within adolescent self-harm preventive intervention, these have been demonstrated in Chapter 2. Within this background context, the findings gained from within this study give a strong impetus to continue to address the research access barriers that are present in schools in Wales, in order to complete much larger scale school context research for adolescent self-harm preventive intervention purposes, with the support of key system-level stakeholders including that of youth with lived experience of adolescent self-harm in the secondary school context in Wales.

The results within this study may be situated within wider research that centres upon the conceptualisation of stigma *(as delineated in Chapter 2 Section 2.4.5),* and they also offer a contribution to this wider research. The grounded theory model of stigma contributes to the call by Staniland (et al. 2021) for research upon the constructs in self-harm stigma and the need for their conceptualisation, as well as the call by Evans and Hurrell (2016) for the development of theory within adolescent self-harm preventive intervention support and in understanding the mechanisms within the school context. The model aligns with the stigma research findings within the prior small-scale initial exploratory study upon adolescent self-harm that was completed in schools in Wales in 2017 (Parker 2018ab), but the modelling in this PhD thesis is more detailed and comprehensive due to it being a larger scale project. The grounded theory stigma model in this current study aims to make a contribution to adolescent self-harm stigma research specific to the secondary school context in Wales. The model demonstrates stigma as being at an institutional, socio-cultural level and is illustrative of structural stigma (Corrigan et al. 2004; Corrigan et al. 2005; Bos et al. 2013; Hatzenbuehler & Link 2014; Hatzenbuehler 2017). As the model is also for the purpose of preventive intervention support, it mirrors some of the new directions in structural-level stigma intervention research (Hatzenbuehler 2017; Sukhera et al. 2022) that seeks to map, understand and address stigma at a system-level due to its long duration and pervasiveness within critical social contexts such as education, health and social care.

The school context generates the institutionalised social norms which bestow and maintain power dynamics and hierarchies (Lucas et al. 2017), and which underlie the grounded theory model of stigma, its categories and subcategories. From an institutional-level and context-based stigma approach, structural-level stigma theory research highlights the problematic issue of power that resides within the socio-cultural settings that are embedded within human development and life course trajectories (Link & Phelan 2001; Link et al. 2017), such as education or healthcare settings. Structural-level stigma theory research targets power as fundamental in stigma and highlights how power inequalities occur and are maintained at a whole system-level through institutional norms and practices which risk the development of structural stigma if unmitigated (Link & Phelan 2001; Bos et al. 2013; Link et al. 2017; Sukhera et al. 2022). The grounded theory model of stigma in this thesis is an illustration of these

processes. The model also captures the pervasive nature of stigma in the secondary school context, this pervasiveness stemming from the structural power dynamics in the school setting which give rise to the institutional-level conditions that risk accumulative negative impacts at an individual-level for adolescent self-harm. These characteristics are why stigma is deemed to be "a fundamental cause of population health inequalities" (Hatzenbuehler et al. 2013, p. 813). These types of conditions that can arise from the institutionalised social norms are also why sociological-informed research views the socio-cultural context as being of paramount importance for understanding and conceptualising self-harm, and makes a contrast with approaches that are centred upon the individual or at an individual-level only which are deemed as too limited (Chandler, Myers & Platt 2011; Millard 2015; Ekman 2016; Steggals et al. 2020a; Steggals et al. 2022). The grounded theory model of stigma makes a contribution to this field for adolescent self-harm centred upon the socio-cultural context of the secondary school in Wales. Furthermore, within the emerging research that is focussed upon conceptualising self-harm stigma (Staniland et al. 2021) it highlights the issue of power as being critical within this newly developing framework, but that more research is needed to comprehend its influence in stigma. Hence the grounded theory stigma model in this thesis may be able to offer an approach to help understand the influence of power in the conceptualising of adolescent self-harm stigma, through its application of a structural stigma lens that is embedded in a specific socio-cultural context, that of the secondary school in Wales.

7.4.2 Policy & Practice Implications

The results findings in this study can be placed within the recent adolescent self-harm policy and practice guidance developments, where the school has a pivotal role in providing support within multilevel adolescent self-harm preventive intervention *(as outlined in Chapter 2, Section 2.4)*. The research findings could therefore be applied within the implementation framework of these adolescent self-harm policy and practice guidance developments, to help support planning, awareness, training and education regarding the impact of structural stigma upon pupils' self-harm needs within the secondary school context, to help take this work forward with key stakeholders in Wales. Schools could be provided with resources and support (including supervision,

which is a key support framework for staff working with adolescent self-harm in health settings), to facilitate their knowledge and understanding in regards to their support role and good practice, which is delineated in the recent policy and practice guidance *(as illustrated in Chapter 2, Section 2.4.2)*. Staff in this study also wanted to have quality training about adolescent self-harm, and this could take place at a school system level, to implement the recent policy and guidance. This could help to build the confidence in schools in Wales in regards to adolescent self-harm, equipping them with new knowledge and skills. Implementation research could take place alongside this, to continue to help improve practice through the use of multilevel intervention research targeted to the school context in Wales. However schools would need to be given additional resources and support for all of these proposals.

Alongside the proposals within this chapter section, a large scale pupil self report questionnaire about adolescent self-harm could be completed in Wales, as a segment in routine school-based health surveys, similar to the 2014 and 2018 HBSC surveys for England (Brooks et al. 2017; 2020). This would help to understand pupils' experiences and needs in regards to adolescent self-harm, providing an evidence base that could be applied within policy and practice in Wales. *Chapter 2 Section 2.4.1* provides more details on these types of school context surveys. A similar approach could be taken forward in Wales, utilising the established framework of the Student Health and Well-being Survey that is administered through the School Health Research Network (DECIPHER 2022) in Wales. Within this survey, 15 years and older aged pupils could complete an additional pupil health behaviour research self-report segment for Wales, for these pupils to be asked similar questions as the HBSC self-harm survey, as well as asking these pupils about any self-harm or suicide behaviour support that they had used, or would chose to use in these situations. Given the unexpected results findings in this thesis of the peers' crisis incidents that pupils are providing support within and their lack of knowledge and support *(as demonstrated in Chapter 5 Section 5.3)*, the survey could also ask pupils if they are providing support to their peers in regards to self-harm, how often and for how many peers. As chapter 2 (*sections 2.2.2. and 2.4.1*) has demonstrated, given the public health surveillance barriers for community-based adolescent self-harm, this type of school survey administered in schools in Wales could also help to provide community surveillance information alongside that of hospital

admissions data, to gain prevalence and incidence estimates for hospital presenting and community-based adolescent self-harm in Wales.

A self report questionnaire format may be more acceptable and feasible for research with schools, which could help to build partnerships with schools for future research consultations and work targeted to adolescent self-harm and suicide prevention. Other adolescent self-harm research has deployed pupil self report surveys in schools safely regarding self-harm (Hawton et al. 2002; O'Connor et al. 2014; Geulayov et al. 2022b), so it can be argued that this type of research can be safely undertaken within schools in Wales similar to these other studies, which could also be supported by the applied ethical research framework within the current project. There is a strong impetus to complete this in schools in Wales, given the research findings in this thesis, the potential increase in adolescent self-harm over the last decade, as well as the problems with its visibility to health support services and surveillance, and the support challenges (as demonstrated in *Chapter* 2). Resources and support from key stakeholders would be needed to take this work forward in Wales.

This pupil survey and its content that is specific to pupils' lived experiences of self-harm could enable this information to be gathered and shared within the health surveillance systems in Wales, such as for health equity purposes for pupils and adolescent self-harm, so that the specific needs can be demonstrated and made visible in order for action and investment to take place such as within: the Population Needs Assessments framework (Welsh Government 2021d) that supports the Social Services and Wellbeing (Wales) Act 2014; or through the Public Health Wales well-being and health equity resource framework (2016; 2019) which aims to support policy and practice in Wales. Furthermore, well-being, equity and inclusion are pivotal components within the new evaluation and improvement framework for schools in Wales (Welsh Government 2022f), and are to be embedded at a whole-school level in schools (Welsh Government 2022g). This whole-school ethos targeted to well-being, equity and inclusion could be transformational for supporting pupils' health equity, and offers the potential for schools in Wales to be able to achieve these goals in regards to pupils and adolescent self-harm.

One point to highlight is that an absence of quality adolescent self-harm health education in the school context for pupils and school staff is a serious concern, as there is no health knowledge for them to draw upon to help address the critical issues and risks that are present. Youth and school staff in this study wanted to have health education about adolescent self-harm. The Welsh Government adolescent self-harm guidance for use in schools states that "there is no evidence that a conversation with a young person where you try to understand the reasons and circumstances for self-harming makes them more likely to self-harm or puts the idea into their head" (Welsh Government 2021a, p.47). This is why, in the context of the stigma model, ensuring that school staff receive training and practice-based skills in how to talk safely about adolescent self-harm with pupils is of paramount importance.

A major challenge for the health education of pupils regarding adolescent self-harm is that the findings in this study demonstrated that many school staff did not want pupils to have contact with the topic of adolescent self-harm in the school context such as within health education or information. However, given the findings in this study of what pupils are experiencing in regards to adolescent self-harm, and the serious risks this presents to their health and well-being, finding a way forward so that pupils can be safely educated about adolescent self-harm for their health and support needs is of paramount importance. This includes equipping pupils to have first aid knowledge to draw upon within a self-harm crisis point for their peers' acute needs *(as demonstrated in Chapter 5 Section 5.3)*, as well as in supporting pupils to know how to gain access to health support for their peers' shock symptoms and injuries. Further research with pupils is warranted upon these points, applying the principles within this study's overarching applied ethical research framework, of prioritising the potential risk of harm to the youth participants yet also balancing this within the Welsh context of youth rights which include: youth participation rights to have their voice heard on this complex issue; co-production with youth in regards to adolescent self-harm service support and design provision; and the right for youth to have health education regarding an important topic that concerns them.

The findings in this study gained important and valuable detail about the school context from the youth participants, which can be taken forward in adolescent self-harm

preventive intervention support design in Wales. One small example (out of the many illustrated throughout the results chapters) was of youth raising awareness of their peers' use of pencil sharpeners to gain access to a razor blade for their self-harm behaviour in the school context (*Chapter 5 in Section 5.3.1*). The specificity in these details can aid adolescent self-harm community-based prevention. For example public health prevention work has targeted self-harm via self-poisoning and reduced public access to paracetamol and salicylate through legislation to change the pack size and amount available in the UK (Hawton et al. 2001). A similar public health approach centred upon pupils in the school context could focus upon the blade design within pencil sharpeners, to ensure that they do not have razor blades within them, and that there are some safety planning features incorporated within the pencil sharpeners' design, given this is an everyday item that most pupils carry for the purposes of school. This could be a public health approach to reduce pupils' access to a razor blade within the school context. These findings were able to be gained from youth who wanted to take part in this study and who were able to be offered this choice and opportunity to do. This is why the research barriers that this study has demonstrated are a critical issue for youth participation rights in Wales in regards to adolescent self-harm preventive intervention support design, and this is a reason why the findings in this study are important as they offer a way forward to help begin to address this critical issue in Wales.

7.5 Conclusion

This chapter has demonstrated how the thesis has explored schools' influence upon pupils' experiences of adolescent self-harm in Wales, for the purpose of system-level preventive intervention support. It has situated the results within the study's research aims. It has presented an overview of the study's strengths and limitations. It has drawn conclusions from the study's findings in regards to their implications for research, policy and practice, and made further recommendations from the insights gained in this study, for the school context and adolescent self-harm preventive intervention support in Wales.

Appendix 1: An Overview Of The Participatory Research Interviews

Appendix 1A: The Qualitative Interview With Youth Participants

<u>Introduction Activity.</u>

The initial part of the interview with pupils was a Participatory Appraisal informed warm up and introductory activity, designed to orientate the pupils within the qualitative research interview. A "prompt sheet" had been designed for pupils to complete (*see below*). This activity was to help the pupils: understand that they were the experts upon their school context; to draw upon their answers within the prompts for the focus group discussion in the interviews; to become familiar with the method used within the interviews. The initial activity was also designed to help the pupils understand that their perspective and views would be central within the qualitative research, and that their "quotes" regarding specific aspects of the school would inform the research project. The interview prompt sheet questions in 1 and 2 contextualised and supported the pupils in thinking about the research topic for the interview purposes. The interview was designed to apply a semi-structured focus group discussion (*see below, after the pupil interview question prompt sheet, "The qualitative interview script with sixth form pupils"*), but would follow what the pupils wanted to discuss, within the pupil safeguarding boundaries and interview safety protocols that were in place within the interview (*see Appendix 2*).

INTERVIEW QUESTIONS PROMPT SHEET:

Your views are really important and valuable in this project.

Please can you write your initial thoughts to the questions in the quote box space provided. Thank you!

This sheet will be collected at the end of the interview.

Please can you write your age and gender identity in the quote box below.

QUESTION 1 - PROMPT SHEET:

PLEASE START HERE:

1(a). Firstly, in the box below, can you write down what you enjoy about being in school?

1 (b). Secondly, in the box below, what don't you enjoy about being in school?

1 (c). In regards to you enjoying, or not enjoying secondary school – *is there anything else you feel that could have impacted your current well-being in the 6th form at secondary school ?*

- For example, you may have had positive or negative school experiences prior to being in the 6th form, that you feel have impacted your well-being.
- Or anything else that you feel may be impacting your current well-being at school, either positively or negatively.

*If so, please can you briefly write what you feel these are or were (i.e. the positive and/or negative experiences), & WHY you feel they are having an impact on your **current well-being in school.***

1 (d). Please **circle** whether you agree (YES) or disagree (NO) with the following statements:

STATEMENT	Agree (YES) or Disagree (NO)?
I get on well with most people in school.	Yes No
Most teachers and school staff are fair.	Yes No
I feel safe at school.	Yes No
I am accepted by others at school.	Yes No
There are clear rules in place about how to behave in my school.	Yes No
I am treated with respect at school.	Yes No
I can manage my work in school.	Yes No
I can ask teachers and school staff for help if I needed to.	Yes No
Teachers and school staff manage students' behaviour positively and well in my school.	Yes No
Overall, my school experience is a positive one.	Yes No
I would ask for help and support from teachers and school staff, if there was a problem.	Yes No
I would ask my peers for help and support if there was a problem.	Yes No
If there was a problem for me in school it would get resolved.	Yes No
I have access to an adult that I trust in school, that I could talk to and ask for help from, if I was worried about one of my friends or peers. *If you answered YES to this question, please state the* *professional role* *of this person HERE:*	Yes No ………………………………..
I feel it is safe to ask for help and support in school from a member school staff about confidential issues, problems or concerns that I have.	Yes No
I understand the limits of confidentiality, and sharing confidential information about myself or my peers, in my school setting.	Yes No
I trust that any confidential information I share will be managed appropriately in my school setting by school staff.	Yes No

2(a). So **firstly,** when you think or talk about young people who self-harm, what do you mean by "self-harm"? How would you define it in your own words?

> QUOTE
> ....

2(b). Secondly, do you think self-harm occurs within your school community?

> QUOTE
> ....

2 (c). Thirdly, how often do you come into contact with the topic of self-harm in your school?

> QUOTE
> ....

2 (d). Fourthly, thinking about your last year in school, *can you give an estimate* of how often it has been for you to come into contact, in any way, with the behaviour of self-harm?

> QUOTE
> ....

2 (e). Thinking about the support available in your school, is there anything you would like to briefly add here, regarding adolescent self-harm?

> QUOTE
> ....

2. The qualitative interview script with sixth form pupils (semi-structured interview)

1. So I am here today to get your views on what you feel about your school and its role in providing help and support for the health topic of self-harm. Many people don't know what it feels like to be in a school today, and the issues that are facing young people today, which I why I am here. So can we just introduce ourselves?

2. Everything you say will be anonymous and confidential.

- But obviously as we are in school, the school safeguarding procedures surround this interview work today – these are the same ones we have discussed when we arranged the interview together. So just to remind you, if you disclose that you are at risk from harm, for example, that you are currently self-harming, then we would get help and support for you from the school safeguarding officer today. There are also the school pastoral staff to talk to if you need them today during or after the interview. If we get upset or distressed in the interview, we use the interview support strategies that we talked about. We also respect each other's views in the interview session.

3. My role is to get your voices heard, about what support you want to have in schools for help with self-harm.

- So I have an initial prompt sheet for you to fill in (prompt sheet questions 1). This will help us talk together.

- This first sheet has a set of questions regarding what you think about some aspects of your school, to help me understand what you think about them. We will talk about these together afterwards.

4. *AFTER PROMPT SHEET 1 COMPLETED*: So what do you feel about school's impact on your own well-being?

- What are the good bits about school for your own well-being?

- What are the some of the problems with school?

- How do you feel you are treated at school?

- What types of decisions can you make at school, such as in regards to your well-being needs? Are decisions shared? Who takes the decisions? Do you have input?

Do you think any of this might have an impact on pupils' mental health and well-being?

3. OK can you work through the next prompt sheet, this is more targeted to self-harm (prompt sheet questions 2)

4. AFTER PROMPT SHEET 2 COMPLETED. So how are you defining self-harm?

Is self-harm something you can talk about in school?

- To teachers? Other types of staff?

- To peers?

- What about at home? Can you talk to your parents about it?

- Who would you choose to talk to about self-harm?

Do you think people in school understand about self-harm? Are they supportive?

Are you taught about self-harm in school?

Do you know where to go for help and support with self-harm in school?

What do you think about this support?

The good things? Any problems with it?

How would you like the support to be provided in school about self-harm?

- How taught? By whom? Do you want this type of support in schools?

- What is to be taught?

- What about if there was an actual self-harm incident by a friend that you needed to help with today?

- Where would you want to go for help?

- Also what skills would you like to have, so you could help?

4. OK so thinking about everything we've talked about today. My role is to get your voices heard about this topic in Wales, for self-harm support planning. So is there anything else you want to say here, about schools and self-harm?

5. End of interview – complete a brief pupil well-being check (i.e. use interview distress protocol, check verbal and non-verbal signs of distress – see Appendix 2) whilst undertaking the following:

- Collect the activity sheets. Ask why they decided to take part in the interview. Ask how they found the research interview, e.g. ask "was it O.K for you to be part of a research interview like this?", ask for feedback. Thank the participants.

- Remind them of pastoral support if they want or need to discuss anything about self-harm. Remind them about the signposting and support leaflets and the blog for help and support with self-harm. If any participant needs this support now, I facilitate it.

- Ask what are they up to next in school today?   Ask if they want to take any of the interview snacks with them.   *Interview closure at this point*

Appendix 1B: The Qualitative Interview With School Staff

The interview was designed to apply a semi-structured focus group discussion, but would follow what the staff wanted to discuss, within the adult safeguarding boundaries and interview safety protocols that were in place within the interview (*see Appendix 2*).

Interview script:

1. Thank you so much for your support for this research project. It's focused upon exploring the health topic of adolescent self harm and community-based support in schools in Wales, such as your school. So I am just going to ask a few background context questions, and we can then talk about this topic together.

2. So as a starting point, can you tell me a little about you and your professional role in the school?

3. Thinking about pupils' well-being in school, could I ask how you define pupil well-being? Can you outline what might be some of the barriers and facilitators to this in schools?

4. Could you describe any well-being support that you regularly provide to pupils in school?

5. Are there any things that you can think of within the school context, that might act as barriers and facilitators upon your ability or the school's ability to provide well-being support to pupils?

6. We will now centre the discussion more specifically upon adolescent self-harm.

The following questions are used to help to structure the discussion (but I will follow any points that staff raise and want to discuss within the interview):

• How do you define adolescent self-harm?

• Do you have any contact young people's self-harm in school?

• What happens if/when you do have contact with self-harm?

• Can you outline what you would do if you came into contact with a pupil who self-harmed?

• Do you feel confident about accessing help and support for pupils' self-harm? What support have you accessed? Was it helpful?

• Where have you gained your knowledge about self-harm and what to do?

• Is there a school self-harm policy, or another policy framework you follow?

• Have you had any training? Can you outline this? Is it useful?

• Who decides what to do in schools about self-harm?

• Thinking about what yourself as a school professional who may come into contact with self harm. Is there any other school support you would like to have for supporting a young person who self-harms?

• Is self-harm taught as a health topic to pupils in school?

• What types of support do you think pupils need regarding adolescent self-harm? What support do you think could help protect pupils' well-being in school, for example, from the risk of self-harming behaviour? What support could be offered in school?

• Do you have any other local community support available for adolescent self-harm?

• Thinking about adolescent self-harm and schools in Wales, and everything we've discussed together today, is there anything else you would like to add at this point?

• Is there a anything else you would like to add at this point, to raise awareness of any issues that you feel are important to get out there about this topic, or your own needs or pupils' needs?

• Could I ask why you decided to participate in this research project about adolescent self-harm?

7. Interview closure at this point.

Appendix 1C: The Qualitative Interview With Wider Support Network Professionals

The interview was designed to apply a semi-structured focus group discussion, but would follow what the staff wanted to discuss, within the adult safeguarding boundaries and interview safety protocols that were in place within the interview (see Appendix 2).

Interview script:

Thank you so much for your support for this research project. It's focused upon exploring the health topic of adolescent self-harm and community-based support in schools in Wales.

1. Could you tell me a little about your role and your organisation?

2. Can you talk about how your work comes into contact with the topic of adolescent self-harm in Wales?

3. How would you define adolescent self-harm?

4. Can you talk about how your work is relevant to adolescent self-harm and schools?

5. Does your work provide any adolescent self-harm support for schools in any shape or form? Can you outline this in detail?

6. What has been your experience of working with schools to provide this support?

   • The positives? Things that have acted as facilitator to your work with schools?

   • The negatives? Things that act as barriers to your work with schools?

7. Do you have any thoughts on the support that is currently being provided for schools with the issue of adolescent self-harm?

8. What are your thoughts on what good quality support in schools would look like, or does look like, for adolescent self-harm?

   • Prior to self-harm occurring. Any barriers or facilitators to providing this that you can think of?

   • After a self-harm incident has occurred. Any barriers or facilitators to providing this that you can think of?

9. Who should provide this support? What is good support for teachers? What is good support for pupils?

10. Do you provide support in any other areas of the community for adolescent self-harm?

Any support further afield, such as at a government policy, national or international level? Are you linked to any other sectors or organisations?

11. How is consensus reached in your organisation for the direction of your work with adolescent self-harm? Do you have any say in the direction of your work with adolescent self-harm?

12. Why are you doing your work with adolescent self-harm at this point in time? Has anything changed recently that has given your work more focus, or less of a focus upon adolescent self-harm?

13. Where do you think we are in finding solutions for adolescent self-harm in Wales?

   • Why do you think we are at this point now?

   • What do you think is needed for the future?

   • What can you see are the barriers to this? What do you think are the facilitators?

   • At this point in time, in regards to the issue of adolescent self-harm and schools in Wales, what do you think should happen next?

14. Is there anything else you would like to add at this point?

15. And finally, could I ask why you decided to participate in this research project about adolescent self-harm?

16. Interview closure at this point.

Appendix 2: The Interview Safety Protocols

Appendix 2A: Interview Safety Protocol For Managing Participant Distress Behaviours Within The Interview Context

*An outline of the interview safety protocol and steps to be taken within the research interview by the researcher **if any participant demonstrates distress behaviours.** This interview protocol incorporates the school safeguarding framework which is a protective factor in managing the risk of distress in the school context where the qualitative adolescent self-harm research interviews occurred.*

TABLE 1: Safety protocol for managing participant distress behaviours within the interview context[146]		
Characteristics of participant distress behaviours that activate the safety protocol intervention:	Researcher actions at an ***individual*** research participant level. **1ˢᵗ stage**	Researcher actions at a ***group*** research participant level. **2ⁿᵈ stage**
VERBAL: • Participant statement of distress. NON-VERBAL: • Crying. • Shaking. • "Spaced out" and/or other dissociative style	**Step 1.** Acknowledge and validate the distress. **Step 2**. Ask for feedback from participant about their distress level. **Step 3**. Offer access to school pastoral support resources.	**Step 1.** (*2ⁿᵈ stage starts after 1ˢᵗ stage completed*) • Acknowledge to the group that some participants may experience distress in research interviews, which is why the safety protocols are in place. • Remind the group of the confidentiality

146 This is modified from the distress protocol in Drauker et al. 2009 (as well as a revised version of this protocol in Haigh and Witham 2015).

behaviours (overwhelming and sudden mood shifts).

- Physical discomfort gestures.
- Agitation.
- Incoherency.
- Incongruent behaviours, such as irritation and aggression, directed as self/and or others.
- Physical self-soothing behaviours associated with younger developmental trajectories (thumb sucking, rocking).

Step 4a. Participant accepts support offer. *Researcher facilitates participant access to school pastoral support (this is the school's pastoral member of staff on standby for the research interviews)*

OR

Step 4b. Participant rejects external support offer because they wish to continue with the interview.

Step 5. If 4b, researcher completes a *mini risk assessment* (see the supplementary table below) of this request.

This leads to:

- A: Researcher accepts request to continue, with agreement in place that *participant accesses the school pastoral support at the end of the research interview.* OR:
- B: Researcher offers an alternative date and time for the interview, and explains why (risk assessment decision). *Researcher facilitates access to the school pastoral support.*

agreement in place for the research interviews.

Step 2. Check if the group members are O.K. to go on with the interview.

- If YES, continue interview.
- If NO, for those group members, go to STEP 1 of 1st stage response, and follow the steps.

The mini risk assessment for participant distress

For use within the safety protocol for managing participant distress behaviours within the interview context

<div style="border:1px solid">

<u>*Mini risk assessment details[147]:*</u>

- I the researcher provide the participant with a brief psychosocial skills training exercise, that of self-soothing[148]. This is a distress tolerance skill strategy, that uses the "interview welcome" resources and activities in the interview setting.

- All of the pupils will have been introduced to and have accessed these "interview welcome" resources and activities at the beginning of the interview. These resources and activities have been planned in order to help pupils to feel more at ease in the interviews, but also that they can be used as a self-soothing strategy if needed.

- The "interview welcome" resources and activities are: eating the healthy snacks and/or drinks that I have made available in the interview setting; opening or closing the blinds on the windows to make the room more comfortable for the research participants in regards to light levels; moving to a window and looking out to assess the weather and temperature needs of the interview room; standing up and walking around the room to take a break from sitting down; moving the furniture around in the room to make it more comfortable; listening to the noise levels outside of the room, to sit in part of the room where it feels more private and quiet within the school setting. Each of these activities can be used in a more targeted way, for the purposes of self-soothing, in order to help the research participant focus on their physical senses for distress management.

- Furthermore, due to all of the pupils in the interview having access to these "interview welcome" resources and activities, at any point in the interview I can ask the whole group to participate in taking a break whilst they have a drink, or eat, or walk around the room. This means that I can concentrate on the needs of the research participant who is demonstrating distress (but also give the group a break

</div>

147 This is modified from the distress protocol in Drauker et al. 2009 (as well as a revised version of this protocol in Haigh and Witham 2015).

148 Linehan 2014 & 2015 – I am trained in Dialectical Behaviour Therapy for working with adolescent self-harm. Self-soothing in DBT is a psychosocial skills training strategy to focus upon the senses (i.e. taste, smell, touch, movement, sight and hearing) to reduce the level of emotional distress a person is currently experiencing.

and downtime if needed).

- The research participant is given time to use the self-soothing activity.
- After this is completed, I ask the mini risk assessment questions:
  - Q1: How do you feel right now?
  - Q2: Do you feel you will be able to go on with your day today?
  - Q3: Do you feel safe?
- I review the participant's distress levels, the level of the changes, and current level, based on the characteristics of participant distress behaviours as outlined in the first column of this table.
- In order to help support me to review the pupil's current distress level I also draw upon my interview observations of the pupil research participant prior to the distress incident.
- I work in partnership with the pupil, to support their informed decision making (*see note below*). Informed decision making means that a participant would not choose to continue the interview if they are still in distress. If participant distress is still present, school pastoral support is elicited and an alternative interview date is offered, to take place to suit the participant's convenience. This is to ensure non-discrimination and address potential barriers for interview participation by making "reasonable adjustments" (Equality Act 2010).

Supporting pupils' informed decision making: To balance and manage the potential risk and protective factors for pupils in regards to them coming into contact with a sensitive research topic (Santelli et al. 2003), two characteristics of age and legal status of pupils had been targeted within this study for student participants, so that they had the legal capacity for informed decisions. Opt-in parental consent was also required. In the UK 16 to 18 year olds have the legal status of Gillick competence (Griffiths 2016) and do not need to be assessed for capacity in being able to give consent for intelligent decision making, unlike children under 16 years who do require a Gillick assessment (Griffiths 2016). These characteristics informed the research interview safety protocols because this meant I could work in partnership with pupils as they had the legal capacity to make their own informed decisions about how they wished to progress, for example as within the mini risk

assessment, which I would be able to support. Pupils were orientated to the interview safety protocols through the informed consent procedure with a discussion centred upon how the protocols were in place to safeguard pupils (which they were familiar with due to their school safeguarding norms), also to support pupils' informed decision within the interviews and what this informed decision making might look like in the interviews.

This table outlines the interview safety protocol and steps to be taken within the research interview by the researcher if any participant discloses current self-harm and/or suicide ideation. This interview protocol incorporates the school safeguarding framework which is a protective factor in managing the risk of current self-harm and/or suicide ideation (also suicide behaviour and suicide attempt) in the school context where the qualitative adolescent self-harm research interviews occurred.

TABLE 2: Safety protocol for managing participant disclosure of current self-harm and/or suicide ideation (also suicide behaviour and suicide attempt) within the interview context

Researcher actions at *individual* research participant level. 1st stage.	Researcher actions at *group* research participant level. 2nd stage.
Step 1. Acknowledges and validates the disclosure. Ensures empathetic and non-judgemental stance. **Step 2**. Reminds participant of the safety protocol (safeguarding). Explains this will now take place. **Step 3**. *Researcher facilitates participant's access to the school safeguarding support via pastoral member of staff on standby for the research interviews.*	**Step 1.** (*2nd stage starts at step 2 of 1st stage*). • Ask the group to remain in the room and wait for the researcher to return. Remind the group that the school's pastoral officer has been on standby whilst the interviews take place, and the researcher is just going to access them to support participant X (participant who made the disclosure). **Step 2.** When the researcher returns to the group (After step 5 in 1st stage): • Acknowledge to the group that

254

Step 4. On the way to accessing the school's pastoral member of staff, the participant is given the researcher's contact details card. This includes:

- Information on how to contact the researcher to re-arrange the interview should the participant wish.
- Affirmation of the young person - the researcher will have already handwritten on the contact card an affirming and positive message for the young person – for example "really good to be with you today", "thank you for sharing your views today, I respect and value them".
- Signposting to individualised support. The card will have two youth friendly and valid adolescent self-harm support contact details on it (both local and national).

Step 5. Boundaried closure/ending of the interaction. Researcher does not leave the participant until in the presence of the pastoral support (or school safeguarding officer), and facilitates the hand over process to go smoothly, focused upon the participant's needs. The researcher then thanks the participant for their time and positive contributions in the research interview, and then leaves the participant.

some participants disclose their current self-harm and/or suicide ideation in research interviews about the topic of self-harm, which is why the safety protocols are in place.

- Remind participants that if current self-harm and/or suicide ideation is disclosed in the research interview, the safety protocol is in place, due to safeguarding pupils. Nb. This point is to help manage the risk of other participants in the group wishing to also disclose current self-harm and/or suicide ideation.
- Remind participants of who the NAMED safeguarding officer is in school if any student in the school wishes to disclose current self-harm and/or suicide ideation.
  Remind the group of the confidentiality agreement in place for the research interviews.

Step 3. Check if the group members are O.K. to go on with the interview.

- If YES, continue interview.
- If NO, for those group members, go to the *safety protocol for managing participant distress*. Start from STEP 1 of 1ˢᵗ stage response, and follow the steps.

Appendix 2C: Safeguarding School Staff & Wider Support Network Professionals: Cardiff University's Adult Safeguarding Protocol

Adolescent self-harm can be a potentially sensitive research topic. The school staff and wider support network professionals who are being interviewed are experienced education, health and social care professionals who have professional knowledge about adolescent self-harm. Their professional role, their professional context, and their professional knowledge, these are likely to be protective factors for participating in sensitive research, including adolescent self-harm. These staff will also be trained and knowledgeable about child and adult safeguarding, within their specific professional contexts (i.e. education, health and social care). However there is always the potential in research to come into contact with vulnerable adults, however small the risk within this research project.

The following points are used to plan how to respond to the issue of adult safeguarding.

1. Apply the "Cardiff University Safeguarding Children and Adults at Risk: Policy and Guidance"[149] (*see flowchart at end of point 3 below*). This policy document is operationalised through Cardiff University's safeguarding support resources[150]. These are the steps that the researcher will follow if an adult safeguarding issues arises during the research project.

2. The guidance in point 1 applies to any school staff or wider support network professionals who disclose to the researcher about their current self-harm or current suicide behaviour, suicide ideation and suicide attempts. All potential research participants will be made aware of this – i.e. if any adult participant discloses their current self-harm or current suicide behaviour, or suicide ideation or suicide attempt to the researcher, this means the adult safeguarding protocol is activated. A self-harm fact sheet for information and support resources will be given to all research participants (adults who are professionals, and young people), as part of the informed consent and safeguarding processes in this project *(see Appendix 4)*.
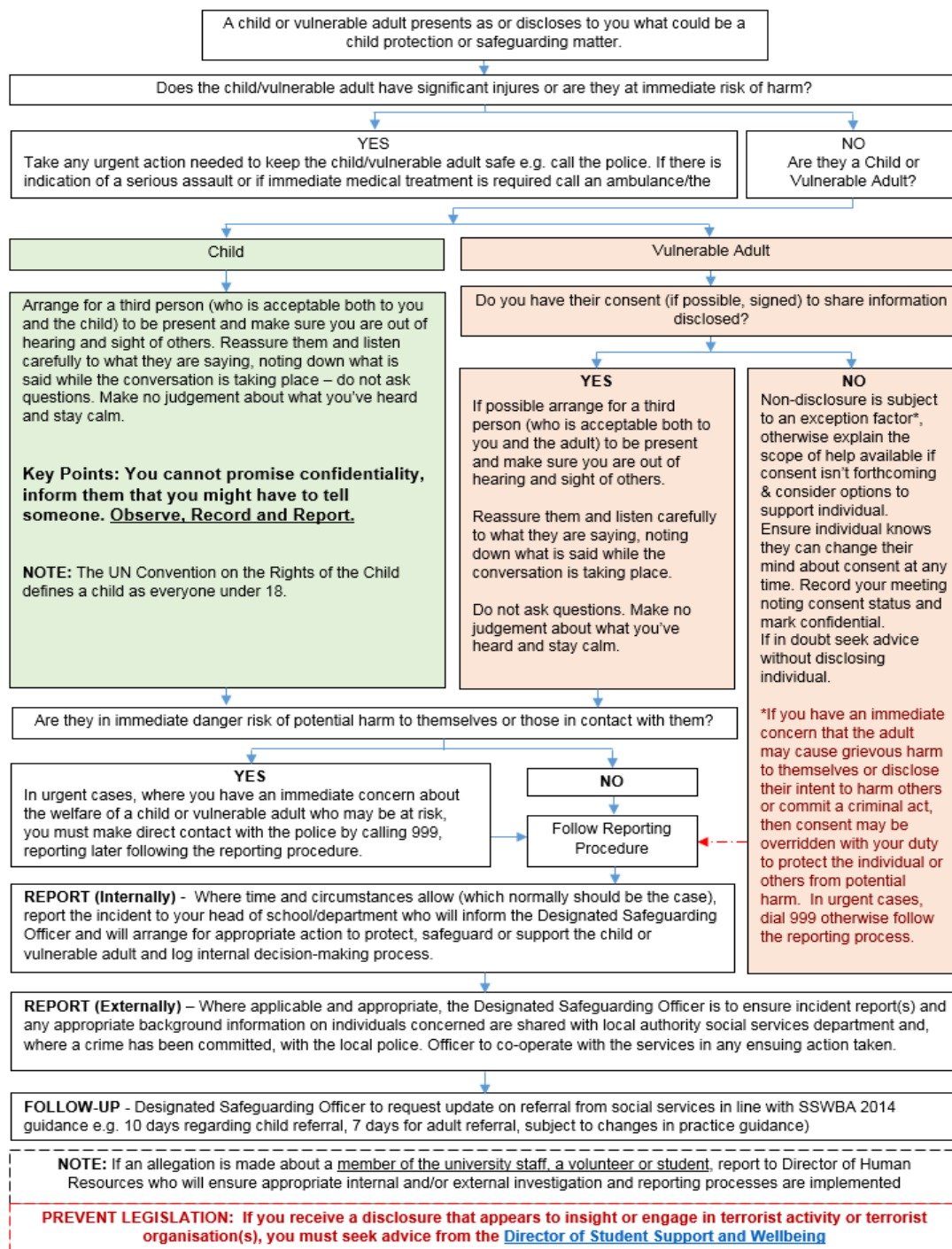
---

149 https://www.cardiff.ac.uk/public-information/policies-and-procedures/safeguarding

150 https://www.cardiff.ac.uk/public-information/policies-and-procedures/safeguarding/supporting-compliance-and-practice

3. As there is no Designated Safeguarding Officer for this project, and using the specific information contained in the policy document named in point 1 in relation to Cardiff University's reporting procedures for any incident that occurs, the safeguarding officer for this project is the Principle Safeguarding Officer. This is Sue Midha. Her contact details are as follows. Email: midha@cardiff.ac.uk Telephone: 029 20879243. The researcher will also report the incident by email to both her supervisors, Dr. Evans, and Professor Scourfield, as outlined in the safeguarding policy document
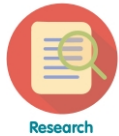
Recording and Reporting Safeguarding Incidents Flowchart

A child or vulnerable adult presents as or discloses to you what could be a child protection or safeguarding matter.

Does the child/vulnerable adult have significant injures or are they at immediate risk of harm?

YES
Take any urgent action needed to keep the child/vulnerable adult safe e.g. call the police. If there is indication of a serious assault or if immediate medical treatment is required call an ambulance/the

NO
Are they a Child or Vulnerable Adult?

Child

Arrange for a third person (who is acceptable both to you and the child) to be present and make sure you are out of hearing and sight of others. Reassure them and listen carefully to what they are saying, noting down what is said while the conversation is taking place – do not ask questions. Make no judgement about what you've heard and stay calm.

Key Points: You cannot promise confidentiality, inform them that you might have to tell someone. Observe, Record and Report.

NOTE: The UN Convention on the Rights of the Child defines a child as everyone under 18.

Vulnerable Adult

Do you have their consent (if possible, signed) to share information disclosed?

YES
If possible arrange for a third person (who is acceptable both to you and the adult) to be present and make sure you are out of hearing and sight of others.

Reassure them and listen carefully to what they are saying, noting down what is said while the conversation is taking place.

Do not ask questions. Make no judgement about what you've heard and stay calm.

NO
Non-disclosure is subject to an exception factor*, otherwise explain the scope of help available if consent isn't forthcoming & consider options to support individual. Ensure individual knows they can change their mind about consent at any time. Record your meeting noting consent status and mark confidential. If in doubt seek advice without disclosing individual.

*If you have an immediate concern that the adult may cause grievous harm to themselves or disclose their intent to harm others or commit a criminal act, then consent may be overridden with your duty to protect the individual or others from potential harm. In urgent cases, dial 999 otherwise follow the reporting process.

Are they in immediate danger risk of potential harm to themselves or those in contact with them?

YES
In urgent cases, where you have an immediate concern about the welfare of a child or vulnerable adult who may be at risk, you must make direct contact with the police by calling 999, reporting later following the reporting procedure.

NO

Follow Reporting Procedure

REPORT (Internally) - Where time and circumstances allow (which normally should be the case), report the incident to your head of school/department who will inform the Designated Safeguarding Officer and will arrange for appropriate action to protect, safeguard or support the child or vulnerable adult and log internal decision-making process.

REPORT (Externally) – Where applicable and appropriate, the Designated Safeguarding Officer is to ensure incident report(s) and any appropriate background information on individuals concerned are shared with local authority social services department and, where a crime has been committed, with the local police. Officer to co-operate with the services in any ensuing action taken.

FOLLOW-UP - Designated Safeguarding Officer to request update on referral from social services in line with SSWBA 2014 guidance e.g. 10 days regarding child referral, 7 days for adult referral, subject to changes in practice guidance)

NOTE: If an allegation is made about a member of the university staff, a volunteer or student, report to Director of Human Resources who will ensure appropriate internal and/or external investigation and reporting processes are implemented

PREVENT LEGISLATION: If you receive a disclosure that appears to insight or engage in terrorist activity or terrorist organisation(s), you must seek advice from the Director of Student Support and Wellbeing

257

Appendix 3: The Research Contract With Schools

Self-harm Preventive Intervention in Secondary Schools

RESEARCH AGREEMENT FOR SCHOOLS

For the purposes of the study from the School of Social Sciences, CARDIFF UNIVERSITY.

The MAIN RESEARCH STUDY QUESTIONS ARE:

- **What do staff and 16 to 18 year old pupils think are the influences within the secondary school context upon adolescent self-harm?**

- **What types of preventive intervention support do staff and 16 to 18 year old students think is viable within the secondary school context for adolescent self-harm?**

This agreement dated _____ is made between:

School of Social Sciences, Cardiff University, 1-3 Museum Place, Cardiff, CF10 3BD

AND School (X)

IT IS AGREED AS FOLLOWS:

1   Commitment from the study researcher

The researcher will:

- Work with your school to identify the most convenient times to conduct focus groups and/or interviews with school staff and pupils.

- Visit your school to give information about the project, and answer any questions that staff and pupils may have.

- Ensure that school staff and pupils are aware of the ethical procedures, the research interview safety protocols and limits to confidentiality that arise from safeguarding concerns.

- Provide sources of help sheets to all staff and pupils who attend focus groups or interviews.

- Pass information on to schools in the event that concerns around child protection or serious risk of harm to a student is disclosed.

- Disseminate study findings to schools.

- Anonymise all published data from the study, so no schools or individuals can be identified from any reports.

2   Commitment from the schools

All participating schools will:

- Provide a contact in the school to liaise with the researcher and co-ordinate all research activities.

- Agree with the researcher the number of focus groups and/or interviews that can be feasibly conducted at your school.

- Identify and support recruitment of school staff and 16 to 18 year old pupils to attend a focus group or interview.

- Release identified school staff and pupils to attend a focus group or interview.

- Allow the researcher to conduct focus groups and interviews at the school site.

- Inform the researcher of child protection and risk of harm procedures. Identify your school's safeguarding officer to the researcher for the management of any pupil safeguarding concerns that arise when the researcher is in the school context. Have pastoral support available when interviews are scheduled, to

meet pupils' pastoral support needs that may arise during the interviews. **Abide by the research safety protocols established for the research project to ensure participants' safety and well-being** *(Nb. the researcher will liaise with the appropriate school staff to support these arrangements, so they are in place as part of the pupil research interviews).*

AS AGREED BY:

The researcher: School of Social Sciences, Cardiff University. Name:　　RACHEL PARKER Position:　　PhD Student 　　　　Signature: Date:	For and on behalf of: School (X) Name: Position: Signature: Date:

CONTACT:
Rachel Parker
DECIPHER Centre
Cardiff University School of Social Sciences
1-3 Museum Place
Cardiff
CF10 3BD
Email: ParkerR9@cardiff.ac.uk

Appendix 4: Additional Safety Protocol Resource: Self-Harm Fact Sheet

The fact sheet was designed to equip any student, their parents/and or carers, and school-based staff with information and support resources about adolescent self-harm, as a protective factor, and to manage any potential harm stemming from the sensitive research topic.

THE SELF-HARM FACT SHEET:

SELF-HARM FACT SHEET for INFORMATION & SUPPORT RESOURCES:

What is Adolescent Self-Harm? Adolescents are 13 to 19 years old. Self-harm is when someone intentionally damages or injures their body. It's usually a way of coping with, or expressing, overwhelming emotional distress. There have been increasing rates of UK adolescent self-harm over the last decade, & the majority of incidents are invisible to health services. Current research states that we need to understand the school context & needs, to provide help in schools for adolescent self-harm. This is what the current project is aiming to achieve.

Here are a list of help resources. If you are feeling stressed, anxious or down you may find it useful to consult the help sources listed here. If you are experiencing **extreme feelings of distress**, we strongly encourage you to speak to your GP, so they can offer you appropriate help & support. The NHS has information & support services for self-harm - see the webpage: http://www.nhs.uk/Conditions/Self-injury/Pages/Treatment.aspx

Help Sources for Students	*Help Sources for Staff*
Association for Young People's Health Online guide for young people supporting each other. Website: http://Behealthy-peersupport.org.uk	**MIND** Mental health charity providing advice and information. Telephone: 0300 123 3393 or text 86463 Email: info@mind.org.uk

ChildLine

Helpline for children and young people to discuss their concerns or problems in confidence: 0800 1111

Website: www.childline.org.uk

Papyrus

Information for young people who self-harm, or who are concerned about friends who do. HopelineUK - confidential helpline weekdays 10am-10pm, weekends 2pm-10pm:

0800 068 41 41

Website: http://www.papyrus-uk.org

Self-Injury Support

Information and support for girls and women affected by self-injury or self-harm.

Self-injury helpline: 0808 8008088

Website: http://www.selfinjurysupport.org.uk/

Young Minds

Provides information to children and young people about mental health and emotional wellbeing.

Website: www.youngminds.org

Youth in Mind

Information for stressed young people.

Website: http://youthinmind.info/py/yiminfo/

Website: www.mind.org.uk

Depression Alliance

Information about depression and access to self-help groups.

Website: www.depressionalliance.org

Education Support Partnership (formerly Teacher Support Network)

Online advice and information for teachers.

24/7 helpline number for teachers:

08000 562 561

Website: http://teachersupport.info/

MindEd

Free educational resource on children and young people's mental health for all adults.

Website: https://www.minded.org.uk/

Royal College of Psychiatrists

Leaflets and expert advice on mental health.

Website:

http://www.rcpsych.ac.uk/expertadvice.aspx

Samaritans

24/7 helpline number: 116 123

Email: jo@samaritans.org

Website: www.samaritans.org

Appendix 5: Examples Of The Study's Informed Consent Resources

Appendix 5A: The Study's Information Sheet For Schools

RESEARCH PROJECT INFORMATION SHEET

Adolescent Self-harm Preventive Intervention Support

for Secondary Schools in Wales

THE MAIN RESEARCH QUESTIONS:

1. What do staff and 16 to 18 year old pupils think are the influences within the secondary school context upon adolescent self-harm?

2. What types of preventive intervention support do staff and 16 to 18 year old students think is viable within the secondary school context for adolescent self-harm?

What is the purpose of this study?

This study aims to find out what staff and pupils (aged 16 to 18 years) think in regards to the influence of the secondary school context upon adolescent self-harm. It wants to find out what school-based staff and pupils think are acceptable and feasible for schools in providing preventive intervention support for adolescent self-harm.

The project will explore the viewpoints of staff and pupils, using small focus groups within the school setting, or one-to-one interviews.

Eight secondary schools in Wales will be part of the research project. There will be between two to four focus groups in each school: one or two of the focus groups will consist of staff, the others of 16 to 18 year old pupils. One-to-one interviews may also take place.

This study builds upon prior work completed with schools in Wales about the development of effective, school-based approaches to student self-harm preventive intervention support. It aims to contribute further to this work and make key recommendations.
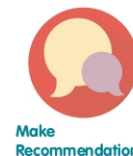
Who is undertaking this study? Rachel Parker is completing this study. She is a PhD researcher at the School of Social Sciences at the University of Cardiff. She has completed research on the topic of adolescent self-harm previously; worked with adolescent self-harm in Child and Adolescent Mental Health Services; and been part of a Task and Finish Group established for adolescent self-harm in secondary schools. She has an up-to-date police check.

What am I being asked to do? We would like you to attend an informal focus group with the researcher. For school staff this will be a focus group with three of your colleagues; for pupils, this will be a focus group with three other 16 to 18 year old pupils from your school. One-to-one interviews are also available. The researcher will explore your views about the influence of the secondary school context upon adolescent self-harm preventive intervention, and also what you feel is both wanted and acceptable in the school context for adolescent self-harm preventive intervention support.

The researcher will use a range of participatory methods to support the discussion. **You do not need to prepare anything in advance**. If you have been invited to a focus group but would rather speak to the researcher in private then we can arrange an individual interview instead. *We are interested in your views – there are no right or wrong answers.*

How is data managed in this project? Will information I give be anonymous and confidential? All personal data that is collected during this study will remain private, confidential and securely stored. Any information that is delivered within the research interviews will be anonymised, for example, all participants will be provided with a non-identifiable code and only broad descriptors will be used to characterise settings or participants. This means an individual or setting won't be able to be identified.

Data will only be available to the research team and will be securely stored using password protection on the Cardiff University networks. Data will be stored for at least five years and then destroyed. Findings from this research and its key recommendations will be presented to public bodies, education, health and social care organisations in Wales (and in other countries) responsible or interested in public health and well-being. When we present or publish the findings we may use quotes from the interviews and focus groups. However, all names of participating schools and individuals will be removed.

Please note that the confidentiality of this study will be broken if the researcher becomes concerned about child protection issues.

What if I change my mind? Participation in this research is entirely voluntary and you are not obliged to take part. If you do consent to participate and then change your mind you are free to do so. Any data that has been collected can be erased on request.

Has this study had ethical approval? The study has been awarded ethical approval by Cardiff University's School of Social Sciences Ethics Committee. If you have any questions about this please contact: Professor Alan Felstead: alanfelstead@cardiff.ac.uk Postal Address: Cardiff University's School of Social Science Research Ethics Committee. Chair of Research Ethics Committee. Cardiff University School of Social Sciences. Glamorgan Building, King Edward V11 Avenue. Cardiff. CF10 3WT.

What do I do now? If you are happy to take part in this study, please return your completed consent form to the researcher Rachel Parker in the envelope provided, **to your school reception.**

*For **16 to 18 year old pupils** who would like to be part of this research study:*	*For **staff** who wish to participate in this research study:*
1. Please complete the pupil consent form (see **FORM B**). 2. You also need your parental/carer permission to be part of this study (see **FORM C**). 3. So pupils need to return TWO consent forms to the school reception: their own signed consent form, along with a signed consent form by the parents/carers. 4. **ALL STUDENTS CAN BRING A FRIEND WITH THEM TO THE INTERVIEW.** 16 to 18 year pupils can choose to bring a friend within their school (aged 16 to 18 years) to the research interview. Each of the student's friends must also complete their consent forms (steps 1 to 3 above).	1. Please complete and return the staff consent form (**FORM A**).

On return of the signed forms, the researcher Rachel Parker will arrange a focus group at your convenience. Her email is: ParkerR9@cardiff.ac.uk Rachel is happy to answer any questions you have.

There is also a **blog site** about the project, with more detail and information.

Please see: https://talkresearchblog.wordpress.com/

Appendix 5B: Staff Consent Form

STAFF CONSENT FORM A

Please return this signed form to the researcher:

STAFF CONSENT FORM – RESEARCH PROJECT.

Please can school staff who wish to take part in the research study sign and return this form to the school reception in the envelope provided. Thank you.

RESEARCH FOCUS GROUPS AND INTERVIEWS

PLEASE NOTE: ALL IDENTIFYING DETAILS WILL BE REMOVED AS PART OF THE RESEARCH PROCESS	*Please initial in the boxes*	
I have read & understood the information sheet & have had the opportunity to ask questions.		
I understand that my participation & consent are voluntary. I am free to stop & withdraw my consent at any time. All my data will be erased on my request.		
I consent to the focus group/interview being digitally recorded.		
I understand the recording & transcript will be stored securely & used in the write up of the project.		
I understand that my (anonymised) data will be retained for at least five years.		
I agree to take part in the focus group / interview.		

Staff Name _____ DATE

Staff Signature _____

School Name _____

CONTACT:
Rachel Parker
DECIPHER Centre
Cardiff University School of Social Sciences
1-3 Museum Place
Cardiff
CF10 3BD
Email: ParkerR9@cardiff.ac.uk

Appendix 5C: Pupil Consent Form

PUPIL CONSENT FORM B

Please return this signed form to the researcher:

PUPIL CONSENT FORM – RESEARCH PROJECT.

Please can 16 to 18 years old pupils who wish to take part in the research study get permission from their parents/carers. Please can students and parents/carers initial, sign and return this form to the school reception in the envelope provided. Thank you.

RESEARCH FOCUS GROUPS AND INTERVIEWS

PLEASE NOTE: ALL IDENTIFYING DETAILS WILL BE REMOVED AS PART OF THE RESEARCH PROCESS	*Pupil Consent: Please initial in the boxes.*	*Parent to countersign in the boxes please.*
I have read & understood the information sheet & have had the opportunity to ask questions.		
I understand that my participation & consent are voluntary. I am free to stop & withdraw my consent at any time. All my data will be erased on my request.		
I consent to the focus group/interview being digitally recorded.		
I understand the recording & transcript will be stored securely & used in the write up of the project.		
I understand that my (anonymised) data will be retained for at least five years.		
I agree (& have parental permission) to take part in the focus group / interview.		

PUPIL Name _____ DATE

Signatures: *PUPIL* _____

                    PARENT/CARER _____

School Name _____

CONTACT:
Rachel Parker
DECIPHER Centre
Cardiff University School of Social Sciences
1-3 Museum Place
Cardiff
CF10 3BD
Email: ParkerR9@cardiff.ac.uk

267

Appendix 5D: Parent/carer Consent Form

PARENT/CARER CONSENT FORM C

Please return this signed form to the researcher:

FOR 16 to 18 YEAR OLD PUPILS TO TAKE PART IN THE RESEARCH PROJECT.

Please can parents/carers initial and sign the boxes below to give permission for their child to take part in the research study. Please return this signed consent form to the school reception, with the pupil signed consent form, in the envelope provided. Thank you.

RESEARCH FOCUS GROUPS AND INTERVIEWS

PLEASE NOTE: ALL IDENTIFYING DETAILS WILL BE REMOVED AS PART OF THE RESEARCH PROCESS	*Parental/carer Consent. Please initial these boxes*
I have read & understood the information sheet & have had the opportunity to ask questions.	
I understand that my child's participation & consent is voluntary, & I am free to withdraw my child & my consent at any time. All data will be erased on my request.	
I give parental permission for my child to take part in the focus group / interview.	
I consent to the focus group/interview being digitally recorded, & my child being part of this.	
I understand the recording & transcript will be stored securely & used in the write up of the project.	
I understand that my child's (anonymised) data will be retained for at least five years.	

PUPIL Name: _____

PARENT/CARER Name _____

I confirm by my signature that I give permission for my child to be part of this research study. ***Parent/Carer Signature :***

_____DATE:

School Name _____

CONTACT:
Rachel Parker
DECIPHER Centre
Cardiff University School of Social Sciences
1-3 Museum Place
Cardiff
CF10 3BD
Email: ParkerR9@cardiff.ac.uk

W My Site 🔲 Reader

Talking About Research

Research Project – Talking About: Teen Self-Harm   About   What is Adolescent Self-Harm?   Health Risks & Interventions

Understanding the School Context   Background Context   Ethics   Project Methodology   Outcomes & Impacts   Contact

Project Context Overview – Full Article

Adolescent Self-Harm Research Project

This is an information site about a current research project from Cardiff University.

It's centred upon **talking to 16 year old pupils and school staff in Wales.**

It wants to find out what participants think **in regards to the influence of the secondary school context upon adolescent self-harm.**

Please use the links at the TOP MENU BAR of this page to explore the project further.

YOUR FEEDBACK: This project is interested in **your feedback & comments** about it. Once you have looked at the project, if you are interesting in providing comments please **go to the CONTACT PAGE** to leave your feedback. *Your feedback is an important part of this project, which the researcher will read carefully, as it could help to develop the project further, through understanding your perspective and comments.*

Appendix 6: The Research Study Participants

This appendix gives an overview of the research study participants (including details of the organisational setting the research participant was part of):

• 30 sixth form pupils aged 16 to 18 years (*see Appendix 6A below*);

• 19 school-based staff (*see Appendix 6B below*);

• 7 young people aged 17 to 24 years (*see Appendix 6C below*);

• 20 wider system support network professionals with knowledge of adolescent self-harm (*see Appendix 6D below*);

There were 76 research participants in total. For the 37 youth participants aged from 16 to 24 years, 11 were male and 26 were female.

The study found that all 76 participants had lived experience of adolescent self-harm. Although each of the participants had contact with the behaviour of adolescent self-harm, these experiences differed and were dependent upon which group participants were part of in regards to either being pupils and young people, school staff or wider system professionals (*Chapters 4, 5, 6 and 7 of this thesis provide more information upon this point*). Some participants also shared that they had lived experience of pupils' suicide ideation, suicide attempts and pupils' death by suicide.

Appendix 6A: Details Of Sixth Form Pupil Research Participants

School ID code	School characteristics	ID Participant Code	Interview group or single interview code	Participant Gender and Age	Lived experience of self-harm? Y/N	Details given by participant regarding pupil suicide ideation, pupil suicide attempts and pupil death by suicide.	Details given by participant regarding the nature of their lived experience of adolescent self-harm.
School 1 (*The pupil interview groups in this school were ABC*)	FSM. Low. KS4 Level. Medium. Language. Bilingual. School size. Medium. National school categorisation. Red (in need of greatest improvement).						
		P1	Group A	F - 17yrs	Y		*Peer self-harm.*
		P2	Group A	F - 16yrs	Y		*Peer self-harm. Own self-harm (long-term).*
		P3	Group A	F - 16yrs	Y		*Peer self-harm.*
		P4	Group B	F - 17yrs	Y		*Peer self-harm. Own self-harm.*
		P5	Group B	F - 17yrs	Y		*Peer self-harm.*
		P6	Group B	F - 17yrs	Y		*Peer self-harm.*
		P7	Group C	F - 17yrs	Y		*Peer self-harm.*
		P8	Group C	M - 17yrs	Y		*Peer self-harm.*
		P9	Group C	M - 18yrs	Y		*Peer self-harm.*
		P10	Group C	M - 18yrs	Y		*Own suicide attempt. Peer self-harm. Peer suicide ideation. Peer suicide attempt.*
		P11	Group C	M - 18yrs	Y		*Peer self-harm.*

School ID code	School characteristics	ID Participant Code	Interview group or single interview code	Participant Gender and Age	Lived experience of self-harm? Y/N	Details given by participant regarding pupil suicide ideation, pupil suicide attempts and pupil death by suicide.	Details given by participant regarding the nature of their lived experience of adolescent self-harm.
School 2 *(The pupil interview groups in this school were DE)*	FSM. Medium KS4 Level. Low. Language. English Medium. School size. Medium National school categorisation. Amber (in need of improvement).						
		P12	Group D, also single interview E	M - 16yrs		*Peer self-harm. Own self-harm. Peer suicide.*	
		P13	Group D	F - 16yrs	Y	*Peer self-harm. Peer suicide.*	
		P14	Group D	F - 16yrs	Y	*Peer self-harm. Peer suicide.*	
		P15	Group D	F - 16yrs	Y	*Peer self-harm. Peer suicide.*	
		P16	Group D	F - 17yrs	Y	*Peer self-harm. Peer suicide.*	
		P17	Group D	F - 17yrs	Y	*Peer self-harm. Peer suicide.*	
		P18	Group D	F - 17yrs	Y	*Peer self-harm. Peer suicide.*	
School 3 (*The pupil interview groups in this school were FGHI*)	FSM. Low. KS4 Level. Medium. Language. English Medium. School size. Medium National school categorisation. Yellow (an effective school)						

School ID code	School characteristics	ID Participant Code	Interview group or single interview code	Participant Gender and Age	Lived experience of self-harm? Y/N	Details given by participant regarding pupil suicide ideation, pupil suicide attempts and pupil death by suicide.	Details given by participant regarding the nature of their lived experience of adolescent self-harm.
		P19	Group F	M - 17yrs	Y		*Own self-harm.* *Peer self-harm.* *Peer suicide ideation.*
		P20	Group F	M - 16yrs	Y		*Own self-harm.* (Nb. deep healed scars across both wrists).
		P21	Group F	F - 17yrs	Y		*Peer self-harm.*
		P22	Group F	F - 17yrs	Y		*Peer self-harm.*
		P23	Group F	F - 17yrs	Y		*Peer self-harm.* *Peer suicide ideation.*
		P24	Group F	F - 17yrs	Y		*Peer self-harm.* *Peer suicide ideation.*
		P25	Group G	F - 17yrs	Y		*Peer self-harm.* *Peer suicide ideation.*
		P26	Group G	F - 17yrs	Y		*Peer self-harm.* *Peer suicide ideation.*
		P27	Group G	F - 17yrs	Y		*Peer self-harm.*
		P28	Group G	F - 17yrs	Y		*Peer self-harm.* *Own self-harm.*
		P29	Interview H	F - 17yrs	Y		*Own self-harm (long-term).* *Own suicide ideation.* *and behaviour.* *Own suicide attempt.*
		P30	Interview I	F - 17yrs	Y		*Own self-harm (long-term)*

Appendix 6B: Details Of School Staff Research Participants

School ID code.	School characteristics.	ID Participant Code.	Participant gender and role	Lived experience of self-harm? Y/N	Details given by participant regarding pupil suicide ideation, pupil suicide attempts and pupil death by suicide.	Details given by participant regarding the nature of their lived experience of adolescent self-harm.
School 1 (*The pupil interview groups in this school were ABC*)	FSM. Low. KS4 Level. Medium. Language. Bilingual. School size. Medium. National school categorisation. Red (in need of greatest improvement).					
		S9	F - Head of Sixth Form	Y		*Pupil self-harm.*
		S10	F - Health, Social Care & PE Teacher	Y		*Pupil self-harm.*
		S11	F - Head of Safeguarding & Pastoral Support	Y		*Pupil self-harm.*
		S12	F - Pastoral Support Officer & PE Teacher	Y		*Pupil self-harm.* *Pupil suicide ideation.*
School 2 (*The pupil interview groups in this school were DE*)	FSM. Medium KS4 Level. Low. Language. English Medium. School size. Medium National school categorisation. Amber (in need of improvement).					

School ID code	School characteristics	ID Participant Code	Participant gender and role	Lived experience of self-harm? Y/N	Details given by participant regarding pupil suicide ideation, pupil suicide attempts and pupil death by suicide.	Details given by participant regarding the nature of their lived experience of adolescent self-harm.
		S13	F - Assistant Head Teacher and Safeguarding Lead.	Y		*Pupil self-harm.*
		S14	M - Head of Sixth Form	Y		*Pupil self-harm. Pupil suicide.*
		S15	F - School Welfare Officer	Y		*Pupil self-harm.*
School 3 (*The pupil interview groups in this school were FGHI)*	FSM. Low. KS4 Level. Medium. Language. English Medium. School size. Medium National school categorisation. Yellow (an effective school)					
		S5	F - Head of Sixth Form	Y		*Pupil self-harm. Pupil suicide.*
		S6	F - Head Teacher	Y		*Pupil self-harm.*
		S7	F - Sixth Form School Well-being Support Officer	Y		*Pupil self-harm. Pupil suicide attempt. Pupil suicide.*
		S8	F - School Nurse	Y		*Pupil self-harm. Pupil suicide attempt. Pupil suicide.*

School ID code	School characteristics	ID Participant Code	Participant gender and role	Lived experience of self-harm? Y/N	Details given by participant regarding pupil suicide ideation, pupil suicide attempts and pupil death by suicide.	Details given by participant regarding the nature of their lived experience of adolescent self-harm.
School 4 *(No pupils were permitted by the school to be interviewed)*	FSM. Low. KS4 Level. High. Language. English Medium. School size. Small National school categorisation. Green (a highly effective school)					
		S1	F - Assistant Head Teacher and Pupil Well-being Lead	Y	*Pupil self-harm.*	
		S2	F - Teacher	Y	*Pupil self-harm.*	
		S3	F - Head Teacher	Y	*Pupil self-harm.*	
		S4	F - Teacher	Y	*Pupil self-harm.*	
School 5 *(No pupils were permitted by the school to be interviewed*	FSM. Low. KS4 Level. High. Language. Welsh Medium. School size. Small National school categorisation. Green (a highly effective school)					
		S16	F - Head of Year	Y	*Pupil self-harm.*	
		S17	M - Head of Year	Y	*Pupil self-harm.*	
		S18	F - Assistant Head Teacher and Well-being Lead	Y	*Pupil self-harm.*	
		S19	M - PE Teacher	Y	*Pupil self-harm.*	

Appendix 6C: Details Of Community Centre Youth Participants

Setting Detail.	ID Participant Code	Participant Role within the setting.	Participant Gender and Age.	Lived experience of self-harm? Y/N	Details given by participant regarding pupil suicide ideation, pupil suicide attempts and pupil death by suicide.	Details given by participant regarding the nature of their lived experience of adolescent self-harm.
Community Youth Centre in a rural community area in Wales	WYP8	Youth Volunteer *Also daughter of participant W2 (see Table 6D below)*	F - 22yrs	Y		*Has experience in school context of: peer self-harm; own self-harm (long-term throughout school).*
	WYP9	Youth Volunteer.	M - 21yrs.	Y		*Has experience in school context of; peer self-harm; peer suicide attempt; peer suicide. Current experience of student peers' self-harm in university.*
	WYP10	Youth Volunteer.	M - 21yrs	Y		*Has experience in school context of: peer self-harm; peer suicide attempt; peer suicide. Current experience of student peers' self-harm in university.*
	SUYP1	Service User.	M - 18yrs	Y		*Has experience in school context of: peer self-harm; own self-harm (long-term throughout school); own suicide ideation; own suicide attempt; peer suicide attempt; in addition to the prior events, also a joint suicide attempt; peer suicide. Best friend in school context died by suicide (aged 15yrs).*
	SUYP2	Service User.	F - 24yrs	Y		*Has experience in school context of: own self-harm (long-term throughout school); own suicide ideation; own suicide attempt. Ongoing self-harm.*
	SUYP3	Service User.	F - 17yrs	Y		*Has experience in school context of: own self-harm (long-term throughout school); own suicide ideation; own suicide attempt.*
	SUYP4	Service User.	M - 22yrs	Y		*Has experience in school context of: own self-harm; peer self-harm.*

Appendix 6D: Details Of Wider Support Network Professionals

All of these settings are in Wales	Setting Details	ID Participant Code.	Participant Role within the setting	Participant Gender	Lived experience of self-harm? Y/N	Details given by participant regarding pupil suicide ideation, pupil suicide attempts and pupil death by suicide. Details given by participant regarding the nature of their lived experience of adolescent self-harm. Details given by participant regarding lived experience of adolescent self-harm.
A. *Charity* Children's charity		W1	Community Child and Adolescent Mental Health Project Manager (to provide support to schools)	M	Y	*Worked with pupil self-harm in school context.* *Also as a parent: daughter's self-harm (during secondary school).*
B. *Charity* Community youth centre *also delivered the school counselling service, county-wide*		W2	Support worker and CYP Counsellor.	F	Y	*Worked with pupil self-harm in school context.* *Worked with self-harm and suicide ideation in the young people who dropped in to the youth centre and used the support service.* *Also as a parent: daughter's self-harm (during secondary school, which was long-term). Her daughter was participant WYP8.*
Setting B.		W3	Support Worker and CYP Counsellor.	F	Y	*Worked with pupil self-harm in school context.* *Worked with self-harm and suicide ideation in the young people who dropped in to the youth centre and used the support service.*
Setting B.		W4	General Manager.	F	Y	*Worked with self-harm in the young people who dropped in to the youth centre and used the support service.*
Setting B.		W5	School Counselling Services Manager.	F	Y	*Worked with pupil self-harm in school context.* *Worked with self-harm in the young people who dropped in to the youth centre and used the support service.* *Also as a parent: daughter's self-harm (during secondary school, which was long-term).*

All of these settings are in Wales	Setting Details	ID Participant Code.	Participant Role within the setting	Participant Gender	Lived experience of self-harm? Y/N	Details given by participant regarding pupil suicide ideation, pupil suicide attempts and pupil death by suicide.	Details given by participant regarding the nature of their lived experience of adolescent self-harm.	Details given by participant regarding the nature of their lived experience of adolescent self-harm.
Setting B.		W6	Director.	F	Y	*Worked with pupil self-harm in school context.*		*Worked with pupil self-harm in school context.* *Worked with self-harm in the young people who dropped in to the youth centre and used the support service.*
Setting B.		W7	Support Worker and CYP Counsellor.	F	Y			*Worked with pupil self-harm in school context.* *Worked with self-harm and suicide ideation in the young people who dropped in to the youth centre and used the support service. Also provided support for young people who had experienced their own suicide attempts and peers' suicide.*
C. *Local Government Service* CAMHS		W11	Lead Manager, CAMHS Primary Care Team.	F	Y			*Worked with pupil self-harm in school context.* *Worked with adolescent self-harm, suicide ideation, suicide attempts in CAMHS setting.*
D. *Charity* Community youth charity		W12	Adolescent Self-harm Community-based Support Project Manager, also CYP Counsellor.	F	Y			*Outreach support for adolescent self-harm.* *Worked with pupil self-harm in school context.* *Worked with adolescent self-harm in community setting context.*

Setting Details *All of these settings are in Wales*	ID Participant Code.	Participant Role within the setting	Participant Gender	Lived experience of self-harm? Y/N	Details given by participant regarding pupil suicide ideation, pupil suicide attempts and pupil death by suicide. / Details given by participant regarding the nature of their lived experience of adolescent self-harm. / Details given by participant regarding adolescent self-harm.
E. *Charity* Child and family support charity	W13	Self-Harm Consultant and Trainer (nation-wide, all areas in Wales)	M	Y	*Worked with pupil self-harm, pupil suicide attempts and pupil suicide – provided advice and support for schools (and wider linked school system) in trainer role.* *Worked with adolescent self-harm, suicide attempts in youth community support setting.* *Also in work history: work colleague died by suicide.* *Also in personal history: ex partner died by suicide in university setting (aged 19yrs).*
F. *Charity* Children's charity	W14	Children and Young People Helpline Advisor.	F	Y	*Worked regularly with adolescent self-harm in her current professional role.* *Also as a parent: daughter's peers self-harmed during secondary school.*
Setting F.	W15	Project Director.	F	Y	*Worked with adolescent self-harm as part of her role within charity service provision.*
Setting F.	W16	Project Manager.	F	Y	*Worked with adolescent self-harm as part of her role within charity service provision.* *Also as a parent: daughters' peers self-harmed during secondary school.*
G. *Government* National Assembly for Wales	W17	National Assembly Committee Member.	F	Y	*Child and youth mental health policy work focus, adolescent self-harm was one area within this policy focus.* *Also as a parent: son's best friend in school context died by suicide (aged 15yrs)*

All of these settings are in Wales / Setting Details	ID Participant Code.	Participant Role within the setting	Participant Gender	Lived experience of self-harm? Y/N	Details given by participant regarding pupil suicide ideation, pupil suicide attempts and pupil death by suicide.	Details given by participant regarding the nature of their lived experience of adolescent self-harm.
H. *Local Government Service.* Specialist Pupil Referral Unit	W18	Teacher in charge.	F	Y		*Her role in the unit was to teach and support excluded pupils who experienced self-harm, also suicide ideation and suicide attempts. She also had visited and supported her pupils when they were in health settings due to their self-harm, suicide ideation and suicide attempts.*
I. *Local Government Service* Pupil support department	W19	Pupil Attendance Support Manager.	F	Y		*Supported pupils who self-harmed.*
J. *Local Government Service* School counselling and pupil wellbeing service.	W20	Senior Service Manager.	F	Y		*Worked with pupil self-harm in school context.* *Also suicide prevention for school context due to pupils' deaths by suicide (these deaths took place on or near school grounds during the school day).*
K. *National Government Service* Public health agency	W21	Public Health Professional.	F	Y		*Child and youth well-being policy work. Schools were one public health context within this work. Within the national school consultations she was part of, adolescent self-harm was a topic that some school staff were concerned about.* *Also as a parent: daughter's peers self-harmed during secondary school.*

Setting Details *All of these settings are in Wales*	ID Participant Code.	Participant Role within the setting	Participant Gender	Lived experience of self-harm? Y/N	Details given by participant regarding the nature of their lived experience of adolescent self-harm. Details given by participant regarding pupil suicide ideation, pupil suicide attempts and pupil death by suicide.
L. *Charity* Community-based centre for child, youth, and family support.	W22	Youth Emotional Well-being Project Manager.	F	Y	*Worked with pupil self-harm in school context.* *Worked with youth self-harm in community workshops, also suicide ideation, suicide attempts.*
M. *University*	W23	Professor. Member of Government Advisory Group.	F	Y	*Worked within adolescent self-harm and suicide preventive intervention as part of her professional role.* *Also front-line health practice working with adolescent self-harm and suicide preventive intervention.*

CHAPTER 8: REFERENCES

Additional Learning Needs and Educational Tribunal (Wales) Act 2018. London: HMSO.

Adler, P.A. and Adler. P. 2022. The social transformation of self-injury. *Qualitative Sociological Review,* 18(4), pp. 64-91. doi: https://doi.org/10.18778/1733-8077.18.4.04

Agurs-Collins, T., Persky, S., Paskett, E.D., Barkin, S.L., Meissner, H.I., Nansel, T.R., Arteaga, S.S., Zhang, X., Das, R. and Farhat, T. 2019. Designing and assessing multilevel interventions to improve minority health and reduce health disparities. *American Journal of Public Health*, 109 (S1), S86-S93. doi: https://doi.org/10.2105/AJPH.2018.304730

Alvesson,M. and Skoldberg, K. 2017. *Reflexive methodology. New vistas for qualitative research.* London: SAGE Publications Ltd.

Andrews, T., Martin, G., Hasking, P. and Page, A. 2014. Predictors of onset for non-suicidal self-injury within a school-based sample of adolescents. *Prevention Science,* 15, pp. 850–859. doi:https://doi.org/10.1007/s11121-013-0412-8

Arcaya, M.C., Arcaya, A.L. and Subramanian, S.V. 2015. Inequalities in health: definitions, concepts, and theories. *Global Health Action*, 8, 27106 (12pp). doi:https://doi.org/10.3402/gha.v8.27106

Archer, M., Bhaskar, R., Collier, A., Lawson, T. and Norrie, A. 1998. *Critical Realism: Essential readings.* London: Routledge

Arensman, A., Corcoran, P. and McMahon, E. 2018. The iceberg model of self-harm: new evidence and insights. *Lancet Psychiatry,* 5 (2), pp. 100-101. doi: https://doi.org/10.1016/S2215-0366(17)30477-7

Argento, A., Simundic, A., Mettler, J., Mills, D.J. and Heath, N.L. 2022. Evaluating the effectiveness of a brief mindfulness activity in university students with non-suicidal self-injury engagement. *Archives of Suicide Research*, 26, pp. 871–885. doi:https://doi.org/10.1080/13811118.2020.1841052

Armijo-Olivo, S., Stiles, C.R., Hagen, N.A., Biondo, P.D. and Cummings, G.G. 2012. Assessment of study quality for systematic reviews: a comparison of the Cochrane Collaboration Risk of Bias Tool and the Effective Public Health Practice Project Quality Assessment Tool: methodological research. *Evaluation in Clinical Practice*, 18, pp. 12-18. doi:https://doi.org/10.1111/j.1365-2753.2010.01516.x

Attia, M. and Edge, J. 2017. Be(com)ing a reflexive researcher: a developmental approach to research methodology. *Open Review of Educational Research*, 4 (1), pp. 33-45. doi:https://doi.org/10.1080/23265507.2017.1300068

Aveyard, H. 2023. Doing a literature review in health and social care. Maidenhead: Open University Press.

Baetens, I., Decruy, C., Vatandoost, S., Vanderhaegen, B. and Kiekens, G. 2020. School-based prevention targeting nonsuicidal self-injury: A pilot study. *Frontiers in Psychiatry*, 11, 437 (11pp). doi: https://doi.org/10.3389/fpsyt.2020.00437

Bainbridge, A., Reid, H. and Del Negro, G. 2022. Towards a virtuosity of school leadership: clinical support and supervision as professional learning. *Professional Development in Education*, 48 (4), pp. 546-558. doi: https://doi.org/10.1080/19415257.2019.1700152

Barker, E.D., Arseneault, L., Brendgen, M., Fontaine, N. and Maughan, B. 2008. Joint development of bullying and victimization in adolescence: Relations to delinquency and self-harm. *American Academy of Child and Adolescent Psychiatry*, 47 (9), pp. 1030-1038. doi: https://doi.org/10.1097/CHI.ObO13e31817eec98

Barnard, E., Dempster, G., Krysinska, K., Reifels, L. Robinson, J., Pirkis, J. and Andriessen, A. 2021. Ethical concerns in suicide research: thematic analysis of the views of human research ethics committees in Australia. *BMC Medical Ethics,* 22, 41 (10pp). doi:https://doi.org/10.1186/s12910-021-00609-3

Barr, W., Leitner, M. and Thomas, J. 2005. Psychosocial assessment of patients who attend an accident and emergency department with self-harm. *Psychiatric and Mental Health Nursing*, 12, pp. 130–138. doi: https://doi.org/10.1111/j.1365-2850.2004.00804.x

Bauer, M.S. and Kirchner, J. 2020. Implementation science: What is it and why should I care? *Psychiatry Research*, 283, 112376 (6pp). doi:https://doi.org/10.1016/j.psychres.2019.04.025

Benton, T. and Craib, I. 2011. *Philosophy of Social Science*. London: Palgrave Macmillan.

Berger, E., Hasking, P. and Reupert, A. 2014. '"We're Working in the Dark Here". Education needs of teachers and school staff regarding student self-injury. *School Mental Health,* 6 (3), pp.201–212. doi: https://doi.org/10.1007/s12310-013-9114-4

Berger, E., Hasking, P. and Reupert, A. 2015. Developing a policy to address nonsuicidal self-injury in schools. *School Health*, 85, pp. 629–647. doi: https://doi.org/10.1111/josh.12292

Bergold, J. and Thomas, S. 2010. Participatory research methods: A methodological approach in motion. *Forum: Qualitative Social Research,* 13 (1), 30 (31pp). doi:https://doi.org/10.17169/fqs-13.1.1801

Best, R. 2006. 2006. Deliberate self-harm in adolescence: a challenge for schools. *Guidance and Counselling*, 34, pp.161–74. doi:https://doi.org/10.1080/03069880600583196

Best, V., Akbari, A., Bedston, S., Davies, G., Lowthian, E., Lyons, J., Torabi, F. and Lyons, R.A. 2022. *Informing better use of Welsh hospital admissions data in the SAIL Databank. A review of the clinical coding completeness and lag in the Patient Episode Database for Wales (PEDW).* Cardiff: ADR Wales.

Bethell, C. D., Carle, A., Hudziak, J., Gombojav, N., Powers, K., Wade, R. and Braveman, P. 2017. Methods to assess Adverse Childhood Experiences of children and families: Toward approaches to promote child well-being in policy and practice. *Academic pediatrics*, 17(7S), S51–S69. doi: https://doi.org/10.1016/j.acap.2017.04.161

Bhaskar, R. 1989. *Reclaiming Reality.* London: Verso.

Bhaskar, R. 2008. *A Realist Theory of Science*. London: Routledge.

Bhaskar, R. 2014. Foreward. In Edwards, P.K., O' Mahoney, J. and Vincent, S.eds. *Studying Organizations Using Critical Realism*. Oxford: Oxford University Press, pp. v-xv.

Bicchieri, C., Muldoon, R. and Sontuoso, A. 2018. Social Norms. In Zalta, E.N. ed. The Stanford Encyclopedia of Philosophy [online edition]. Stanford: Stanford University. Available at: https://plato.stanford.edu/archives/win2018/entries/social-norms/ (Accessed: 1 August 2022).

Biddle, L., Cooper, J., Owen-Smith, A,, Klineberg, E., Bennewith, O., Hawton, K., Kapur, N., Donovan, J. and Gunnell, D. 2013. Qualitative interviewing with vulnerable populations: individuals' experiences of participating in suicide and self-harm based research. *Affective Disorders,* 145(3), pp. 356-362. doi: https://doi.org/10.1016/j.jad.2012.08.024

Birks, M., Hoare, K. and Mills, J. 2019. Grounded Theory: FAQs. *International Journal of Qualitative Methods,* 18, pp. 1-7. doi: https://doi.org/10.1177/1609406919882535

Birks, M. and Mills, J. 2022. Grounded Theory. A practical guide. London: SAGE Publications.

Bolton, D. and Gillett, G. 2019. *The biopsychosocial model of health and disease.* London: Palgrave Macmillan.

Bonell, C., Jamal, F., Harden, A., Wells, H., Parry, W., Fletcher, A., Petticrew, M., Thomas, J., Whitehead, M., Campbell, R., Murphy, S. and Moore, L. 2013. Systematic review of the effects of schools and school environment interventions on health: evidence mapping and synthesis. *Public Health Research*, 1, 1 (340pp). doi: https://doi.org/10.3310/phr01010

Borschmann, R. and Kinner, S.A. 2019. Responding to the rising prevalence of self-harm. *Lancet Psychiatry,* 6 (7), pp. 548-459. doi: https://doi.org/10.1016/S2215-0366(19)30210-X

Bos, A.E.R., Pryor, J.B., Reeder, G.D. and Stutterheim, S.E. 2013. Stigma: Advances in theory and research. *Basic and Applied Social Psychology,* 35 (1),pp. 1-9. doi:https://doi.org/10.1080/01973533.2012.746147

Bould, H., Mars, B., Moran, P., Biddle, L and Gunnell, D. 2019. Correspondence: Rising suicide rates among adolescents in England and Wales. *Lancet Psychiatry*, 394, pp. 116. doi:https://doi.org/10.1016/S0140-6736(19)31102-X

Braveman, P. 2014. What are health disparities and health equity? We need to be clear. *Public Health Reports,* 129 (2), pp. 5-8. doi: https://doi.org/10.1177/00333549141291S203

Breuer, F. and Roth, W.M. 2003. Subjectivity and reflexivity in the Social Sciences: Epistemic windows and methodical consequences. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 4 (2): 25 (14pp). doi: https://doi.org/10.17169/fqs-4.2.698

Brookes, S.T and Ben-Shlomo, Y. 2013. `Measuring and summarising data`, in Ben-Shlomo, Y., Brookes, S.T. and Hickman, M. eds. *Epidemiology, evidence-based medicine and public health.* Chichester: Wiley Blackwell, pp. 11-19.

Brooks, F., Chester, K., Klemera, E. and Magnusson, J. 2017. *Intentional self-harm in adolescence: An analysis of data from the Health Behaviour in School-aged Children (HBSC) survey for England, 2014.* London: Public Health England.

Brooks, F., Klemera, E., Chester, K., Magnusson, J. and Spencer, N. 2020. *HBSC England national report: Findings from the 2018 HBSC study for England.* Hatfield, England: University of Hertfordshire.

Bruce, N., Pope, D. and Stanistreet, D. 2008. *Quantitative Methods for Health Research.* Chichester: John Wiley & Sons.

Bunt, S. 2016. Critical realism and grounded theory. Analysing the adoption outcomes for disabled children using the retroduction framework. *Qualitative Social Work*, 17 (2), pp. 176-194. doi: https://doi.org/10.1177/1473325016664572

Cairns, J., Graham, E. and Bambra, C. 2017. Area-level socioeconomic disadvantage and suicidal behaviour in Europe: A systematic review. *Social Science and Medicine*, 192, pp.102-111. doi:https://doi.org/10.1016/j.socscimed.2017.09.034.

Campbell, M., Fitzpatrick, R., Haines, A., Kinmonth, A. L., Sandercock, P., Spiegelhalter, D. and Tyrer, P. 2000. Framework for design and evaluation of complex interventions to improve health. *BMJ,* 321, pp. 694-696. doi: https://doi.org/10.1136/bmj.321.7262.694

Campbell, R., Goodman-Williams, R., Feeney, H. and Fehler-Cabral, G. 2018. Assessing triangulation across methodologies, methods, and stakeholder groups: The joys, woes, and politics of interpreting convergent and divergent data. *American Journal of Evaluation*, 41 (1), pp. 125-144. doi: https://doi.org/10.1177/1098214018804195

Care Council For Wales. 2017. Social Services and Well-being (Wales) Act 2014. *The key principles underpinning the Act: Voice and control, prevention and early intervention, well-being, co-production, and multi agency.* Cardiff: Care Council for Wales.

Care Quality Commission. 2015. *Right Here. Right Now. People's experiences of help, care and support during a mental health crisis.* Gallowgate: Care Quality Commission.

Care Quality Commission. 2017. *Review of children's and young people's mental health services.* Newcastle upon Tyne: Care Quality Commission.

Care Quality Commission. 2018. *Are we listening? Review of children's and young people's mental health services.* Newcastle upon Tyne: Care Quality Commission.

Carr, M.J., Steeg, S., Webb, R.T., Kapur, N., Chew-Graham, C. A., Abel, K.M., Hope, H., Pierce, M. and Ashcroft, D.M. 2021. Effects of the COVID-19 pandemic on primary care-recorded mental illness and self-harm episodes in the UK: a population based cohort study. *Lancet Public Health*, (2), e124-35. doi:https://doi.org/10.1016/S2468-2667(20)30288-7

Carter, T., Latif, A., Callaghan, P. and Manning, J.C. 2018. An exploration of predictors of children's nurses' attitudes, knowledge, confidence and clinical behavioural intentions towards children and young people who self-harm. *Clinical Nursing,* 27, pp. 2836–2846. doi:https://doi.org/10.1111/jocn.14361

Castelpietra, G., Knudsen, A.K.S., Agardh, E.E., Armocida, B., Massimiliano, Beghi., Iburg, K.M., Logroscino, G. et al. 2022. The burden of mental disorders, substance use disorders and self-harm among young people in Europe, 1990−2019: Findings from the Global Burden of Disease Study 2019. *The Lancet Regional Health – Europe,* 16, 100341 (18pp). doi:https://doi.org/10.1016/j.lanepe.2022.100341

Centre for Critical Realism. 2017. *Critical Realism. Key concepts.* Available at: https://centreforcriticalrealism.com/about-critical-realism/basic-critical-realism/ (Accessed: 15 April 2018).

Cerel, J., Maple, M., van de Venne, J., Brown, M., Moore, M. and Flaherty, C. 2017. Suicide exposure in the population: perceptions of impact and closeness. *Suicide and Life Threatening Behaviour*, 47, pp. 696-708. doi: https://doi.org/10.1111/sltb.12333

Chambers, R. 1992. *Rural Appraisal: Rapid, relaxed and participatory. Discussion Paper 311.* Brighton: Institute of Development Studies

Chambers, R. 1994a. Participatory Rural Appraisal (PRA): analysis of experience. *World Development,* 22 (9), pp. 1253-1268. doi: https://doi.org/10.1016/0305-750X(94)90003-5

Chambers, R. 1994b. Participatory Rural Appraisal (PRA): challenges, potentials and paradigm. *World Development*, 22 (10), pp. 1437-1454. doi: https://doi.org/10.1016/0305-750X(94)90030-2

Chambers, R. 1997. *Whose reality counts; putting the last first.* London: Intermediate Technology Publications.

Chambers, R. 2002. *Relaxed and Participatory Appraisal: notes on practical approaches and methods for participants in PRA/PLA-related familiarisation workshops.* Brighton: Institute of Development Studies.

Chambers, R. 2013. From rapid to reflective: 25 years of Participatory Learning and Action. *Participatory Learning and Action*, 66, pp. 12-15. Available at: https://www.iied.org/g03654 (Accessed: 13 August 2023).

Chandler, A., Myers, F. and Platt, S. 2011. The Construction of self-injury in the clinical literature: A sociological exploration. *Suicide and Life-Threatening Behaviour,* 41, pp. 98-109. doi:https://doi.org/10.1111/j.1943-278X.2010.00003.x

Chandler, A. 2016. *Self-injury, medicine and society*. London: Palgrave Macmillan.

Chandler, A. 2017. Seeking secrecy: A qualitative study of younger adolescents' accounts of self-harm. *YOUNG*, 26 (4), pp. 313–331. doi: https://doi.org/10.1177/1103308817717367

Chandra, Y. and Shang, L. 2019. *Qualitative Research Using R: A Systematic Approach*. Singapore: Springer.

Charmaz, K. 2006. *Constructing Grounded Theory: A practical guide through qualitative analysis.*London: Sage Publications.

Children, Young People and Education Committee. 2018. *Mind over matter. A report on the step change needed in emotional and mental health support for children and young people in Wales.* Cardiff: National Assembly for Wales.

Children's Commissioner. 2018. *Children's mental health briefing*. London: Children's Commissioner for England.

Chrysanthou, G.M. and Vasilakis, C. 2020. Protecting the mental health of future adults: Disentangling the determinants of adolescent bullying victimisation. *Social Science and Medicine,* 253, 112942 (9pp).doi: https://doi.org/10.1016/j.socscimed.2020.112942

Cook, J.E., Purdie-Vaughns, V., Meyer, I.H. and Busch, J.T.A. 2014. Intervening within and across levels: A multilevel approach to stigma and public health. *Social Science and Medicine,* 103, pp.101-109. doi: https://doi.org/10.1016/j.socscimed.2013.09.023.

Cooke, E. and James, V. 2009. A self-harm training needs assessment of school nurses. *Child Health Care*, 13(3), pp. 260-274.doi: https://doi.org/10.1177/1367493509337440

Coombes, L., Appleton, J., Allen, D. and Yerrell, P. 2013. Emotional health and well-being in schools: Involving young people. *Children and Society*, 27, pp. 220–32. doi:https://doi.org/10.1111/j.1099-0860.2011.00401.x

Corbin, J. and Strauss, S. 1990. Grounded theory research: procedures, canons and evaluative criteria. *Qualitative Sociology*, 13 (1), pp. 3-21. doi: https://doi.org/10.1007/BF00988593

Corbin, J. and Strauss, S. 2015. *Basics of Qualitative Research. Techniques and Procedures for Developing Grounded Theory.* London: SAGE Publications Ltd.

Corrigan, P.W. and Watson A.C. 2002. Understanding the impact of stigma on people with mental illness. *World Psychiatry,* 1(1), pp. 16-20. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489832/

Corrigan, P. W., Markowitz, F. E. and Watson, A. C. 2004. Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin,* 30 (3), pp. 481–491. doi:https://doi.org/10.1093/oxfordjournals.schbul.a007096

Corrigan, P.W., Kerr, A. and Knudsen, L. 2005. The stigma of mental illness: Explanatory models and methods for change. *Applied and Preventive Psychology*, 11 (3), pp. 179-190. doi:https://doi.org/10.1016/j.appsy.2005.07.001.

Cowie, H. and Myers, C. 2020. The impact of the COVID-19 pandemic on the mental health and well-being of children and young people. *Children and Society*, 35, pp.62-74. doi:https://doi.org/10.1111/chso.12430

Craig, P., Di Ruggiero, E., Frohlich, K.L., Mykhalovskiy, E., White, M., Campbell, R., Cummins, S., Edwards, N., Hunt, K.,Kee, F., Loppie, C., Moore, L., Ogilvie, D., Petticrew, M., Poland, B., Ridde, V., Shoveller, J., Viehbeck, S. and Wight, D. 2018. *Taking account of context in population health intervention research: guidance for producers, users and funders of research*. Southampton (UK): NIHR Journals Library

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., Petticrew, M; Medical Research Council Guidance. 2008. Developing and evaluating complex interventions: the new Medical Research Council guidance. *BMJ*, 337:a1655 (6pp). doi:https://doi.org/10.1136/bmj.a1655

Cresswell, J.W. and Poth, C.N. 2016. *Qualitative inquiry and research design*. London: Sage Publications.

Cresswell, M. 2020. Self-harm and moral codes in emergency departments in England. *Social Theory & Health,* 18, pp. 257–269. doi:https://doi.org/10.1057/s41285-020-00137-x

Crouch, W. and Wright, J. 2004. Deliberate self-harm at an adolescent unit: A Qualitative Investigation. *Clinical Child Psychology and Psychiatry,* 9 (2), pp. 185–204. doi:https://doi.org/10.1177/1359104504041918

Cybulski, L., Ashcroft, D. M., Carr, M. J., Garg, S., Chew-Graham, C. A., Kapur, N. and Webb, R.T. 2021. Temporal trends in annual incidence rates for psychiatric disorders and self-harm among children and adolescents in the UK, 2003–2018. *BMC Psychiatry*, 21, 229 (12pp). doi: https://doi.org/10.1186/s12888-021-03235-w

Danermark, B., Ekstrom, M., Jakobsen, L. and Karlsson, J.C. 2002. *Explaining society. Critical Realism and the Social Sciences.* London: Routledge.

Davies, S.H., Langer, M.D., Klein, A., Gonzalez-Hernandez, G. Dowshen, N. 2022. Adolescent perceptions of menstruation on Twitter: Opportunities for advocacy and education. *Adolescent Health*, 71, pp. 94-104. doi: https://doi.org/10.1016/j.jadohealth.2022.01.224

De Souza, D.E. 2013. Elaborating the Context-Mechanism-Outcome Configuration (CMOc) in Realist Evaluation. A Critical Realist Perspective. *Evaluation*, 19 (2), pp. 141-154. doi:https://doi.org/10.1177/1356389013485194

DECIPHER (Centre for Development, Evaluation, Complexity and Implementation in Public Health Improvement). 2022. The School Health Research Network. Cardiff: Cardiff University. Available at: https://decipher.uk.net/public-health-improvement-research-networks-phirns/ the-school-healthresearch-network-shrn/ (Accessed: 28 November 2022).

DelPozo-Banos, M., Lee, S.C., Friedmann, Y., Akbari, A., Torabi, F., Lloyd, K., Lyons, R.A. and John, A. 2022. Healthcare contacts with self-harm during COVID-19: An e-cohort whole-population-based study using individual-level linked routine electronic health records in Wales, UK, 2016 - March 2021. *PLoS ONE*, 17(4), e0266967 (19pp). doi:https://doi.org/10.1371/journal.pone.0266967

Department of Psychiatry University of Oxford. 2023. *Multicentre study of self-harm in England. Oxford: Oxford University.* Available at: https://www.psych.ox.ac.uk/research/csr/ahoj (Accessed: 22 February 2023).

Dickinson T., Wright, K.M. and Harrison J. 2009. The attitudes of nursing staff in secure environments to young people who self-harm. *Psychiatric and Mental Health Nursing*, 16, pp. 947–951.doi: https://doi.org/10.1111/j.1365-2850.2009.01510.x

Diggins, E., Kelley, R., Cottrell, D., House, A. and Owens, D. 2017. Age-related differences in self-harm presentations and subsequent management of adolescents and young adults at the emergency department. *Affective Disorders*, 208, pp. 399-405. doi:https://doi.org/10.1016/j.jad.2016.10.014

Digital Health and Care Wales. 2023. *Annual PEDW data tables.* Cardiff: NHS Wales. Available at: https://dhcw.nhs.wales/information-services/health-intelligence/annual-pedw-data-tables/ (Accessed: 16 February 2023)

Doerschug, K.C. and Schmidt, G.A. 2016. "Shock: Diagnosis and Management", in Oropello, J.M., Kvetan, V. and Pastores, S.M. eds. *Lange Critical Care.* New York:McGraw-Hill Education, pp. 201- 221.

Dogra, N., Parkin, A., Warner-Gale, F. and Frake, C. 2017. *A multidisciplinary handbook of child and adolescent mental health for front-line professionals*. London: Jessica Kingsley Publishers.

Dorko, L.A. 2010. *Development of a website for educators addressing how to understand, recognize, and respond to student self-injury*. ProQuest LLC, Psy.D. Dissertation, San Diego, Alliant International University. Available at: https://www.proquest.com/docview/276585424 (Accessed: 16 May 2023).

Doyle, L., Sheridan, A. and Treacy, M.P. 2017. Motivations for adolescent self-harm and the implications for mental health nurses. *Psychiatric and Mental Health Nursing*, 24, pp. 134–142. doi: https://doi.org/10.1111/jpm.12360

Draucker, C.B., Martsolf, D.S. and Poole, C. 2009. Developing distress protocols for research on sensitive topics. *Archives of Psychiatric Nursing*, 23 (5), pp. 343-350. doi:https://doi.org/10.1016/j.apnu.2008.10.008

Economic and Social Research Council (ESRC). 2018. *Research with potentially vulnerable people.* Available at: https://esrc.ukri.org/funding/guidance-for-applicants/research-ethics/frequently-raised-topics/research-with-potentially-vulnerable-people/ (Accessed: 20 April 2018).

Education Act 2002. London: HMSO.

Edwards, D., Carrier, J., Csontos, J., Evans, N., Elliott, M., Gillen, E., Hannigan, B., Lane, R. and Williams, L. 2023. Review: Crisis responses for children and young people – a systematic review of effectiveness, experiences and service organisation (CAMH-Crisis). *Child and Adolescent Mental Health*, [preprint version] (14pp). doi:https://doi.org/10.1111/camh.12639

Efron, S.E. and Ravid, R. 2019. Doing the literature review. New York: Guildford Press.

Eisman, A.B., Quanbeck, A., Bounthavong, M., Panattoni, L. and Glasgow, R.E. 2021. Implementation science issues in understanding, collecting, and using cost estimates: a multi-stakeholder perspective. *Implementation Science*, 16, 75 (12pp). doi:https://doi.org/10.1186/s13012-021-01143-x

Ekman, I. 2016. Beyond medicalization. *Health,* 20 (4), pp. 346-362. doi:https://doi.org/10.1177/1363459316633280

Equality Act 2010. London: HMSO.

ESTYN. 2018. *Inspection reports*. Available at: https://www.estyn.gov.wales/inspection (Accessed: 12 January 2018).

Evans, R. and Hurrell, C. 2016. The role of schools in children and young people's self-harm and suicide: systematic review and meta-ethnography of qualitative research. *BMC Public Health*, 16, 401 (16pp). doi: https://doi.org/10.1186/s12889-016-3065-2

Evans, R., Scourfield, J. and Murphy, S. 2015. Pragmatic, formative process evaluations of complex interventions and why we need more of them. *Epidemiology and Community Health,* 69, pp. 925–926. doi:https://doi.org/10.1136/jech-2014-204806

Evans, R, Parker, R., Russell, A.E., Mathews, F., Ford, T., Hewitt, G., Scourfield, J. and Janssens, A. 2019. Adolescent self-harm prevention and intervention in secondary schools: a survey of staff in England and Wales. *Child and Adolescent Mental Health,* 24(3), pp. 230-238. doi: https://doi.org/10.1111/camh.12308

Faculty of Public Health. 2023. Public Health Knowledge: Concepts of health, well-being and illness, and the aetiology of illness. Stigma. London: Faculty of Public Health.

Fern, E.F. 2001. *Advanced focus group research.* London: SAGE publications Ltd.

Ferrie, J., Miller, H. and Hunter, S.C. 2020. Psychosocial outcomes of mental illness stigma in children and adolescents: A mixed-methods systematic review. *Children and Youth Services Review*, 113, 104961 (16pp).doi:https://doi.org/10.1016/j.childyouth.2020.104961

Fischer, F., Lange, K., Klose, K., Greiner, W. and Kraemer, A. 2016. Barriers and strategies in guideline implementation. A scoping review. *Healthcare,* 4 (3), 36 (16pp). doi:https://doi.org/10.3390/healthcare4030036

Fleetwood, S. 2014. Bhaskar and Critical Realism. In Adler, P., Du Gay, P., Morgan, G. and Reed, M.eds. *The Oxford Handbook of Sociology, Social Theory and Organizational Studies.* Oxford: Oxford University Press, pp. 182-219.

Fletcher, A., Jamal, F., Moore, G., Evans, R.E., Murphy, S. and Bonell, C. 2016. Realist complex interventions in science. Applying realist principles across all phases of the Medical Research Framework for developing and evaluating complex interventions. *Evaluation*, 22 (3), pp. 286 – 303. doi: https://doi.org/10.1177/1356389016652743

Flick, U. 2018. *Managing quality in qualitative research.* London: SAGE Publications Ltd.

Fortune, S., Sinclair, J. and Hawton, K. 2008a. Adolescents' views on preventing self-harm. A large community study. *Social Psychiatry and Psychiatric Epidemiology*, 43, pp. 96-104. doi:https://doi.org/10.1007/s00127-007-0273-1

Fortune, S., Sinclair, J. and Hawton, K. 2008b. Help-seeking before and after episodes of self-harm: a descriptive study in school pupils in England. *BMC Public Health*, 8, 369 (13pp). doi:https://doi.org/10.1186/1471-2458-8-369

Foulkes, L. and Stringaris, A. 2023. Do no harm: Can school mental health interventions cause iatrogenic harm? *BJPsych Bulletin* [Preprint] (3pp). doi: https://doi.org/10.1192/bjb.2023.9

Friedman, T., Newton, C., Coggan,C., Hooley, S., Patel, R., Pickard, M. and Mitchell, A.J. 2006. Predictors of A&E staff attitudes to self-harm patients who use self-laceration: Influence of previous training and experience. *Psychosomatic Research*, 60 (3), pp. 273-277. doi:https://doi.org/10.1016/j.jpsychores.2005.07.007

Fryers, T. and Brugha, T. 2013. Childhood determinants of adult psychiatric disorder. *Clinical Practice and Epidemiology in Mental Health*, 9 (50pp). doi:https://doi.org/10.2174/1745017901309010001.

Fukumori, T., Kuroda, H., Ito, M. and Kashimura, M. 2017. Effect of guided, structured, writing program on self-harm ideations and emotion regulation. *Medical Investigation,* 64, pp. 74–78. doi: https://doi.org/10.2152/jmi.64.74

Gagliardi, A. R., Brouwers, M. C., Palda, V. A., Lemieux-Charles, L. and Grimshaw, J. M. 2011. How can we improve guideline use? A conceptual framework of implementability. *Implementation Science*, 6, 26 (11pp). doi: https://doi.org/10.1186/1748-5908-6-26

Galobardes, B., Jeffreys, M. and Smith, G.D. 2013. `Inequalities in health`, in Ben-Shlomo, Y., Brookes, S.T. and Hickman, M. eds. *Epidemiology, evidence-based medicine and public health.* Chichester: Wiley Blackwell, pp. 160-169.

Gask, L. and Morriss, R. 2009. Assessment and immediate management of people at risk of harming themselves. *Psychiatry*, 8 (7), pp. 241-245. doi:https://doi.org/10.1016/j.mppsy.2009.04.007

Gauch, H.G. 2012. *Scientific method in brief.* Cambridge: Cambridge University Press.

GBD 2019 Adolescent Mortality Collaborators. 2021. Global, regional, and national mortality among young people aged 10–24 years, 1950–2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet,* 398 (10311), pp.1593-1618. doi:https://doi.org/10.1016/S0140-6736(21)01546-4

Geel, V.M., Goemans, A. and Vedder, P. 2015. A meta-analysis on the relation between peer victimization and adolescent non-suicidal self-injury. *Psychiatry Research,* 230 (2),pp. 364-368. doi: https://doi.org/10.1016/j.psychres.2015.09.017

Geoffroy, M., Boivin, M., Arseneault, L., Turecki, G.,Vitaro, F., Brendgen, M., Renaud, J.,   Séguin, J.R., Tremblay, R.E. and Côté, S.M. 2016. Associations between peer victimization and suicidal ideation and suicide attempt during adolescence: Results from a prospective population-based birth cohort. American Academy of Child and Adolescent Psychiatry, 55 (2), pp. 99-105. doi: https://doi.org/10.1016/j.jaac.2015.11.010

Geulayov, G., Casey, D., McDonald, K. C., Foster P., Pritchard, K., Wells, C., Clements, C., Kapur, N., Ness, J., Waters, K. and Hawton, K. 2018. Incidence of suicide, hospital-presenting non-fatal self-harm, and community-occurring non-fatal self-harm in adolescents in England (the iceberg model of self-harm): a retrospective study. *The Lancet*, 5 (2), pp. 167-174. doi: https://doi.org/10.1016/S2215-0366(17)30478-9

Geulayov, G., Casey, D., Bale, E., Brand, F., Clements, C., Farooq, B., Kapur, N., Ness, J., Waters, K., Patel, A. and Hawton, K. 2022a. Socio-economic disparities in patients who present to hospital for self-harm: patients' characteristics and problems in the Multicentre Study of Self-harm in England. *Affective Disorders*, 318, pp. 238–245. doi:https://doi.org/10.1016/j.jad.2022.08.106

Geulayov, G., Borschmann, R., Mansfield, K.L., Hawton, K., Moran, P. and Fazel, M. 2022b. Utilization and acceptability of formal and informal support for adolescents following self-harm before and during the first COVID-19 lockdown: Results from a large-scale English schools survey. *Frontiers in Psychiatry,* 13, 881248 (14pp).doi:https://doi.org/10.3389/fpsyt.2022.881248

Glennon, S.D., Viola, S.B. and Blakely, A.O. 2020. Increasing school personnel's self-efficacy, knowledge, and response regarding nonsuicidal self-injury in youth. *Psychology in the Schools*, 57, pp. 135–151. doi:https://doi.org/10.1002/pits.22300

Goffman, E. 1963. Stigma: Notes on the Management of Spoiled Identity. New York: Simon and Schuster.

Golden, S.D. and J.A.L. Earp. 2012. Social ecological approaches to individuals and their contexts:Twenty years of health education and behaviour health promotion interventions. *Health Educationand Behaviour,* 39(3), pp. 364–372. doi:https://doi.org/10.1177/1090198111418634

Gratz, K.L. and Roemer, L. 2004. Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Psychopathology and Behavioural Assessment,* 26(1), pp.41–54. doi: https://doi.org/10.1023/B:JOBA.0000007455.08539.94

Griffin, E., McMahon, E., McNicholas, F., Corcoran, P., Perry, I.J. and Arensman, E. 2018. Increasing rates of self-harm among children, adolescents and young adults: a 10-year national registry study 2007-2016. *Social Psychiatry and Psychiatric Epidemiology*, 53, pp.663-71. doi: https://doi.org/10.1007/s00127-018-1522-1

Griffith, R. 2016. What is Gillick Competence? *Human Vaccine and Immunotherapeutics,* 12 (1), pp. 244-247. doi: https://doi.org/10.1080/21645515.2015.1091548

Groschwitz, R., Munz, L., Straub, J., Bohnacker, I., and Plener, P.L. 2017. Strong schools against suicidality and self-injury: Evaluation of a workshop for school staff. *School Psychology Quarterly*, 32 (2), pp.188–198. doi: https://doi.org/10.1037/spq0000185

Haigh, C. and Witham, G. 2015. *Distress protocol for quality data collection.* Manchester: Manchester Metropolitan University.

Hamilton, A.B. and Finley, E.P. 2019. Qualitative methods in implementation research. An introduction. *Psychiatry Research*, 280, 112516 (18pp). doi:https://doi.org/10.1016/j.psychres.2019.112516

Hartley, S., Redmond, T. and Berry, K. 2022.Therapeutic relationships within child and adolescent mental health inpatient services: A qualitative exploration of the experiences of young people, family members and nursing staff. PLoS One, 17(1):e0262070. doi:https://doi.org/10.1371/journal.pone.0262070

Hasking, P., Tatnell, R.C. and Martin, G. 2015a. Adolescents' reactions to participating in ethicallysensitive research: a prospective self-report study. *Child and Adolescent Psychiatry and Mental Health*, 9,39 (12pp). doi: https://doi.org/10.1186/s13034-015-0074-3

Hasking, P., Rees, C.S., Martin, G. and Quigley, J. 2015b. What happens when you tell someone you self-injure? The effects of disclosing NSSI to adults and peers. *BMC Public Health*, 15, 1039 (9pp).doi: https://doi.org/10.1186/s12889-015-2383-0

Hasking, P.A., Lewis, S.P., Robinson, K., Heath, N.L. and Wilson, M.S. 2019. Conducting research on nonsuicidal self-injury in schools: Ethical considerations and recommendations. *School Psychology International*, 40 (3), pp. 217-234. doi:https://doi.org/10.1177/0143034319827056

Hatzenbuehler, M.L., Phelan, J.C. and Link, B.G. 2013. Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health,* 103 (5), pp.813-821. doi: https://doi.org/10.2105%2FAJPH.2012.301069

Hatzenbuehler, M.L. and Link, B.G. 2014. Introduction to the special issue on structural stigma and health. *Social Science and Medicine*, 103, pp.1-6. doi:https://doi.org/10.1016/j.socscimed.2013.12.017.

Hatzenbuehler, M.L. 2016. Structural stigma and health inequalities: Research evidence and implications for psychological science. *American Psychologist,* 71 (8), pp. 742-751. doi :https://doi.org/10.1037/amp0000068

Hatzenbuehler, M.L. 2017. "Structural stigma and health", in Major, B., Dovidio, J.F. and Link, B.G. eds. *The Oxford Handbook of Stigma, Discrimination, and Health.* Oxford: Oxford University Press, pp.105-122. doi:https://doi.org/10.1093/oxfordhb/9780190243470.013.13

Hawton, K., Townsend, E., Deeks, J., Appleby, L., Gunnell, D., Bennewith, O. and Cooper, J. 2001. Effects of legislation restricting pack sizes of paracetamol and salicylate on self poisoning in the United Kingdom: before and after study. *BMJ*, 322(7296), pp. 1203–1207. doi :https://doi.org/10.1136/bmj.322.7296.1203

Hawton, K., Rodham, K., Evans. E. and Weatherall, R. 2002. Deliberate self harm in adolescents: self report survey in schools in England. *BMJ*, 325, pp. 1207-1211. doi:https://doi.org/10.1136/bmj.325.7374.1207

Hawton, K., Saunders, K.E.A. and O'Connor, R.C. 2012a. Suicide 1. Self-harm and suicide in adolescents. *The Lancet,* 379 (9834), pp. 2373-2382. doi: https://doi.org/10.1016/S0140-6736(12)60322-5

Hawton, K., Bergen, H., Kapur, N., Cooper, J., Steeg, S., Ness, J. and Waters, K. 2012b. Repetition of self-harm and suicide following self-harm in children and adolescents: findings from the Multicentre Study of Self-harm in England. *Child Psychology and Psychiatry*, 53 (12), pp. 1212-1219. doi: https://doi.org/10.1111/j.1469-7610.2012.02559.x

Hawton, K., O'Connor, R.C. and Saunders, K.E.A. 2015a. "Suicidal behaviour and self-harm", in Thapar, A., Pine, D.S., Leckman, J.F., Scott, S., Snowling, M.J. and Taylor, E. eds. *Rutter's Child and Adolescent Psychiatry.* Chichester: John Wiley & Sons Ltd, pp. 893-910.

Hawton, K., Witt, K.G., Taylor Salisbury, T.L., Arensman, E., Gunnell, D., Townsend, E., Van Heeringen, K. and Hazell, P. 2015b. Interventions for Self-Harm in Children and Adolescents. *Cochrane Database of Systematic Reviews.* 12, CD012013 (108pp). doi:https://doi.org/10.1002/14651858.CD012013

Hawton, K., Bale, L., Brand, F., Townsend, E., Ness, J., Waters, K., Clements, C., Kapur, N. and Geulayov, G. 2020. Mortality in children and adolescents following presentation to hospital after non-fatal self-harm in the Multicentre Study of Self-harm: a prospective observational cohort study. *Lancet Child and Adolescent Health,* 4 (2), pp. 111-120. doi:https://doi.org/10.1016/S2352-4642(19)30373-6

Health and Care Research Wales. 2023. *About Health and Care Research Wales*. Available at: https://healthandcareresearchwales.org/about (Accessed: 30 January 2023).

Heilbron, N., Franklin, J.C., Guerry, J.D., and Prinstein, M.J. 2014. `Social and Ecological Approaches to Understanding Suicidal Behaviours and Nonsuicidal Self-Injury`, in Nock, M.K. ed. *The Oxford Handbook of Suicide and Self-Injury*. Oxford: Oxford University Press, pp.206-234.

Henderson, S.W. and Martin. A. 2015. `Case formulation and integration of information in child and adolescent mental health` in Rey, J.M. and Martin, A. eds. *IACAPAP e-Textbook of Child and Adolescent Mental Health.* Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions, section A.10 (20pp). Available at: https://iacapap.org/english.html (Accessed: 6 March 2023).

Herbeck-Belnap, B., Schulberg, H.C., He, F., Mazumdar, S., Reynolds, C.F. and Rollman, B.L. 2015. Electronic protocol for suicide risk management in research participants. *Psychosomatic Research*, 78 (4), pp.340-345. doi:https://doi.org/10.1016/j.jpsychores.2014.12.012

Hesse-Biber, S.N. 2007. "Teaching grounded theory", in Brynant, A. and Charmaz, K. eds. *The SAGE handbook of grounded theory.* London: SAGE Publications, pp.311-338.

Hewitt G., Anthony R., Moore G., Melendez-Torres G.J. and Murphy S. 2019. *Student health and wellbeing in Wales: Report of the 2017/18 Health Behaviour in School-aged Children Survey and School Health Research Network Student Health and Wellbeing Survey.* Cardiff University: Cardiff, UK.

Hickman, M., Kipping, R. and Gunnell, D. 2013. `Public health`, in eds. Ben-Shlomo, Y., Brookes, S.T. and Hickman, M. 2013. *Epidemiology, evidence-based medicine and public health*. Chichester: John Wiley and Sons Ltd., pp.135-144.

Hoare, K.J., Mills, J. and Francis, K. 2012. Dancing with data: An example of acquiring theoretical sensitivity in a grounded theory study. *International Journal of Nursing Practice,* 18, pp. 240-245. doi: https://doi.org/10.1111/j.1440-172X.2012.02038.x

Holland, J., Sayal, K., Berry, A., Sawyer, C., Majumder, P., Vostanis, P., Armstrong, M., Harroe, C.,Clarke, D. and Townsend, E. 2020. What do young people who self-harm find helpful? A comparative study of young people with and without experience of being looked after in care. *Child and Adolescent Mental Health*, 25 (3), pp. 157-164. doi:https://doi.org/10.1111/camh.12384

Hollander, J.A. 2004. The social contexts of focus groups. *Contemporary Ethnography*, 33 (5), pp. 602-637. doi: https://doi.org/10.1117/0891241604266988

Holt, M. K., Vivolo-Kantor, A. M., Polanin, J. R., Holland, K. M., DeGue, S., Matjasko, J. L., Wolfe, M. and Reid, G. 2015. Bullying and suicidal ideation and behaviours: a meta-analysis. *Pediatrics*, 135 (2), pp. 496–509. doi: https://doi.org/10.1542/peds.2014-1864

House of Commons Education and Health and Social Care Committees. 2018. T*he Government's Green Paper on mental health: failing a generation.* London: House of Commons. Available at: https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/642/64202.htm (Accessed: 22 December 2022).

House of Commons Health Committee. 2014. *Children's and Adolescents' Mental Health and CAMHS.* London: House of Commons. Available at: https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34203.htm (Accessed: 22 December 2022).

House, A. 2020. Social media, self-harm and suicide. *BJPsych Bulletin*, 44 (4), pp. 131-133. doi :https://doi.org 10.1192/bjb.2019.94.

Hoven, C.W., Tyano, S. and Mandell, D.J. 2013. "Suicide awareness and mental health among youth in the community", in Wasserman, D. and Wasserman, C. eds. *Oxford textbook of suicidology and suicide prevention.* Oxford: Oxford University Press, pp. 501 – 507.

Huang, R. 2016. *RQDA: R-based Qualitative Data Analysis. R package version 0.2-8.* Available at: https://rqda.r-forge.r-project.org/ (Accessed: 10 October 2017)

Huelin, R., Iheanacho, I., Payne, K. and Sandman, K. 2015. What's in a name? Systematic and non-systematic literature reviews, and why the distinction matters. London: Evidera. Available at: https://www.evidera.com/resource/whats-in-a-name-systematic-and-non-systematic-literature-reviews-and-why-the-distinction-matters/ (Accessed: 15 February 2024)

ICO. 2018. *Guide to the General Data Protection Regulation (GDPR).* Cheshire: Information Commissioner's Office.

IIED. 2002. *PLA 44: Local Government and Participation.* Available at: https://www.iied.org/pla-44-local-government-participation (Accessed: 15 April 2018).

IIED. 2023. *Participatory Learning and Action. PLA Notes Archive.* Available at: https://www.iied.org/collection/participatory-learning-action#inthiscollection (Accessed: 14 August 2023).

Inman, D.D., van Bakergem, K.M., LaRosa, A.C. and Garr, D.R. 2011. Evidence-based health promotion programs for schools and communities. *American Journal of Preventive Medicine,* 40(2), pp. 207–219. doi: https://doi.org/10.1016/j.amepre.2010.10.031

Ivanova,O., Cordova-Pozo, K., Segura, Z.E., Vega, B., Chandra-Mouli, V., Hindin, M. J., Temmerman, M., Decat, P., De Meyer, S. and Michielsen, K. 2016. Lessons learnt from the CERCA Project, a multicomponent intervention to promote adolescent sexual and reproductive health in three Latin America countries: a qualitative post-hoc evaluation. *Evaluation and program planning*, 58, pp. 98-105. doi:https://doi.org/10.1016/j.evalprogplan.2016.06.007.

Jarvi, S., Jackson, B., Swenson, L. and Crawford, H. 2013. The Impact of Social Contagion on Non-Suicidal Self-Injury. A Review of the Literature. *Archives of Suicide Research,* 17, pp.1-19. doi: https://doi.org/10.1080/13811118.2013.748404

Jeffery, D. and Warm, A.2002. A study of service providers' understanding of self-harm. *Mental Health,* 11 (3), pp. 295–303. doi: https://doi.org/10.1080/09638230020023679

John, A., DelPozo-Banos, M., Gunnell, D., Dennis, M., Scourfield, J., Ford, D.V., Kapur, N. and Lloyd, L. 2020. Contacts with primary and secondary healthcare prior to suicide: case–control whole-population based study using person-level linked routine data in Wales, UK, 2000–2017. *British Journal of Psychiatry,* 217 (6), pp. 717–724. doi:https://doi.org/10.1192/bjp.2020.137

Kamody, R.C. and Bloch, M.H. 2022. Editorial: Schools on the frontline of suicide prevention. *Child Psychology and Psychiatry,* 63, pp.833-835. doi: https://doi.org/10.1111/jcpp.13663

Kapur, N., Cooper, J., O'Connor, R.C. and Hawton, K. 2013. Editorial. Non-suicidal self-injury v. attempted suicide: new diagnosis or false dichotomy? *British Journal of Psychiatry,* 202 (5), pp. 326–328. doi :https://doi.org/10.1192/bjp.bp.112.116111

Kapur, N., Steeg, S. and Moreton, A. 2020. "Self-harm: Epidemiology and risk factors", in Geddes, J.R., Andreasen, N.C. and Goodwin, G.M. eds. *New Oxford Textbook of Psychiatry.* Oxford: Oxford University Press, pp.1289 – 1295. doi:https://doi.org/10.1093/med/9780198713005.003.0126

Karman, P., Kool, N., Poslawsky, I.E. and van Meijel, B. 2015. Nurses' attitudes towards self-harm. *Psychiatric and Mental Health Nursing,* 22, pp. 65-75. doi:https://doi.org/10.1111/jpm.12171

Kelle, U. 2007. "The development of categories: Different approaches in grounded theory", in Brynant, A. and Charmaz, K. eds. *The SAGE handbook of grounded theory*. London: SAGE Publications, pp.191-213.

Kempster, S. and Parry, K. 2014. Critical realism and grounded theory. In Edwards, P.K., O'Mahoney, J. and Vincent, S. eds. *Studying organizations using critical realism*. Oxford: Oxford University Press, pp.86-108.

Khan, S., Vandermorris, A., Shepherd, J., Begun, J.W.,Lanham, H.J., Uhl-Bien, M. and Berta, W. 2018. Embracing uncertainty, managing complexity: applying complexity thinking principles to transformation efforts in healthcare systems. *BMC Health Services Research,* 18, 192 (8pp).doi:https://doi.org/10.1186/s12913-018-2994-0

Kidger, J., Heron, J., Lewis, G., Evans, J. and Gunnell, D. 2012. Adolescent self-harm and suicidal thoughts in the ALSPAC cohort: a self-report survey in England. *BMC Psychiatry*, 12, 69 (12pp). doi: https://doi.org/10.1186/1471-244X-12-69

Kidger, J., Heron, J., Leon, D.A., Tilling, K., Lewis, G. and Gunnell, D. 2015. Self-reported school experience as a predictor of self-harm during adolescence: A prospective cohort study in the South West of England (ALSPAC). *Affective Disorders,* 173, pp. 163-169. doi:https://doi.org/10.1016/j.jad.2014.11.003

Kisely, S. and Elizabeth Kendall, E. 2011. Critically appraising qualitative research. A guide for clinicians more familiar with quantitative techniques. *Australasian Psychiatry,* 19 (4), pp. 364-367.doi:https://doi.org/10.3109/10398562.2011.562508

Klineberg, E. 2010. *Self-harm in East London adolescents. PhD thesis*. Queen Mary University of London. Available at: https://qmro.qmul.ac.uk/xmlui/handle/123456789/521 (Accessed: 24 May 2023).

Klineberg, E., Kelly, M.J., Stansfeld, S.A. and Bhui, K.S. 2013. How do adolescents talk about self-harm: a qualitative study of disclosure in an ethnically diverse urban population in England. *BMC Public Health,* 13, 572 (10pp). doi: https://doi.org/10.1186/1471-2458-13-572

Klomek, A.B., Sourander, A. and Gould, M. 2010. The association of suicide and bullying in childhood to young Adulthood: A review of cross-sectional and longitudinal research findings. *Canadian Journal of Psychiatry*. 55 (5), pp. 282-288. doi:https://doi.org/10.1177/070674371005500503

Kokkevi, A., Rotsika, V., Arapaki, A. and Richardson, C. 2012. Adolescents' self-reported suicide attempts, self-harm thoughts and their correlates across 17 European countries. *Child Psychology and Psychiatry,* 53, pp. 381-389. doi: https://doi.org/10.1111/j.1469-7610.2011.02457.x

Kuhn, T.S. 1970. *The Structure of Scientific Revolutions.* London: The University of Chicago Press.

Kvale, S. and Brinkmann, S. 2009. *Interviews. Learning the craft of qualitative research interviewing*. London. SAGE Publications.

Lakeman, R. and Fitzgerald. M. 2009a. The ethics of suicide research. The views of ethics committee members. *Crisis,* 30 (1),pp. 13–19. doi: https://doi.org/10.1027/0227-5910.30.1.13

Lakeman, R and Fitzgerald, M. 2009b. Ethical suicide research:a survey of researchers. *International Journal of Mental Health Nursing,* 18, pp.10–17. doi:https://doi.org/10.1111/j.1447-0349.2008.00569.x

Langford, R., Bonell, C. P., Jones, H. E., Pouliou, T., Murphy, S. M., Waters, E., Komro, K. A., Gibbs, L. F., Magnus, D. and Campbell, R. (2014). The WHO Health Promoting School frameworkfor improving the health and well-being of students and their academic achievement. *The Cochrane Database of Systematic Reviews*, (4), CD008958 (249pp). doi: https://doi.org/10.1002/14651858.CD008958.pub2

Langhinrichsen-Rohling, J., Arata, C., O'Brien, N., Bower, D. and Klibert, J. 2006. Sensitive Research With Adolescents. *Violence and Victims,* 21 (4), pp. 425-444. doi:https://doi.org:10.1891/0886-6708.21.4.425

Lascelles, K., Brand, F. and Hawton, K. 2022. *Psychosocial assessment following self-harm: A clinician's guide.* Oxford: Centre for Suicide Research, Oxford University. Available at: https://www.oxfordhealth.nhs.uk/news/conference-psychosocial-assessment-following-self-harm/ (Accessed: 6 March 2023).

Lauderdale, P., Amster, R. and Oliverio, A. 2022. "Power and deviance", in Kurtz, L.R. ed. *Encyclopedia of Violence, Peace and Conflict*. Cambridge, Massachusetts: Academic Press, pp. 369-375. doi: https://doi.org/10.1016/B978-0-12-820195-4.00255-7

Laver-Bradbury, C., Thompson, M.J.J., Gale, C. and Hooper, C.M. 2021. *Child and adolescent mental health. Theory and practice.* Abingdon: Routledge.

Laws, S., Harper, C., Jones, N. and Marcus, R. 2013. *Research for development. A practical guide.*London: SAGE Publications Ltd.

Lee, F. 2016. Self-harm training in secondary schools. An educational psychology intervention using interpretative phenomenological analysis. *Educational and Child Psychology*, 33 (2), pp.105–116. doi: https://doi.org/10.53841/bpsecp.2016.33.2.105

Lee, H.B. and Oldham, M. 2022. The Biopsychosocial Model and Consultation-Liaison Psychiatry: Legacy of George Engel and John Romano. *Academy of Consultation-Liaison Psychiatry*, 63 (3), pp.187-188. doi: https://doi.org/10.1016/j.jaclp.2022.04.002.

Lewis, S. P. and Baker, T. G. 2011. The possible risks of self-injury websites. A content analysis. *Archives of Suicide Research*, 15 (4), pp. 390-396. doi:https://doi.org/10.1080/13811118.2011.616154

Lewis, S.P. and Hasking, P. 2019. Putting the "Self" in self-injury research: Inclusion of people withlived experience in the research process. *Psychiatric Services,* 70 (11), pp. 1058-1060. doi: https://doi.org/10.1176/appi.ps.201800488

Linehan, M.M. 2014. *DBT Skills Training. Handouts and worksheets.* London and New York: The Guilford Press.

Linehan, M.M. 2015. *DBT Skills Training Manual.* London and New York: The Guilford Press.

Link, B.G. and Phelan, J.C. 2001. Conceptualizing stigma. *Annual Review of Sociology,* 27, pp.363-385. doi: https://www.jstor.org/stable/2678626

Link, B.G., Phelan, J.C. and Hatzenbuehler, M.L. 2017. "Stigma as a fundamental cause of health inequality", in Major, B., Dovidio, J.F. and Link, B.G. eds. *The Oxford Handbook of Stigma, Discrimination, and Health.* Oxford: Oxford University Press, pp.53-68. doi:https://doi.org/10.1093/oxfordhb/9780190243470.013.4

Littlecott, H.J., Moore, G.F., Gallagher, H.C. and Murphy S. 2019. From complex interventions to complex systems: Using Social Network Analysis to understand school engagement with health and wellbeing. *International Journal of Environment Research and Public Health*, 16 (10), 1694 (18pp).doi: https://doi.org/10.3390/ijerph16101694

Lloyd-Richardson, E. E., Lewis, S.P., Whitlock, J.L., Rodham, K. and Schatten, H.T. 2015. Research with Adolescents who engage in Non-Suicidal Self-Injury: Ethical Considerations and Challenges. *Child Adolescent Psychiatry Mental Health*, 9, 37 (14pp). doi: https://doi.org/10.1186/s13034-015-0071-6

Lockwood, J., Townsend, E., Royes, L., Daley, D. and Sayal, K. 2018. What do young adolescents think about taking part in longitudinal self-harm research? Findings from a school-based study. *Child and Adolescent Psychiatry and Mental Health,* 12, 23 (13pp). doi:https://doi.org/10.1186/s13034-018-0230-7

Lodebo, B.T., Möller, J., Larsson, J.O. and Engström, K. 2017. Socioeconomic position and self-harm among adolescents: a population-based cohort study in Stockholm, Sweden. *Child and Adolescent Psychiatry and Mental Health*, 11, 46 (9pp). doi:https://doi.org/10.1186/s13034-017-0184-1

Long, M., Manktelow, R. and Tracey A. 2015. The Healing Journey: Help seeking for self-injury among a community population. *Qualitative Health Research,* 25 (7), pp. 932-944. doi:https://doi.org/10.1177/1049732314554092

Long, R. and Roberts, N. 2024. Research briefing. School attendance in England. London: House of Commons Library. Available at: https://commonslibrary.parliament.uk/research-briefings/cbp-9710/ (Accessed: 20 February 2024)

Lucas, J., Ho, H. and Kerns, K. 2017. "Power, status, and stigma: Their implications for health", in Major, B., Dovidio, J.F. and Link, B.G. eds. *The Oxford Handbook of Stigma, Discrimination, and Health.* Oxford: Oxford University Press, pp.69-84. doi:https://doi.org/10.1093/oxfordhb/9780190243470.013.15

Luchenski, S., Maguire, N., Aldridge, R.W., Hayward, A., Story, A., Perri, P., Withers, J., Clint, S., Fitzpatrick, S. and Hewett, N. 2018. What works in inclusion health: overview of effective interventions for marginalised and excluded populations. *Lancet*, 391(10117), pp. 266-280. doi :https://doi.org:/10.1016/S0140-6736(17)31959-1

MacLean, K., Hearle, C. and Ruwanpura, K.N. 2020. Stigma of staining? Negotiating menstrual taboos amongst young women in Kenya. *Women's Studies International Forum*, 78, 102290 (10pp). doi: https://doi.org/10.1016/j.wsif.2019.102290

Madjar, N., Sophie D. Walsh, S.D. and Harel-Fisch, Y. 2018. Suicidal ideation and behaviours within the school context: Perceived teacher, peer and parental support. *Psychiatry Research,* 269, pp. 185-190. doi: https://doi.org/10.1016/j.psychres.2018.08.045

Major, B., Dovidio, J.F., Link, B.G. and Calabrese, S.K. 2018.`Stigma and Its Implications for Health: Introduction and Overview', in Major, B., Dovidio, J.F. and Link, B.G.eds. *The Oxford Handbook of Stigma, Discrimination, and Health.* Oxford: Oxford University, pp.3-28.

Malejko, K., Hafner, S., Brown, R.C., Plener, P.L., Gron, G., Graf, H. and Abler, B. 2022. Neural signatures of error processing in depressed adolescents with comorbid Non-Suicidal Self-Injury (NSSI). *Biomedicines*, 10, 3188 (15pp). doi:https://doi.org/10.3390/biomedicines10123188

Malterud, K. 2001. Qualitative research: Standards, challenges and guidelines. *The Lancet*, 358, pp. 483-488. doi: https://doi.org/10.1016/s0140-6736(01)05627-6

Maniatopoulos, G., Hunter, D.J., Erskine, J. and Hudson, B. 2020 Large-scale health system transformation in the United Kingdom. *Health Organization and Management*, 34 (3), pp.325-344. doi: https://doi.org/10.1108/JHOM-05-2019-0144.

Manning J.C., Carter, T., Latif, A., Horsley, A., Cooper, J., Armstrong, M., Crew, J., Wood, D., Callaghan, P. and Wharrad, H. 2017. 'Our Care through Our Eyes'. Impact of a co-produced digital educational programme on nurses' knowledge, confidence and attitudes in providing care for children and young people who have self-harmed: a mixed-methods study in the UK. *BMJ Open*, 7:e014750 (10pp). doi: https://doi.org/10.1136/bmjopen-2016-014750

Marchant, A., Turner, S., Balbuena, L., Peters, E., Williams, D., Lloyd,K., Lyons, R. and John, A. 2020a. Self-harm presentation across healthcare settings by sex in young people: an e-cohort study using routinely collected linked healthcare data in Wales, UK. *Archives of Disease in Childhood,* 105, pp. 347-354. doi: https:// doi.org/ 10.1136/archdischild- 2019-317248

Marchant, A., Turner, S., Balbuena, L., Peters, E., Williams, D., Lloyd,K., Lyons, R. and John, A. 2020b. Self-harm presentation across healthcare settings by sex in young people: an e-cohort study using routinely collected linked healthcare data in Wales, UK. Supplementary material. Appendix C [archdischild-2019-317248supp003.pdf]. Identification of appropriate codes in Emergency Department data. *Archives of Disease in Childhood,* 105, pp. 347-354. doi: https://doi.org/ 10.1136/archdischild- 2019- 317248.

Mars, B., Heron, J., Klonsky, E.D., Moran, P., O'Connor, R.C., Tilling, K., Wilkinson, P. and Gunnell, D. 2019. Predictors of future suicide attempt among adolescents with suicidal thoughts or non-suicidal self-harm: a population-based birth cohort study. *Lancet Psychiatry*, 6, pp. 327-337. doi: https://doi.org/10.1016/S2215-0366(19)30030-6

May, C.R., Johnson, M. and Finch, T. 2016. Implementation, context and complexity. *Implementation Science,* 11,141 (12pp). doi:https://doi.org/10.1186/s13012-016-0506-3

McAndrew, S. and Warne, T. 2014. Hearing the voices of young people who self-harm: Implications for service providers. *International Journal of Mental Health Nursing*, 23 (6), pp. 570-579. doi: https://doi.org/10.1111/inm.12093

McCann, T., Clark, E., McConnachie, S. and Harvey, I. 2006. Accident and Emergency nurses' attitudes towards patients who self-harm. *Accident and Emergency Nursing*, 14, pp. 4 - 10. doi: https://doi.org/10.1016/j.aaen.2005.10.005

McCosker, H., Barnard, A. and Gerber, R. 2001. Undertaking sensitive research: Issues and strategies for meeting the safety needs of all participants. *Forum Qualitative Sozialforschung Forum: Qualitative Social Research*, 2(1), 22 (14pp). doi:https://doi.org/10.17169/fqs-2.1.983

McGillivray, L., Rheinberger, D., Wang, J., Burnett, A. and Torok, M. 2022. Non-disclosing youth: a cross sectional study to understand why young people do not disclose suicidal thoughts to their mental health professional. *BMC Psychiatry,* 22, 3 (11pp.) doi:https://doi.org/10.1186/s12888-021-03636-x

McLeroy K.R., Bibeau, D., Steckler, A. and Glanz, K. 1988. An ecological perspective on health promotion programs. *Health Education Quarterly*, 15 (4), pp. 351–377. doi:https://doi.org/10.1177/109019818801500401

McMahon, E.M., Keeley, H., Cannon, M., Arensman, E., Perry, I.J., Clarke, M., Chambers, D. and Corcoran, P. 2014. The iceberg model of suicide and self-harm in Irish adolescents: a population-based study. *Social Psychiatry and Psychiatric Epidemiology,* 49, pp. 1929-35. doi: https://doi.org/10.1007/s00127-014-0907-z.

McManus, S., Gunnell, D., Cooper, C., Bebbington, P.E., Howard, L.M., Brugha, T., Jenkins, R., Hassiotis, A., Weich, S. and Appleby, L. 2019. Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population. *Lancet Psychiatry,* 6 (7), pp.573-581.doi: https://doi.org/10.1016/ S2215-0366(19)30188-9

Mental Health Foundation. 2007. *Listen Up! Person-centred approaches to help young people experiencing mental health and emotional problems*. London: Mental Health Foundation.

Meyer, S.B. and Lunnay, B. 2013. The application of abductive and retroductive influence for the design and analysis of theory-driven sociological research. *Sociological Research Online*, 18 (1), 12 (11pp). doi: https://doi.org/10.5153/sro.2819

Michaud, P.A., Michaud, L., Mazur, A., Hadjipanayis, A., Kapp, C. and Ambresin, A.E. 2022. The impact of COVID on adolescent mental health, self-harm and suicide: How can primary care provider respond? A position paper of the European Academy of Pediatrics. *Frontiers in Pediatrics,* 23 (10), 800000 (7pp). doi: https://doi.org/10.3389/fped.2022.800000

Millard, C. 2015. *A history of self-harm in Britain*. Basingstoke: Palgrave Macmillan.

Mingers, J. 2014. *Systems Thinking, Critical Realism and Philosophy.* Abingdon: Routledge.

Mingers, J. and Standing, C. 2017. Why things happen – developing the critical realist view of causal mechanisms. *Information and Organization*, 27, pp. 171-189. doi:https://doi.org/10.1016/j.infoandorg.2017.07.001

Monaghan, L.F. and Gabe, J. 2022. *Key concepts in medical sociology.* London: SAGE Publications Ltd.

Moore, G.F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., Moore, L., O'Cathain, A.,Tinati, T., Wight, D. and Baird, J. 2015a. Process evaluation of complex interventions: Medical Research Council guidance. *BMJ,* 350, 1258 (7pp). doi:https://doi.org/10.1136/bmj.h1258

Moore, G.F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., Moore, L., O'Cathain, A.,Tinati, T., Wight, D. and Baird, J. 2015b. *Process evaluation of complex interventions: Medical Research Council guidance (full guidance document).* London: Medical Research Council. Available at: https://www.ukri.org/publications/process-evaluation-of-complex-interventions/ (Accessed: August 14 2023)

Moore, G.F. and Evans, R.E. 2017. What theory, for whom and in what context? Reflections on the application of theory in the development and evaluation of complex population health interventions.*SSM-Population Health*, 3, pp. 132-135. doi:https://doi.org/10.1016/j.ssmph.2016.12.005.

Moore, G.F., Evans, R.E., Hawkins, J., Littlecott, H.J. and Turley, R. 2017. All interventions are complex, but some are more complex than others: using iCAT_SR to assess complexity [editorial]. *Cochrane Database of Systematic Reviews,* (7), ED000122 (3pp). doi:https://doi.org 10.1002/14651858.ED000122.

Moore,G.F., Campbell, M., Copeland, L., Craig, P., Movsisyan, A., Hoddinott, P., Littlecott,H., O'Cathain, A., Pfadenhauer, L., Rehfuess, E., Segrott,J., Hawe, P., Kee, F., Couturiaux, D., Hallingberg,B. and Evans, R. 2021. Adapting interventions to new contexts—the ADAPT guidance. *BMJ*, 374:n1679 (10pp). doi: https://doi.org/10.1136/bmj.n1679

Morey, Y., Mellon, D., Dailami, N., Verne, J., and Tapp, A. 2017. Adolescent self-harm in the community: An update on prevalence using a self-report survey of adolescents aged 13–18 in England. *Public Health*, 39, 58–64. doi: https://doi.org/10.1093/pubmed/fdw010

Morgan, C., Webb, R.T., Carr, M.J., Kontopantelis, E., Green, J., Chew-Graham, C., Kapur, N. andAshcroft, D.M. 2017. Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care. *BMJ,* 359, j4351 (9pp). doi: https://doi.org/10.1136/bmj.j4351

Morris, P.L. 2017. "Triangulation", in Allen, M. ed. *The SAGE Encyclopedia of Communication Research Methods.* London: SAGE Publications, pp. 1782-1784.

Morrissey, J. and Callaghan, P. 2011. Communication skills for mental health nurses. Maidenhead: Open University Press.

Mrazek, P.J., Haggerty, R.J. and Institute of Medicine (US) Committee on Prevention of Mental Disorders. 1994. *Reducing risks for mental disorders: Frontiers for preventive intervention research.* Washington (DC): National Academies Press (US).

Muehlenkamp, J.J., Walsh, B.W. and McDade, M. 2010. Preventing non-suicidal self-injury in adolescents: The signs of self-injury program. *Youth and Adolescence*, 39, pp. 306–314. doi: https://doi.org/10.1007/s10964-009-9450-8

Muehlenkamp, J.J., Claes, L., Havertape, L. and Plener, P.L. 2012. International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health*, 6, 10 (9pp). doi: https://doi.org/10.1186/1753-2000-6-10

Muehlenkamp, J.J. 2014. "Distinguishing between suicidal and nonsuicidal self-injury". In Nock, M.K. ed. *The Oxford Handbook of Suicide and Self-injury.* Oxford: Oxford University Press, pp. 23-46.

Muehlenkamp, J.J., Swenson, L.P., Batejan, K.L. and Jarvi, S.M. 2015. Emotional and behavioral effects of participating in an online study of Nonsuicidal Self-Injury: An experimental analysis. *Clinical Psychological Science*, 3 (1), pp. 26-37. doi:https://doi.org/10.1177/2167702614531579

Murray, C.J., Ezzati, M., Flaxman, A.D., Lim, S., Lozano, R., Michaud, C. Naghavi, M., Salomon J.A., Shibuya, K., Vos, T., Wikler, D. and Lopez, A.D. 2012. GBD (The Global Burden of Diseases, Injuries, and Risk Factors) 2010. Design, definitions, and metrics. *Lancet,* 380, pp. 2063–2066. doi:https://doi.org/10.1016/S0140-6736(12)61899-6

National Academies of Sciences, Engineering, and Medicine; Policy and Global Affairs; Committee on Science, Engineering, Medicine, and Public Policy; Board on Research Data and Information; Division on Engineering and Physical Sciences; Committee on Applied and Theoretical Statistics; Board on Mathematical Sciences and Analytics; Division on Earth and Life Studies; Nuclear and Radiation Studies Board; Division of Behavioral and Social Sciences and Education; Committee on National Statistics; Board on Behavioral, Cognitive, and Sensory Sciences; Committee on Reproducibility and Replicability in Science. 2019. *Reproducibility and Replicability in Science.* Washington (DC); National Academies Press.

National Cancer Institute and National Institutes of Health. 2012. *Theory at a glance. A guide for health promotion practice.* Washington D.C: U.S. Department of Health and Human Services.

National Collaborating Centre for Mental Health. 2004. *National Clinical Practice Guideline Number 16. Self-harm. The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. London: The British Psychological Society and the Royal College of Psychiatrists.

National Collaborating Centre for Mental Health. 2012. *Self-harm. The longer term management. National Clinical Guideline Number 133.* London: The British Psychological Society and the Royal College of Psychiatrists.

National Collaborating Centre for Mental Health. 2018. *Self-harm and suicide prevention competence framework. Children and young people.* London: National Collaborating Centre for Mental Health.

National Collaborating Centre for Mental Health. 2019. *Advancing mental health equality: Steps and guidance on commissioning and delivering equality in mental health care*. London: National Collaborating Centre for Mental Health.

National Collaborating Centre for Mental Health. 2022. *Meeting the needs of young adults within models of mental health care*. London: National Collaborating Centre for Mental Health.

National Institute for Health and Care Excellence (NICE). 2004. *Self-harm in over 8s. Short-term management and prevention of recurrence*. London: NICE.

National Institute for Health and Care Excellence (NICE). 2011. *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services.* London: NICE.

National Institute for Health and Care Excellence (NICE). 2013. *Self-harm: longer term management. Evidence update April 2013: A summary of selected new evidence relevant to NICE clinical guideline 133 'Self-harm: longer term management'*. Manchester: NICE.

National Institute for Health and Care Excellence (NICE). 2016a. *Surveillance report 2016. Self-harm in over 8s: short-term management and prevention of recurrence (2004) NICE guideline CG16 and Self-harm in over 8s: long term management*. London: NICE.

National Institute for Health and Care Excellence (NICE). 2016b. *Community engagement: improving health and well-being and reducing health inequalities.* London: NICE.

National Institute for Health and Care Excellence (NICE). 2022a. *NICE Guideline. Self-harm:assessment, management and preventing recurrence (NG225).* London: NICE.

National Institute for Health and Care Excellence (NICE). 2022b. *Self-harm. Quality Standard.* Available at:https://www.nice.org.uk/guidance/qs34 (Accessed: 20 February 2023).

National Institute for Health and Care Excellence (NICE). 2022c. *Self-harm: assessment, management and preventing recurrence. Evidence review for assessment in non-specialist settings.* London: NICE. Available at: https://www.nice.org.uk/guidance/ng225/evidence (Accessed: 12 May 2023).

National Institute for Health and Care Excellence (NICE). 2022d. *Self harm: assessment, management and preventing recurrence. Draft guideline*. London: NICE. Available at: https://www.nice.org.uk/guidance/ng225/history (Accessed: 15 June 2023).

National Institute for Health and Care Excellence (NICE). 2022e. *Self harm: assessment, management and preventing recurrence. Consultation on draft guideline - Stakeholder comments table: 18/01/22 – 01/03/22*. London: NICE. Available at: https://www.nice.org.uk/guidance/ng225/history (Accessed: 15 June 2023).

National Institute for Health and Care Excellence (NICE). 2023. *NICE and health inequalities.* Available at: https://www.nice.org.uk/about/what-we-do/nice-and-health-inequalities (Accessed: 21 March 2023).

National Institute for Health Research (NIHR), Chief Scientist Officer, Health and Care Research Wales and Public Health Agency. 2019. *UK standards for public involvement*. London: NIHR. Available at: https://sites.google.com/nihr.ac.uk/pi-standards/home (Accessed: 20 September 2022).

National Institutes for Health. 2011. *Principles of community engagement.* Maryland: National Institutes for Health. Available at: https://www.atsdr.cdc.gov/communityengagement/index.html(Accessed: 7 January 2023).

Nawaz, R.S., Anderson, J.K., Colville, L., Fraser-Andrews, C. and Ford, T.S. 2023. Review: Interventions to prevent or manage self-harm among students in educational settings – a systematic review. *Child and Adolescent Mental Health* [Preprint] (14pp). doi:https://doi.org/10.1111/camh.12634.

Nesamoney, S. N., Mejía-Guevara, I., Cislaghi, B., Weber, A.M., Mbizvo, M.T. and Darmstadt, G. L. 2022. Social normative origins of the taboo gap and implications for adolescent risk for HIV infection in Zambia. *Social Science and Medicine*, 312, 115391 (11pp). doi:https://doi.org/10.1016/j.socscimed.2022.115391

Newman and Newman. 2011. `Theories of adolescence`, in Bradford Brown, B. and Prinstein, M.J. eds. *Encyclopedia of Adolescence, Volume 1.* Cambridge, Massachusetts: Academic Press, pp.20-29. doi:https://doi.org/10.1016/B978-0-12-373915-5.00003-6

NHS (National Health Service) 2020. *Why people self-harm.* Available at: https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/behaviours/self-harm/why-people-self-harm/ (Accessed: 10 January 2023).

NHS (National Health Service) Digital. 2016. *Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatients and Accident and Emergency data, April 2016 to July 2016.* Leeds: NHS Digital. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/provisional-monthly-hospital-episode-statistics-for-admitted-patient-care-outpatient-and-accident-and-emergency-data/provisional-monthly-hospital-episode-statistics-for-admitted-patient-care-outpatients-and-accident-and-emergency-data-april-2016-to-july-2016 (Accessed: 15 January 2023)

NHS (National Health Service) Digital. 2021. *Admissions for mental health and self harm, by gender and age. Timeframe: 2005-06 to 2019-20, and 2020-21 (provisional).* Available at: https://digital.nhs.uk/supplementary-information/2021/admissions-for-mental-health-and-self-harm-by-gender-and-age-2005-06-to-2019-20-and-2020-21-provisional (Accessed: 7 March 2023).

NHS (National Health Service) Digital. 2022. *National Clinical Coding Standards ICD-10 5th Edition.* Leeds: NHS Digital.

NHS (National Health Service) Digital, National Centre for Social Research, the Office for National Statistics and Youthinmind. 2018a. *Mental Health of Children and Young People in England, 2017.* London: NHS Digital - Department of Health and Social Care. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017 (Accessed: 7 March 2023).

NHS (National Health Service) Digital, National Centre for Social Research, the Office for National Statistics and Youthinmind. 2018b*. Mental Health of Children and Young People in England, 2017. Emotional Disorders Tables.* London: NHS Digital - Department of Health and Social Care. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017 (Accessed: 7 March 2023).

NHS (National Health Service) Digital, National Centre for Social Research, the Office for National Statistics and Youthinmind. 2022. *Mental Health of Children and Young People in England, 2022 – wave 3 follow up to the 2017 survey.* London: NHS Digital - Department of Health and Social Care.Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2022-follow-up-to-the-2017-survey (Accessed: 7 March 2023).

NHS Health Research Authority. 2023. *What we do.* Available at: https://www.hra.nhs.uk/aboutus/what-we-do/ (Accessed: 30 January 2023).

Nixon, B. 2011. *CAMHS workforce development: Self-harm in young people and children handbook*. London: National CAMHS Support Services.

Noble, H. and Smith, J. 2015. Issues of validity and reliability in qualitative research. *Evidence-Based Nursing,* 18 (2), pp. 34-35. doi: https://doi.org/10.1136/eb-2015-102054

Nock, M.K. and Prinstein, M.J. 2004. A Functional Approach to the Assessment of Self-Mutilative Behaviour. *Consulting and Clinical Psychology*, 72, pp.885-890. doi:https://doi.org/10.1037/0022-006X.72.5.885.

Nock, M. K., Holmberg, E. B., Photos, V. I., and Michel, B. D. 2007. The self-injurious thoughts and behaviours interview: Development, reliability, and validity of a new measure. *Psychological Assessment,* 19 (3) , pp. 309–317. doi:https://doi.org/10.1037/1040-3590.19.3.309

O'Brien, B.C., Harris, I.B.,Beckman, T.J.,Reed, D.A. and Cook, D.A. 2014. Standards for reporting qualitative research. A synthesis of recommendations. *Academic Medicine*, 89 (9), pp. 1245–1251. doi:https://doi.org/10.1097/ACM.0000000000000388

O'Cathain., A, Croot, L., Duncan, E., Rousseau, N., Sworn, K., Turner, K.M., Yardley, L. and Hoddinott, P. 2019. Guidance on how to develop complex interventions to improve health and healthcare. *BMJ Open,* 9, e029954 (9pp). doi :https://doi.org/10.1136/bmjopen-2019-029954

O'Connell, M.E., Boat, T., Warner, K.E. and the National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults. 2009. *Preventing mental, emotional, and behavioural disorders among young people. Progress and possibilities. Research advances and promising interventions.* Washington (DC): National Academies Press (US).

O'Connor, R.C., Rasmussen, S. and Hawton, K. 2014. Adolescent self-harm: A school-based study in Northern Ireland. *Affective Disorders,* 159, pp. 46-52. doi:https://doi.org/10.1016/j.jad.2014.02.015

O'Connor, R.C. and Pirkis, J. 2016. "Introduction", in O'Connor, R.C. and Pirkis, J. eds. *The International Handbook of Suicide Prevention.* Chichester: John Wiley and Sons, pp. 1-8.

O'Connor, R.C. and Portzky G. 2018. Looking to the future: A synthesis of new developments and challenges in suicide research and prevention. *Frontiers in Psychology,* 9, 2139 (14pp). doi: https://doi.org/10.3389/fpsyg.2018.02139

O'Reilly, M., Kiyimba, N. and Karim, K. 2016. "This is a question we have to ask everyone". Asking young people about self-harm and suicide. *Psychiatric and Mental Health Nursing*, 23, pp. 479–488. doi :https://doi.org/10.1111/jpm.12323

Office for Health Improvement and Disparities (OHID). 2022. *Guidance. Health disparities and health inequalities: applying All Our Health.* Available at: https://www.gov.uk/government/publications/health-disparities-and-health-inequalities-applying-all-our-health/health-disparities-and-health-inequalities-applying-all-our-health (Accessed: 6 March 2023).

Office for Health Improvement and Disparities (OHID). 2023a. *Public Health Profiles. Indicator.Hospital admissions as a result of self-harm (10-14 yrs).* London: HMSO. Available at: https://fingertips.phe.org.uk/search/self%20harm#page/6/gid/1938133404/ pat/159/par/ K02000001/ati/15/are/E92000001/iid/92796/age/5/sex/4/cat/-1/ctp/-1/yrr/1/ cid/4/tbm/1 (Accessed: 13 March 2023).

Office for Health Improvement and Disparities (OHID). 2023b. *Public Health Data: England, Self-harm.* London: HMSO. Available at: https://fingertips.phe.org.uk/search/self%20harm (Accessed: 16 February 2023).

Office for Health Improvement and Disparities (OHID). 2023c. *Public Health Profiles. Indicator. Emergency Hospital Admissions for Intentional Self-harm. Indicator definitions and supporting information.* London: HMSO. Available at: https://fingertips.phe.org.uk/search/self%20harm#page/6/gid/1938133369/pat/159/par/ K02000001/ati/15/are/E92000001/iid/21001/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1 (Accessed: 13 March 2023).

Office for National Statistics (ONS). 2020. *Deaths registered in England and Wales: 2019*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ deaths/bulletins/deathsregistrationsummarytables/2019 (Accessed: 12 May 2023).

Office for National Statistics (ONS). 2022. *Dataset. Suicides in England and Wales*. London: Office for National Statistics. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ deaths/datasets/suicidesintheunitedkingdomreferencetables (Accessed: 17 March 2023).

Office of the United Nations High Commissioner for Human Rights (OHCHR) 1989. *Convention on the Right of the Child.* Geneva: OHCHR.

Oh, A., Abazeed, A. and Chambers, D.A. 2021. Policy implementation science to advance population health: The potential for learning health policy systems. *Frontiers in Public Health*, 9, 681602 (6pp). doi:https://doi.org/10.3389/fpubh.2021.681602

Oh, D.L., Jerman, P., Boparai, S.K.P., Koita, K., Briner, S., Bucci, M. and Harris, N.B. 2018. Review of tools for measuring exposure to adversity in children and adolescents. *Pediatric Health Care,* 32 (6), pp. 564 – 583. doi: https://doi.org/10.1016/j.pedhc.2018.04.021

Oliver, C. 2012. Critical realist grounded theory. *British Journal of Social Work*, 42 (2), pp. 371-387. doi: https://doi.org/10.1093/bjsw/bcr064

Orland-Barak, L. 2002. The theoretical sensitivity of the researcher: Reflections on a complex construct. *Reflective Practice*, 3 (3), pp. 263-278. doi:https://doi.org/10.1080/1462394022000034523

Oxford English Dictionary (OED) 2022a. Euphemism. https://www.oed.com/view/Entry/65021? redirectedFrom=euphemism#eid (Accessed: 20 July 2022)

Oxford English Dictionary (OED). 2022b. (To open) a can of worms. Available at: https://www.oed.com/view/Entry/230283?redirectedFrom=can+of+worms#eid13863212 (Accessed: 7 November 2022)

Oxford English Dictionary (OED). 2022c. Pandora's box. Available at: https://www.oed.com/view/Entry/261413?redirectedFrom=pandora%27s+box#eid (Accessed: 7 November 2022)

Ozer, E.J., Abraczinskas, M., Duarte, C., Mathur, R., Ballard, P.J., Gibbs, L., Olivas, E.T., Bewa, M.J. and Afifi, R. 2020. Youth participatory approaches and health equity: Conceptualization and integrative review. *American Journal of Community Psychology*, 66, pp. 267-278. doi: https://doi.org/10.1002/ajcp.12451

Page, A., Lewis, G., Kidger, J., Heron, J., Chittleborough, C., Evans, J. and Gunnell, D. 2014. Parental socio-economic position during childhood as a determinant of self-harm in adolescence. *Social Psychiatry and Psychiatric Epidemiology*, 49, pp. 193–203. doi:https://doi.org/10.1007/s00127-013-0722-y

Page N., Hewitt G., Young H., Moore G. and Murphy S. 2021. *Student health and wellbeing in Wales: Report of the 2019/20 School Health Research Network Student Health and Wellbeing Survey.* Cardiff University: Cardiff, UK.

Page N., Angel, L., Ogada, E., Young H. and Murphy S. 2023. *Student health and wellbeing in Wales: Report of the 2021/22 Health Behaviour in School-aged Children Survey and School Health Research Network Student Health and Wellbeing Survey.* Cardiff: Cardiff University.

Pain, R. and Francis, P. 2003. Reflections on participatory research. *Area,* 35, pp. 46-54. doi:https://doi.org/10.1111/1475-4762.00109

Parker, R. 2015. *The Signature Strengths pilot programme report, 2013-2014. Report commissioned by Shropshire Child Safeguarding and Support Services.* Shropshire County Council: Shropshire. Available at: https://orca.cardiff.ac.uk/id/eprint/153396/ (Accessed: 18 June 2023).

Parker, R. 2017a. Concerted action by multidisciplinary stakeholders: The development phase of a complex public health intervention in regards to adolescent self-harm. *European Psychiatry*, 41, S738. doi: https://doi.org/10.1016/j.eurpsy.2017.01.1358.

Parker, R. 2017b. Health Topic: Adolescent Self-Harm in the UK. The development phase of a complex public health intervention: The intervention theory. *The 25th European Congress of Psychiatry.* Florence, Italy, 1-4 April 2017. Available at: https://orca.cardiff.ac.uk/id/eprint/115719/ (Accessed: 18 June 2023).

Parker, R. 2018a. A small-scale study investigating staff and student perceptions of the barriers to a preventative approach for adolescent self-harm in secondary schools in Wales - a grounded theory model of stigma. *Public Health*, 159, pp. 8-13. doi:https://doi.org/10.1016/j.puhe.2018.03.016

Parker, R. 2018b. Report for the journal paper: a small-scale study investigating staff and student perceptions of the barriers to a preventative approach for adolescent self-harm in secondary schools in Wales - a grounded theory model of stigma. *Public Health*, 159, pp. 8-13. doi :https://doi.org/10.13140/RG.2.2.23781.70882.

Parker, R. 2021*a*. Managing ethical issues in community-based adolescent self-harm research. Ethical practice in an adolescent self-harm preventive intervention research project with pupils in secondary schools in Wales. *European Psychiatry,* 64 (S1),S580. doi:https://doi.org 10.1192/j.eurpsy.2021.1547

Parker, R. 2021*b*. Ethics in school-based adolescent self-harm preventive intervention research. A research safety protocol to manage ethical tensions and address research barriers to facilitate pupil participation. *2021 IASR/AFSP International Summit on Suicide Research*, Virtual, 24-27 October 2021. Available at: https://orca.cardiff.ac.uk/id/eprint/145785 (Accessed: 30 January 2023)

Parker, R. 2022. Applying a human rights-based framework for health equity purposes in community-based adolescent self-harm research. A participatory research methods case study of the barriers and facilitators for adolescents' and young people's participation in adolescent self-harm preventive intervention research in secondary schools in Wales. Presented at: *International Society for the Study of Self-Injury*, Virtual, 22-24 June 2022. Available at: https://orca.cardiff.ac.uk/id/eprint/150852 (Accessed: 30 January 2023)

Partridge, I., Richardson, G., Casswell, G. and Jones, N. 2010. `Multidisciplinary working`, in Richardson, G., Partridge, I. and Barrett, J. eds. *Child and Adolescent Mental Health Services. An operational handbook.* London: Royal College of Psychiatrists, pp. 69 – 77.

Patalay, P. and Gage, S.H. 2019. Changes in millennial adolescent mental health and health-related behaviours over 10 years: a population cohort comparison study. *International Journal of Epidemiology*, 48(5), pp.1650-1664. doi :https://doi.org/10.1093/ije/dyz006

Patalay, P. and Fitzsimons, E. 2021. Psychological distress, self-harm and attempted suicide in UK 17-year-olds: prevalence and sociodemographic inequalities. *British Journal of Psychiatry,* 219 (2), pp.437-439. doi: https://doi.org/10.1192/bjp.2020.258

Patton, G.C., Sawyer, S.M., Santelli, J.S., Ross, D.A., Afifi, R., Allen, N.B., Arora, M., Azzopardi, P., Baldwin, W., Bonell, C., Kakuma, R., Kennedy, E., Mahon, J., McGovern, T., Mokdad, A.H., Patel, V., Petroni, S., Reavley, N., Taiwo, K., Waldfogel, J., Wickremarathne, D., Barroso, C., Bhutta, Z., Fatusi, A.O., Mattoo, A., Diers, J., Fang, J., Ferguson, J., Ssewamala, F. and Viner, R.M. 2016. Our future: a Lancet commission on adolescent health and wellbeing. *The Lancet*, 387(10036), pp. 2423-2478. doi:https://doi.org/10.1016/S0140-6736(16)00579-1

Pawson, R. 1989. *A Measure for Measures: A Manifesto for Empirical Sociology*. London: Routledge.

Pawson, R. 1996. Theorising the Interview. *British Journal of Sociology,* 47 (2), pp. 295-314. doi:https://doi.org/10.2307/591728

Pawson, R. 2013. *The Science of Evaluation: A Realist Manifesto.* London: SAGE Publications.

Pierret, A.C.S., Anderson, J.K., Ford, T.J. and Burn, A.M. 2022. Review: Education and training interventions, and support tools for school staff to adequately respond to young people who disclose self-harm – a systematic literature review of effectiveness, feasibility and acceptability. *Child and Adolescent Mental Health,* 27, pp. 161-172. doi:https://doi.org/10.1111/camh.12436

Ports, K.A., Ford, D.C., Merrick, M.T. and Guinn, A.S. 2020. "ACEs: Definitions, measurement, and prevalence", in Asmundson, G.J.G. and Afifi, T.O. eds. *Adverse Childhood Experiences. Using Evidence to Advance Research, Practice, Policy, and Prevention*. London: Academic Press, pp. 17 – 34.

Posner, K., Brodsky, B., Yershova, K., Buchanan, J. and Mann, J. 2014. `The classification of suicidal behaviours`, in Nock, M.K. ed. *The Oxford Handbook of Suicide and Self-injury.* Oxford: Oxford University Press, pp. 2-22.

Pretty, J.N., Guijt, I., Scoones, I. and Thompson, J. 1995. *IIED Participatory Methodology Series. A trainer's guide for Participatory Learning and Action.* London: International Institute for Environment and Development

Price, W.L. 2015. *Measuring the effectiveness of a professional development workshop on attitudes and knowledge in working with self-injurious youth.* ProQuest LLC, Psy.D. Dissertation, Newton, Massachusetts, William James College. Available at: https://www.proquest.com/pqdtglobal/docview/1739002613/fulltextPDF/ D884156790DF4E61PQ/1?accountid=9883 (Accessed: 16 May 2023).

Public Health England. 2015. *Preventing suicides in public places. A practice resource.* London: Public Health England.

Public Health England. 2017. *Reducing health inequalities: system, scale and sustainability.* London: Public Health England.

Public Health England. 2018. *Research and analysis. The wider determinants of health.* London: HMSO. Available at: https://www.gov.uk/government/publications/health-profile-for-england-2018/chapter-6-wider-determinants-of-health (Accessed: 16 March 2023).

Public Health Wales Observatory. 2018. *Emergency admissions for self-harm, count and three year rolling rate per 100,000, males and females aged 10-24, Wales, financial years 2007/2008 to 2016/2017.* Cardiff: Public Health Wales Observatory. Available at: https://phw.nhs.wales/services-and-teams/observatory/data-and-analysis/emergency-admissions-for-self-harm-2007-08-2016-17/ (Accessed: 16 February 2023).

Public Health Wales. 2012. *Midpoint Review of the Implementation of "Talk to Me": The Wales Suicide and Self Harm Prevention Action Plan.* Cardiff: Public Health Wales.

Public Health Wales. 2016. *Making a difference: Investing in sustainable health and well-being for the people of Wales.* Cardiff: Public Health Wales.

Public Health Wales. 2019. *How to make the case for sustainable investment in well-being and health equity.* Cardiff: Public Health Wales.

Rai, L., Shepherd, L. and O' Boyle, C.P. 2019. Quantitative and thematic analysis of burns surgeons' attitudes, beliefs and surgical decision-making in self-harm burn injuries: The use of a questionnaire and hypothetical cases. *Burns*, 45, pp. 180 – 189. doi:https://doi.org/10.1016/j.burns.2018.08.003

Ransome, P. 2010. *Social Theory.* Bristol: The Policy Press.

Rao, D., Elshafei, A., Nguyen, M., Hatzenbuehler, M.L., Frey, S. and Go, V.F. 2019. A systematic review of multi-level stigma interventions: state of the science and future directions. *BMC Medicine,* 17, 41 (11pp). doi: https://doi.org/10.1186/s12916-018-1244-y

Reichertz, J. 2007. Abduction: The logic of discovery of grounded theory. In Brynant, A. and Charmaz, K. eds. *The SAGE handbook of grounded theory*. London: SAGE Publications, pp. 214-228.

Reichertz, J. 2019. Abduction: The logic of discovery of grounded theory – An updated review. InBrynant, A. and Charmaz, K. eds. *The SAGE handbook of current developments in grounded theory*. London: SAGE Publications, pp. 259-281.

Rietbergen-McCracken, J. and Narayan, D.1998. *Participation and social assessment. Tools and techniques.* Washington D.C.: The World Bank.

Rights of Children and Young Persons (Wales) Measure 2011. Available at: https://www.legislation.gov.uk/mwa/2011/2/contents (Accessed: 18 June 2023).

Roberts, V., Joiner, R., Russell, C., Bradley, R., Bowles, M., Bowes, A. and Nice, T. 2019. Mind and Body: an early intervention group programme for adolescents with self-harm thoughts and behaviours. *Education and Health*, 37 (2), pp.46-53. Available at: https://sheu.org.uk/content/page/education-and-health-archive?body_value=veronica+roberts (Accessed: 19 May 2023).

Robinson, J., Gook, S., Yuen, H.P., McGorry, P.D. and Yung, A.R. 2008. Managing deliberate self-harm in young people: An evaluation of a training program developed for school welfare staff using a longitudinal research design. *BMC Psychiatry*, 8, 75 (11pp). doi:https://doi.org/10.1186/1471-244X-8-75

Robinson, J. and Clarke, A. 2019. Commentary: Adolescent self-harm prevention and intervention in secondary schools: a survey of staff in England and Wales – a reflection on Evans et al. *Child and Adolescent Mental Health*, 24 (3), pp. 239–241. doi:https://doi.org/10.1111/camh.12335

Rodway, C., Ibrahim, S., Tham, S., Turnbull, P., Kapur, N. and Appleby, L. 2022. Bereavement and suicide bereavement as an antecedent of suicide in children and young people: Prevalence and characteristics. *Affective Disorders,* 300, pp. 280-288. doi:https://doi.org/10.1016/j.jad.2021.12.063

Rosenrot, S.A. and Lewis, S.P. 2020. Barriers and responses to the disclosure of non-suicidal self-injury: a thematic analysis. *Counselling Psychology Quarterly*, 33 (2), pp.121-141. doi :https://doi.org/10.1080/09515070.2018.1489220

Roth, A.D., Calder, F. and Pilling, S. 2011. A competence framework for Child and Adolescent Mental Health Services. Edinburgh: NHS Education for Scotland.

Rowe, S. L., French, R.S., Henderson, C., Ougrin, D., Slade, M. and Moran, P. 2014. Help-seeking behaviour and adolescent self-harm: A systematic review. *Australian and New Zealand Journal of Psychiatry,* 48 (12), pp. 1083–1095. doi:https://doi.org/10.1177/0004867414555718

Royal College of Psychiatrists. 2010. *Self-harm, suicide and risk: helping people who self-harm.* London: Royal College of Psychiatrists.

Royal College of Psychiatrists. 2016. *Self-harm.* London: Royal College of Psychiatrists.

Rüsch, N., Angermeyer, M. and Corrigan, P. 2005. Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry,* 20 (8), pp. 529-539. doi:https://doi.org/10.1016/j.eurpsy.2005.04.004

Russell, A.E., Hemani, G., Jones, H.J., Ford, T., Gunnell, D., Heron, J., Joinson, C., Moran, P., Relton, C., Suderman, M.,Watkins, S. and Mars, B. 2021. An exploration of the genetic epidemiology of non-suicidal self-harm and suicide attempt. *BMC Psychiatry,* 21, 207 (12pp). doi:https://doi.org/10.1186/s12888-021-03216-z

Rycroft-Malone, J., Burton, C., Wilkinson, J., Harvey, G., McCormack B., Baker, R., Dopson, S., Graham, I., Staniszewska, S., Thompson, C., Ariss, S., Melville-Richards, L. and Williams, L. 2015. Collective action for knowledge mobilisation: a realist evaluation of the Collaborations for Leadership in Applied Health Research and Care. *Health Services Delivery Research*, 3 (44), (200pp). doi: https://doi.org/10.3310/hsdr03440

Samaritans. 2020. *Communicating sensitively with users in distress.* Cardiff: Samaritans. Available at: https://www.samaritans.org/wales/about-samaritans/research-policy/internet-suicide/guidelines-tech-industry/communicating-with-users/ (Accessed: 1 November 2021)

Sampson, R.J. 2001. "The sociology of delinquency", in Smelser, N.J. and Paul B. Baltes, P.B. eds. *International Encyclopedia of the Social & Behavioural Sciences.* Oxford: Pergamon Press, pp.3380-3384.

Santelli, J.S., Smith-Rogers, A., Rosenfeld, W.D., DuRant, R.H., Dubler, N., Morreale, M., English, A., Lyss, S., Wimberly, Y., Schissel, A. and Society for Adolescent Medicine. 2003. Guidelines for adolescent health research. A position paper of the Society for Adolescent Medicine. *Adolescent Health,* 33 (5), pp. 396-409. doi:https://doi.org/10.1016/j.jadohealth.2003.06.009

Savin-Baden, M. and Howell-Major, C. 2013. *Qualitative Research. The essential guide to theory and practice.* Abingdon: Routledge.

Sawyer, S.M., Azzopardi, P.S., Wickremarathne, D. and Patton, G.C. 2018. The age of adolescence. *Lancet Child and Adolescent Health*, 2, pp. 223-28. doi:https://doi.org/10.1016/S2352-4642(18)30022-1

Sayal, K., Owen, V., White. K., Merrell, C., Tymms, P. and Taylor. E. 2010. Impact of early school-based screening and intervention programs for ADHD on children's outcomes and access to services: Follow-up of a school-based trial at age 10 years. *Archives of Pediatrics and Adolescent Medicine,* 164 (5), pp.462–469. doi:https://doi.org:10.1001/archpediatrics.2010.40

Sayer, A. 2000. *Realism and Social Science*. London: SAGE Publishing.

School Health Research Network (SHRN) 2023. *The School Health Research Network.* Available at: https://www.shrn.org.uk/ (Accessed: 10 January 2023).

Scourfield, J., Roen, K. and McDermott, E. 2011. The non-display of authentic distress. Public-private dualism in young people's discursive construction of self-harm. *Sociology of Health and Illness*, 33 (5), pp. 777-791. doi: https://doi.org/10.1111/j.1467-9566.2010.01322.x

Seale, C. 1999. *The quality of qualitative research*. London: SAGE Publications Ltd.

Senedd Research. 2023. Increased school absence – how did the pandemic affect school attendance? Available at: https://research.senedd.wales/research-articles/increased-school-absence-how-did-the-pandemic-affect-school-attendance/ (Accessed: 20 February 2024).

Sharma, N.P. and Gupta, V. 2023. Therapeutic Communication. Available at: https://www.ncbi.nlm.nih.gov/books/NBK567775/ (Accessed: 22 February 2024)

Shaw, I. and Gould, N. 2001. *Qualitative research methods series: Qualitative research in social work*. London: Sage Publications Ltd.

Sheehan, L., Oexle, N., Armas, S.A., Wan, H.T., Bushman, M.,Glover, L. and Lewy, S.A. 2019. Benefits and risk of suicide disclosure. *Social Science and Medicine*, 223, pp. 16-23. doi:https://doi.org/10.1016/j.socscimed.2019.01.023

Sheehan, L., Palermo, C., and Corrigan, P. 2022. "Theoretical models to understand stigma of mental illness", in D. Vogel, D. and Wade, N. eds. *The Cambridge Handbook of Stigma and Mental Health.* Cambridge: Cambridge University Press. pp. 11-30

Shellenbarger, T. 2016. Simplifying Synthesis. *Nurse Author & Editor*, 26, pp.1-10. https://doi.org/10.1111/j.1750-4910.2016.tb00224.x

Shin, H.Y., Kim, K.Y. and Kang, P. 2020. Concept analysis of community health outreach. *BMC Health Services Research,* 20, 417 (9pp). doi: https://doi.org/10.1186/s12913-020-05266-7

Short, S.E. and Mollborn, S. 2015. Social determinants and health behaviours. Conceptual frames and empirical advances. *Current Opinion in Psychology*, 5, pp. 78–84. doi:https://doi.org/10.1016/j.copsyc.2015.05.002

Silverman, M.M. 2016. `Challenges to defining and classifying suicide and suicidal behaviours`, in O'Connor, R.C. and Pirkis, J. eds. *The International Handbook of Suicide Prevention.* Chichester: John Wiley and Sons, pp.11-35.

Simm, R., Roen, K. and Daiches, A. 2010. Primary school children and self harm: The emotional impact upon education professionals, and their understandings of why children self harm and how this is managed. *Oxford Review of Education*, 36, pp. 677–92. doi:https://doi.org/10.1080/03054985.2010.501139

Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., Boyd, K.A., Craig, N., French, D.P., McIntosh, E., Petticrew, M., Rycroft-Malone, J., White, M. and Moore, L. 2021a. A new framework for developing and evaluating complex interventions: update of Medical Research Council guidance. *BMJ,* 374, n2061 (11pp). doi:https://doi.org/10.1136/bmj.n2061

Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., Boyd, K.A., Craig, N., French, D.P., McIntosh, E., Petticrew, M., Rycroft-Malone, J., White, M. and Moore, L.2021b. Framework for the development and evaluation of complex interventions: gap analysis, workshop and consultation-informed update. *Health Technology Assessment,* 25 (57), (172pp). doi:https://doi.org/10.3310/hta25570

Smith-Gowling, C., Knowles, S.F. and Hodge, S. 2018. Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs. *Clinical Child Psychology and Psychiatry,* 23(4), pp. 528–541. doi :https://doi.org/10.1177/1359104518755216

Social Care Institute for Excellence. 2021. *Using evidence in social services and social care in Wales*. London: Social Care Institute for Excellence.

Social Care Wales. 2018. *Social care research and development strategy for Wales 2018-2023*. Cardiff: Social Care Wales.

Social Services and Well-being (Wales) Act 2014. London: HMSO.

Stallard, P., Phillips, R., Montgomery, A.A., Spears, M., Anderson, R., Taylor, J., Araya, R., Lewis, G., Ukoumunne, O.C., Millings, A., Georgiou, L., Cook, E. and Sayal, K. 2013a. A cluster randomised controlled trial to determine the clinical effectiveness and cost-effectiveness of classroom-based cognitive-behavioural therapy (CBT) in reducing symptoms of depression in high-risk adolescents. *Health Technology Assessment*, 17(47) (132pp). doi:https://doi.org/10.3310/hta17470.

Stallard, P., Spears, M., Montgomery, A.A., Phillips, R. and Sayal, K. 2013b. Self-harm in young adolescents (12–16 years): onset and short-term continuation in a community sample. *BMC Psychiatry,* 13, 328 (14pp). doi:https://doi.org/10.1186/1471-244X-13-328

Standl, T., Annecke, T., Cascorbi, I., Heller, A. R., Sabashnikov, A. and Teske, W. 2018. The Nomenclature, Definition and Distinction of Types of Shock. *Deutsches Arzteblatt International*, 115 (45), pp.757–768. doi: https://doi.org/10.3238/arztebl.2018.0757

Stangl, A.L., Earnshaw, V.A., Logie, C.H., Brakel, W.V., Simbayi, L.C., Barre, I. and Dovidio, J.F.2019. The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Medicine,* (17) 31, (13pp). doi: https://doi.org/10.1186/s12916-019-1271-3

Staniland, L., Hasking, P., Boyes, M. and Lewis, S. 2021. Stigma and nonsuicidal self-injury: Application of a conceptual framework. *Stigma and Health*, 6 (3), pp.313–323. doi:https://doi.org/10.1037/sah0000257

Steggals, P., Graham, R. and Lawler, S. 2020a. Self-injury in social context: an emerging sociology. *Social Theory and Health,* 18, pp. 201–210. doi:https://doi.org/10.1057/s41285-020-00149-7

Steggals, P., Lawler, S. and Graham, R. 2020b. The social life of self-injury: exploring the communicative dimension of a very personal practice. *Sociology of Health and Illness*, 42, pp. 157-170. doi: https://doi.org/10.1111/1467-9566.12994

Steggals, P., Lawler, S. and Graham, R. 2022. The personal is social: Four sociological approaches to nonsuicidal self-injury. *Sociology Compass*, 16 (5), e12970 (13pp). doi:https://doi.org/10.1111/soc4.12970

Stevens, K., Thambinathan, V., Hollenberg, E., Inglis, F., Johnson, A., Levinson. A., Salman, S., Cardinale, L., Lo, B., Shi, J., Wiljer, D., Korczak, D.J. and Cleverley, K. 2021. Core components and strategies for suicide and risk management protocols in mental health research: a scoping review. *BMC Psychiatry*, 21(1),13 (14pp). doi:https://doi.org/10.1186/s12888-020-03005-0

Stokols, D. 2000. Social ecology and behavioural medicine: implications for training, practice, and policy. *Behavioural Medicine*, 26 (3), pp. 129-138. doi:https://doi.org/10.1080/08964280009595760

Sudarsan, I., Hoare, K., Sheridan, N., and Roberts, J. 2022. Giving voice to children in research: The power of child-centered constructivist grounded theory methodology. *Research in Nursing and Health*, 45, pp.488– 497. doi: https://doi.org/10.1002/nur.22231

Sukhera, J., Knaak, S., Ungar. T. and Rehman, M. 2022. Dismantling structural stigma related to mental health and substance use: An educational framework. *Academic Medicine*, 97 (2), pp. 175-181. doi: https://doi.org/10.1097/ACM.0000000000004451

Susi, K., Glover-Ford, F., Stewart, A., Knowles Bevis, R. and Hawton, K. 2023. Research Review: Viewing self-harm images on the internet and social media platforms: systematic review of the impact and associated psychological mechanisms. *Child Psychology and Psychiatry* [preprint] (25pp). doi: https://doi.org/10.1111/jcpp.13754

Tavory, I. and Timmermans, S. 2019. "Abductive analysis and grounded theory", in Bryant, A. and Charmaz, K. eds. *The SAGE handbook of current developments in grounded theory*. London: Sage Publications, pp. 532-546. doi:https://doi.org/10.4135/9781526485656.n28

Taylor, J. D., and Ibañez, L. M. 2015. Sociological approaches to self-injury. *Sociology Compass,* 9, pp. 1005-1014.doi: https://doi.org/10.1111/soc4.12327

Teixeira, S., Augsberger, A., Richards-Schuster, K. and Sprague Martinez, L. 2021. Participatory research approaches with youth: Ethics, engagement, and meaningful action. *American Journal of Community Psychology,* 68, pp. 142-153. doi:https://doi.org/10.1002/ajcp.12501

Thapar, A., Pine, D.S., Leckman, J.F., Scott, S., Snowling, M.J. and Taylor E. 2018. *Rutter's Child and Adolescent Psychiatry.* Chichester: Wiley and Sons Ltd.

The Lancet. 2020. Editorial. Child mental health services in England: a continuing crisis. *Lancet,* 395 (10222), p. 389. doi: https://doi.org/10.1016/S0140-6736(20)30289-0

Theis, J. and Grady, H.M. 1991. *Participatory Appraisal. A training manual based on experiences in the Middle East and North Africa.* London: International Institute for Environment and Development; Save the Children Federation.

Timson, D., Priest, H. and Clark-Carter, D. 2012. Adolescents who self-harm: Professional staff knowledge, attitudes and training needs. *Adolescence*, 35 (5), pp. 1307-1314. doi:https://doi.org/10.1016/j.adolescence.2012.05.001

Townsend, E. 2019. Comment. Time to take self-harm in young people seriously. *Lancet Psychiatry,* 6 (4), pp. 279-280. doi: https://doi.org/10.1016/S2215-0366(19)30101-4

Townsend, M.L., Gray, A.S., Lancaster, T.M. and Grenyer, B.F.S. 2018. A whole of school intervention for personality disorder and self-harm in youth: A pilot study of changes in teachers' attitudes, knowledge and skills. *Borderline Personality Disorder and Emotion Dysregulation,* 5, 17 (9pp). doi: https://doi.org/10.1186/s40479-018-0094-8

Trafford, A.M., Carr, M.J., Ashcroft, D.M., Chew-Graham, C.A., Cockcroft, E., Cybulski, L., Garavini, E., Garg, S., Kabir, T., Kapur, N., Temple, R.K., Webb, R.T. and Mok, P.L.H. 2023. Temporal trends in eating disorder and self-harm incidence rates among adolescents and young adults in the UK in the 2 years since onset of the COVID-19 pandemic: a population-based study. *Lancet Child and Adolescent Health*, 7 (8), pp. 544-55. doi:https://doi.org/10.1016/S23524642(23)00126-8

Turecki, G. and Brent, D.A. 2016. Suicide and suicidal behaviour. *Lancet*, 19 (387), pp. 1227-39. doi: https://doi.org/10.1016/S0140-6736(15)00234-2

UNICEF. 2021. *Defining social norms and related concepts*. New York: UNICEF.

United Nations. 1981. *International youth year: Participation, development, peace. Report of the Secretary-General*. New York: United Nations. Available at: https://daccess-ods.un.org/tmp/267634.987831116.html (Accessed: 18 September 2023).

United Nations. 2022. *Global issues: Youth*. Available at: https://www.un.org/en/global-issues/youth (Accessed: 18 September 2023).

Van Heeringen, K. 2012. `Stress–Diathesis Model of Suicidal Behaviour`, in Dwivedi, Y. ed. *The Neurobiological Basis of Suicide*. Boca Raton (FL): CRC Press/Taylor and Francis Taylor.

Vannoy, S., Whiteside, U. and Unützer, J. 2010. Current practices of suicide risk management protocols in research. *Crisis,* 31(1), pp. 7–11. doi:https://doi.org/10.1027/0227-5910/a000004

Veenema, T.G., Thornton, C.P. and Corley, A. 2015. The public health crisis of child sexual abuse in low and middle income countries: An integrative review of the literature. *International Journal of Nursing Studies*, 52, pp. 864 – 881. doi:https://doi.org/10.1016/j.ijnurstu.2014.10.017

Viner, R.M., Ozer, E.M., Denny, S., Marmot, M., Resnick, M., Fatusi, A. and Currie, C. 2012. Adolescence and the social determinants of health. *Lancet*, 379 (9826), pp. 1641-52. doi:https://doi.org/10.1016/S0140-6736(12)60149-4

Vollstedt, M. and Rezat, S. 2019. `An introduction to grounded theory with a special focuson axial coding and the coding paradigm` , in Presmeg, N. and Kaiser, G. eds. *Compendium for early career researchers in mathematics education*. Cham, Switzerland: Spinger, pp. 81-100.

Waller, G., Newbury-Birch, D., Simpson, D., Armstrong, E., James, B., Chapman, L., Ahmed, F. and Ferguson, J. 2023. The barriers and facilitators to the reporting and recording of self-harm in young people aged 18 and under: a systematic review. *BMC Public Health,* 23, 158 (21pp). doi: https://doi.org/10.1186/s12889-023-15046-7

Walsh, B.W. 2014. *Treating Self-Injury. A Practical Guide*. London: The Guilford Press.

Wasserman, D., Hoven, C.W., Wasserman, C., Wall, M., Eisenberg, R., Hadlaczky, G., Kelleher, I., Sarchiapone, M., Apter, A., Balazs, J., Bobes, J., Brunner, R., Corcoran, P., Cosman, D., Guillemin, F., Haring, C., Iosue, M., Kaess, M., Kahn, J., Keeley, H., Musa, G.J., Nemes, B., Postuvan, V., Saiz, P., Reiter-Theil, S., Varnik, A., Varnik, P. and Carli, V. 2015. School-based suicide prevention programmes: the SEYLE cluster-randomised, controlled trial. *The Lancet*, 385 (9977), pp. 1536–44. doi: https://doi.org/10.1016/S0140-6736(14)61213-7

Welsh Government Social Research. 2015. *2013/14 Health Behaviour in School-aged Children (HBSC) Wales.* Cardiff: Welsh Government.

Welsh Government. 2010. *Practical Approaches to Behaviour Management in the Classroom. A handbook for classroom teachers in secondary schools*. Cardiff:Welsh Government.

Welsh Government. 2012. *Practical approaches to behaviour management in the classroom. A handbook for classroom teachers in primary schools*. Cardiff: Welsh Government.

Welsh Government. 2013. *Guidance on penalty notices for regular non-attendance at school*. Cardiff: Welsh Government.

Welsh Government. 2015a. *Keeping learners safe. The role of local authorities, governing bodies and proprietors of independent schools under the Education Act 2002. Guidance document no: 158/2015.* Cardiff: Welsh Government.

Welsh Government. 2015b. *Specific learning difficulties framework*. Cardiff: Welsh Government.

Welsh Government. 2017. Cabinet written statement: Providing for the Emotional and Mental Health Needs of Young People in Schools. Available at: https://gov.wales/written-statement-providing-emotional-and-mental-health-needs-young-people-schools (Accessed: 22 Feb 2021).

Welsh Government. 2018a. *In brief. A healthier Wales: Our plan for health and social care*. Cardiff: Welsh Government.

Welsh Government. 2018b. *My Local School*. Available at: https://mylocalschool.gov.wales/Schools/SchoolSearch?lang=en (Accessed: 12 January 2018).

Welsh Government. 2019a. *Responding to issues of self-harm and thoughts of suicide in young people*. Cardiff: Welsh Government.

Welsh Government. 2019b. *National school categorisation system*. Cardiff: Welsh Government.

Welsh Government. 2021a. *Framework on embedding a whole-school approach to emotional and mental well-being*. Cardiff: Welsh Government.

Welsh Government. 2021b. *A healthier Wales: Actions.* Cardiff: Welsh Government.

Welsh Government. 2021c. *A healthier Wales: Our plan for health and social care.* Cardiff: Welsh Government.

Welsh Government. 2021d. *Population need assessment – supplementary advice for Regional Partnership Boards.* Cardiff: Welsh Government.

Welsh Government. 2022a. *NHS Wales Performance Framework 2022-23 (interim framework)*. Cardiff: Welsh Government.

Welsh Government. 2022b. *NHS Wales Performance Framework and Guidance Document 2022-23 (interim framework)*. Cardiff: Welsh Government.

Welsh Government. 2022c. *Student health and well-being survey.* Cardiff: Welsh Government. Available at: https://www.gov.wales/student-health-and-well-being-survey#Backgroundinformation(Accessed: 10 January 2023).

Welsh Government. 2022d. Developing a vision for curriculum design. Available at: https://hwb.gov.wales/curriculum-for-wales/designing-your-curriculum/developing-a-vision-for-curriculum-design/ (Accessed: 14 August 2023).

Welsh Government. 2022e. *Keeping learners safe. Guidance document no: 283/2022*. Cardiff: Welsh Government.

Welsh Government. 2022f. *Well-being, equity and inclusion*. Available at: https://hwb.gov.wales/evaluation-improvement-and-accountability/the-national-resource-evaluation-and-improvement/what-is-the-national-resource/well-being-equity-and-inclusion/ (Accessed: 17 October 2023).

Welsh Government. 2022g. *School improvement guidance: framework for evaluation, improvement and accountability.* Available at: https://hwb.gov.wales/evaluation-improvement-and-accountability/school-improvement-guidance-framework-for-evaluation-improvement-and-accountability/ (Accessed: 17 October 2023).

Welsh Government. 2022h. Summary of absenteeism at school before and during the coronavirus (COVID-19) pandemic: September 2014 to August 2022. Cardiff: Welsh Government. Available at: https://www.gov.wales/summary-absenteeism-school-and-during-coronavirus-covid-19-pandemic-september-2014-august-2022-html (Accessed: 20 February 2024).

Welsh Government. 2023. *NEST framework. Full report.* Welsh Government: Cardiff.

Wester, K.L., Morris, C.W. and Williams, B. 2018. Nonsuicidal Self-Injury in the schools: A tiered prevention approach for reducing social contagion. *Professional School Counselling*, 21 (1), pp.142-151. doi: https://doi.org/10.5330/1096-2409-21.1.142

Westers, N.J. and Plener, P.L. 2020. Managing risk and self-harm: Keeping young people safe. *Clinical Child Psychology and Psychiatry,* 25 (3), pp. 610-624. doi:https://doi.org/10.1177/1359104519895064

Westlund Schreiner, M., Klimes-Dougan, B., Begnel, E.D. and Cullen, K.R. 2015. Conceptualizing the neurobiology of non-suicidal self-injury from the perspective of the Research Domain Criteria Project. *Neuroscience and Biobehavioural Reviews,* 57, pp. 381-91. doi:https://doi.org/10.1016/j.neubiorev.2015.09.011

Whitehead, M. and Dahlgren, G. 2007. *Concepts and principles for tackling social inequities in health.* Geneva: World Health Organization.

Whitlock, J., Exner-Cortens, D., and Purington, A. 2014. Assessment of nonsuicidal self-injury: Development and initial validation of the Non-Suicidal Self-Injury–Assessment Tool (NSSI-AT). *Psychological Assessment,* 26(3), pp.935–946. doi: https://doi.org/10.1037/a0036611

Willis-Powell, R., Fox, A., and Cerel, J. 2022. `Disclosure of youth suicidality: Views from lived experience`, in Ackerman, J.P. and Horowitz, L.M. eds. *Youth suicide prevention and intervention.* Springer: Cham Switzerland, pp.161-169. doi: https://doi.org/10.1007/978-3-031-06127-1_18

Windfuhr, K., Steeg, S., Hunt, I.M. and Kapur, N. 2016. `International perspectives on the epidemiology and aetiology of suicide and self-harm`, in O' Connor, R.C. and Pirkis, J. eds. *The International Handbook of Suicide Prevention.* Chichester: Wiley-Blackwell, pp.36-pp.60.

Witt, K.G., Hetrick, S.E., Rajaram, G., Hazell, P., Taylor Salisbury, T.L., Townsend, E. and Hawton,K. 2021. Interventions for self-harm in children and adolescents. *Cochrane Database of Systematic Reviews*, 3, CD013667 (101pp).doi:https://doi.org/10.1002/14651858.CD013667.pub2

WJEC CBAC. 2016. *Welsh Baccalaureate Foundation (Post-16): Specification.* Cardiff: WJEC CBAC Ltd.

WJEC CBAC. 2022. *Welsh Baccalaureate National/Foundation: Specification.* Cardiff: WJEC CBAC Ltd.

Won, G.H., Bae, S., Kim, H.K. and Choi, T.Y. 2023. Subcortical volume analysis in non-suicidal self-injury adolescents: A pilot study. *Psychiatry Research: Neuroimaging,* 331 (7pp). doi:https://doi.org/10.1016/j.pscychresns.2023.111617

World Health Organization (WHO). 2005. *TEACH-VIP. Training, Educating and Advancing Collaboration in Health on Violence and Injury Prevention. User's Manual.* Geneva: World Health Organization.

World Health Organization (WHO). 2008. *Closing the gap in a generation. Health equity through action on the social determinants of health.* Geneva: World Health Organization.

World Health Organization (WHO). 2010a. *A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice).* Geneva: World Health Organization.

World Health Organization (WHO). 2010b. *Youth-friendly health policies and services in the European Region*. Geneva: World Health Organization.

World Health Organization (WHO). 2012a. *Public health action for the prevention of suicide.* Geneva: World Health Organization.

World Health Organization (WHO). 2012b. *TEACH-VIP2. Training, Educating and Advancing Collaboration in Health on Violence and Injury Prevention. User's Manual.* Geneva: World Health Organization.

World Health Organisation (WHO). 2012c. *Making health services adolescent friendly. Developing national quality standards for adolescent friendly health services*. Geneva: WHO.

World Health Organization (WHO). 2015a. *Building and adolescent competent workforce.* Geneva: World Health Organization.

World Health Organization (WHO). 2015b. *Global standards for quality health-care services for adolescents: a guide to implement a standards-driven approach to improve the quality of health care services for adolescents*. Geneva: World Health Organization.

World Health Organization (WHO). 2016. *Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm.* Geneva: World Health Organization.

World Health Organization(WHO). 2017. *WHO recommendations on adolescent health*. Geneva: World Health Organization.

World Health Organization (WHO). 2018. *Preventing suicide. A community engagement toolkit.* Geneva: World Health Organization.

World Health Organization (WHO). 2020a. *WHO methods and data sources for global burden of disease estimates 2000-2019*. Geneva: World Health Organization.

World Health Organization (WHO). 2020b. *Guidelines on mental health promotion and preventive interventions for adolescents*. Geneva: World Health Organization.

Yang, L., Jia, F., , Lu, X. and Jia, C. 2023. Internalizing and externalizing problems mediate the relationship between maltreatment and self-harm among UK adolescents. *Affective Disorders,* 333, pp. 240-248. doi: https://doi.org/10.1016/j.jad.2023.04.046.

Yao, L. and Kabir, R. 2023. Person-Centred Therapy. Available at: https://www.ncbi.nlm.nih.gov/books/NBK589708/

(Accessed: 22 February 2024)

Young Minds. 2021. *A guide for young people. Supporting a friend with their mental health.* Available at: https://www.youngminds.org.uk/young-person/supporting-a-friend-with-their-mental-health/(Accessed: 1 November 2021).

Young Wales. 2017. *Children and Young People's National Participation Standards*. Cardiff: Welsh Government.

Yucel, R. 2018. Scientists' ontological and epistemological views about science from the perspective of critical realism. *Science and Education,* 27, pp.407–433. doi:https://doi.org/10.1007/s11191-018-9983-x

Zsamboky, M., Haskell, B., Vick, R. and Schroer, M. 2021. Treating child and adolescent depression and anxiety in primary care. *Journal for Nurse Practitioners,* 17, pp. 54-59. doi:https://doi.org/10.1016/j.nurpra.2020.08.019