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**Barriers to adolescent self-harm preventative work
in secondary schools in Wales:
A GROUNDED THEORY MODEL OF STIGMA**

REPORT

FOR THE JOURNAL PAPER

Parker, R. 2018. 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.



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TITLE: 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.

ABSTRACT PAPER SUMMARY:

Objectives. Qualitative research and grounded theory analysis of secondary school staff and pupil perceptions about the barriers to preventative work for adolescent self-harm within the secondary school setting in Wales.

Study design. Qualitative and Grounded Theory.

Methods. Two secondary schools in Wales were purposefully sampled for variation. Four group interviews took place using qualitative research methods (Participatory Rapid Appraisal) with six school-based professionals and six post-16 year old students. Three pupil participants had long-term experience themselves of self-harming behaviours, all the remaining participants had encountered pupils who self-harmed. The research interviews were transcribed verbatim, generating school-context-dependent information. This was analysed through the logic of abduction using the constant comparative grounded theory method due to its ability to focus upon axial coding for context.

The ontology that shaped this work was critical realism within a public health paradigm.

Results. A theoretical model of stigma resulted from the grounded theory analytical process, specifically in relation to staff and student perceptions about adolescent self-harm within the institutional context. This meant that social-based behaviours in the secondary school setting centred upon the topic and behaviour of adolescent self-harm were structured by stigma.

Conclusions. The findings of this study offer an explanation upon the exclusion of adolescent self-harm from preventative work in secondary schools. The stigma model demonstrates that adolescent self-harm is excluded from the socio-cultural norms of the institutional setting. Another term for this when applying the UK's Equality Act of 2010 is discrimination. Further research on the institutional-level factors impacting adolescent self-harm in the secondary school context in England and Wales is now urgently needed.

• **Keywords.** Self-harm, Adolescents, School, Grounded Theory, Stigma, Public Health.

Figure 1: THE GROUNDED THEORY STIGMA MODEL

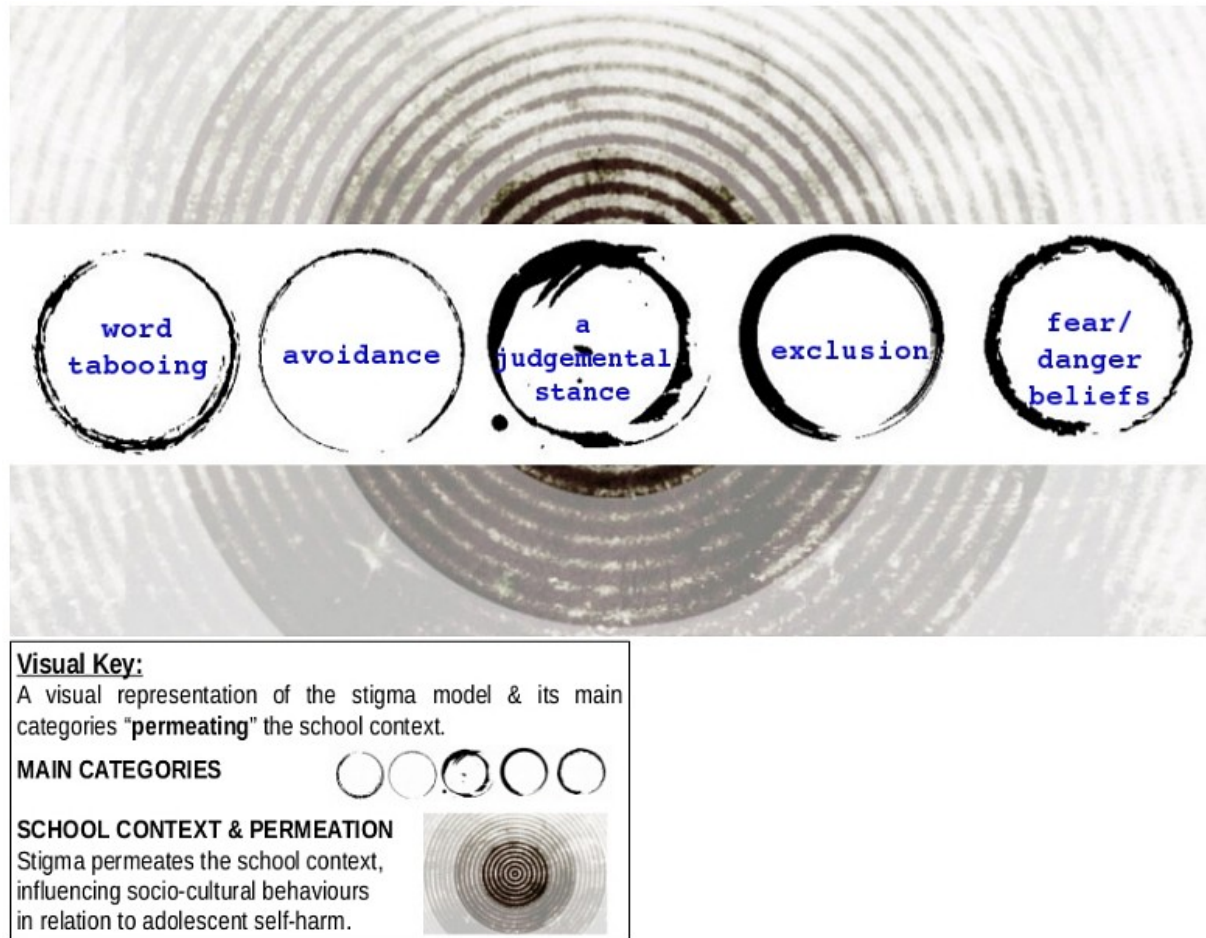







FIGURE 1 DETAIL: This is a visual representation of the **grounded theory model of stigma**, drawn from staff & student perceptions. The model permeates socio-cultural behaviours in relation to the topic & behaviour of adolescent self-harm within the secondary school context. The TABLE below outlines the stigma model's main & sub-categories.

Main categories:	Summary detail:	Sub-categories:
	Avoidance of the word "self-harm" within the interview settings.	Replacement words – use of "it" & euphemisms. Long pauses – these are centred around the oblique or non-oblique word usage. Physical discomfort gestures.
	Social interaction-based behaviours to physically avoid or limit contact with the topic.	Refusal to engage with the topic. Keeping a physical distance. Excluding the person from social norms. Only specialists being used to deliver care & support. Passivity & inaction.
	Negative judgemental behaviours centred upon the topic.	Minimisation. Negative joking behaviours – these belittle the seriousness of adolescent self-harm. Direct criticism – includes "extreme" labelling.
	Public exclusion of the topic from the whole-school arena.	Topic not taught in whole-school context. Training not given in whole-school context. No public information is being given about the topic – this includes no public signposting to facilitate help-seeking behaviours or recovery.
	The topic evokes a negative emotional response of fear and/or danger.	Dangerous topic belief – belief it can't be taught safely in schools, includes contagion fear. Stigma fear. Panic response – impacts rational response to working safely with the topic & behaviour. Fear the potential complexity of the behaviour & topic – fear of not being able to work safely because of this.

Summary Overview. *This is the report for the journal paper:*

Parker, R. 2018. 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.

This report delivers in-depth detail, discussion and recommendations about the results of the research project, the Grounded Theory Stigma Model.

PROJECT BACKGROUND: In 2016 the GW4 alliance (the research consortium of Bristol, Cardiff and Exeter universities) surveyed 148 UK secondary schools to ascertain their adolescent self-harm interventions and future support needs. This demonstrated that currently UK schools do very little work to prevent or raise awareness of adolescent self-harm, highlighting the need to understand the school-based context more fully in regards to adolescent self-harm (Evans et al. 2016*ab*). The current small-scale qualitative study was designed to begin to address this research gap, to build upon the GW4 work and to explore the potential contextual factors impacting a whole-school preventative support approach for adolescent self-harm (Moore et al. 2015). The project also accessed the perspectives of secondary school pupils, which had not been feasible within the initial GW4 study.

PART 1: The Grounded Theory Stigma Model.

The results of this small-scale qualitative research study delivered **a theoretical model centred upon the concept of stigma**, and delineated its categories and sub-categories within the secondary school context. Staff and student perceptions about adolescent self-harm were structured by the stigma model, shaping the social-based behaviours within the secondary school setting in regards to adolescent self-harm.

The model gives the specific details of the stigma-informed behaviours in relation to adolescent self-harm, meaning that the topic is excluded from the whole-school public environment, the consequence of which is that no whole-school preventative work is being undertaken.

Figure 1 on page 4 of this report is a visual representation of the Grounded Theory Stigma Model.

The visual representation also aims to portray a particular aspect of the model, using the analogy of “permeation”: the stigma model **permeates** socio-cultural behaviours in relation to the topic & behaviour of adolescent self-harm within the secondary school context.

Five main categories define the theoretical model of stigma and include:

1. **Word tabooing** - the actual use of the term self-harm is avoided in the interview conversation.
2. **Avoidance (individual)** - these are individual techniques/behaviours used to physically avoid the topic and behaviour of adolescent self-harm.
3. **A judgemental stance** - this involves negative judgemental behaviours centred upon the topic and behaviour of adolescent self-harm.
4. **Exclusion (public)** – this is the adolescent self-harm topic exclusion within the whole-school public arena.
5. **Fear and/or danger beliefs** – the topic and behaviour of adolescent self-harm evokes a negative emotional response of fear and/or danger.

A detailed exposition of the stigma model will now be undertaken, structured within five sections that each correlate with one of the five main categories of the model. Examples are provided to illustrate each point, using selected quality extracts from the interview transcripts, which includes context-based analysis and discussion. In this way, the grounded theory stigma model and its impact upon the topic and behaviour of adolescent self-harm is evidenced. Sub-categories expound the specific dimensions and variants within each of the main categories (Corbin and Strauss 2015). At present there is no hierarchy within the categories and sub-categories, further research would need to take place to investigate this further.

1.The model category of “word tabooing”

Word tabooing existed within the school context setting, which meant both students and staff at times avoided the actual use of the word “self-harm” within the research interviews. There were a number of sub-categories to the main category of word-tabooing behaviour which included: *replacement words* (the use of “it”, and euphemisms); *long pauses* (which centred around the oblique or non-oblique word usage) and *physical discomfort gestures*.

Replacement words included the pronoun “it” being used for the word self-harm, both as a descriptive label in noun form, and also as a verb, meaning the action of self-harm. The following two extract examples show this in action.

Student Group A - Extract 1.1

P3: Because everyone is keeping really quiet about it¹. And they are like, "Oh, I don't want to be really open about it, because then everyone is talking about it".

Student Group B - Extract 1.2

P1: That's the thing. It's² very awkward to talk about in, like, every sense of the word. I think that's just been from how it's been dressed for so long in society.... a lot more people will be like it's less taboo to speak about it in an educated way, but it's still awkward.

P2: There is like, even though more people are talking about it, there is still negative ideas surrounding it obviously. Umm.. .. but it's it's very difficult to talk about in school, because it is not talked about.

The meaning within these two extracts offer contextual explanations in regard to the word-tabooing. In the first extract, this describes the silence and secrecy surrounding the topic, due to the perceived impact if it emerged from the private into the public social domain. An individual cannot control or manage the public interest and response to the private and personal event (which would be sensitive and confidential information). The perception of the risks stemming from the initial disclosure is that information would spread throughout the whole school environment, as a public topic of interest. There is evidence (extract 1.3) that this would indeed be the response (*extract 3.12 also includes the negative impacts stemming from public gossip*).

Student Group B - Extract 1.3

P3: Yes, there are lots of people who act like, "oh my gosh, do you know so-and-so, they did it".

P2: And they go, "are you alright? How are you?".

P3: They are like, "Have a look, can you see anything?". And that kind of thing.

Researcher: And that's not helpful?

P2: If there's like a rumour going around school, like somebody has done it, people are like on the watch for it. And it's not in a protective way. It's not like, "I'll make sure they are O.K", or checking.

P3: It's for gossip reasons.

Staff mirror the word-tabooing, as the following extracts show (1.4 and 1.5) in the use of replacement words (including euphemisms) and long pauses (relevant pauses are italicised).

1 i.e adolescent self-harm

2 i.e adolescent self-harm

Staff Group A - Extract 1.4

S1: Yes. If home is the problem that is causing (*long pause*)....the...the cry for help³, then clearly we are not going to ring home immediately.

Staff Group A - Extract 1.5

S1: Yes. I think if they are that low that they have chosen that way to (*long pause*).... you know⁴. I mean, I'm not saying the only reason they would do it is to get some attention. Because they are not coping. Sometimeserm (*long pause*)....I've had students that say it's actually almost become an addiction. Er, and they are fearful of what could happen if they took it too far. There are also some that have said "It feels nice, so if I'm not gonna do that, what can I do?". Because they've found something that actually they've said as the blood came out that they felt a release. And they are scared of that "lovely" feeling being taken away. How can they get that from .. pinching an elastic band, or do you know what I mean? So it's exploring that. It is very individual I would say.

In extract 1.5 the member of staff is attempting to talk within an interview framework to the interviewer about what her pupils have told her about their acts of adolescent self-harm, in an attempt to make sense of it through their viewpoints. The blood is discussed, which for some people could be sensitive and potentially distressing detail (McCosker, Barnard and Gerber 2001). However, even when talking about the actual consequence of the act of self-harm (the blood coming out) this staff member still chooses not to use the word "self-harm". This could demonstrate the two differing social rules in action here, between on the one hand talking about blood (the consequence of the self-harm), and on the other using the actual term "self-harm". This could also be argued to demonstrate the strength of the word-taboo, which is potent enough for the word "self-harm" not to be used, even at the same when talking graphically about the consequence of the act. This strength is shown in the extract 1.6 where physical discomfort behaviours are evidenced – a "group grimace" takes place. This emotion-based facial expression is copied (and learned) by each member of the group, and is a form of non-verbal social communication behaviour situated upon thinking about self-harm in their school setting.

Student Group A - Extract 1.6

In this part of the interview, all three pupils were watching each other closely. Prior to this point, they had been looking at the researcher. As P1 spoke the opening line below, firstly P1 and then P2 each made a physical movement with their face, wrinkling up their noses. P3 copied P1 and P2 facial expressions. This appeared (from the researcher outsider view) like a group of individuals doing a group "grimace" response, starting from P1. It was very brief, and very fast. This "mirrored" physical response appeared to pass from one to another immediately, "like a wave" during the following discussion.

3 Euphemism for adolescent self-harm.

4 Euphemism for adolescent self-harm.

P1. Err, there has been slight ... I wouldn't say serious, serious self-harm. But there has been (long pause).... people in the past have(long pause) done it, slightly in school.

P3: Yes.

P2: Yes.

P1. I think it was almost more just for attention.

P2: Yes.

P1: Not because they were.... (long pause)

P2: Distressed.

2. The model category of “avoidance”

The model category of avoidance involves social interaction-based behaviours on an individual level that were used to physically avoid or limit contact with the self-harm topic and the behaviour. Its sub-categories included: *a refusal to engage with the topic*; *keeping a physical distance* (and giving reasons/excuses why); *excluding a person from social norms* (on grounds of the behaviour and topic); *specialists being used to deliver care and support*; *passivity and inaction*.

In the interviews there was recognition of some staff's refusal to engage with the topic within the school context. For example:

Staff Group A - Extract 2.1

S1: That's why, it's⁵ not something I think ... you couldn't train every person in school to be empathetic ...when ... some teachers don't want to know anyway, and they don't see it⁶ as part of their role. I wouldn't see the point in every teacher going through training.

Extract 2.1 demonstrated how a refusal to engage with the topic might negatively impact the ability to deliver effective whole-school staff training about adolescent self-harm. It also highlighted a key issue in the need for empathy when working with self-harm, which may not be available at times. This links to wider research literature that raises the issue of barriers to an empathetic response to self-harm that are present, including within clinical health settings (Owens et al. 2016). This response of not wanting to know, and its correlation with what teaching staff feel is their professional role and responsibilities means that the topic can be made invisible by staff (see extract 2.2). This is a point which is similarly evidenced in a recent qualitative research systematic review completed by Evans and Hurrell (2016) .

5 i.e. adolescent self-harm

6 i.e. adolescent self-harm

Staff Group B - Extract 2.2

S2: I sometimes feel that self-harm is invisible to lots of people in school.

Researcher: So invisible to other staff? To pupils?

S2: I don't think to other pupils, I think to staff.

Researcher: Why do you think that is?

S1: Um... I guess sometimes it might come down to perhaps.... I'm talking out of turn here I'm putting myself in someone else's shoes to what extent they feel um (long pause).... it's their kind of central purpose.

All school professionals should be fully aware of their safeguarding responsibilities, and have a duty of care to their pupils. Deliberate avoidance mechanisms to make adolescent self-harm invisible within the school context would be a breach of these duties. In extract 2.3 staff members acknowledged this issue, and gave two potential reasons for the refusal to engage which included a lack of training, and the complexity of a topic that could be potentially beyond their professional capacity and skills. Both of these aspects could impact staff's ability to keep a pupil safe, and which might explain why staff are attempting to place themselves at a physical distance from both the topic and self-harm behaviour.

Staff Group B - Extract 2.3

S1: It's very difficult, because everyone is very aware of their safeguarding responsibilities. So it's kind of running counter to that. It's a bit of a subtle one really. I think it might come down to feeling unskilled. In kind of just you know what am I dealing with, and maybe feeling very apprehensive about the whole thing⁷. And so perhaps that creates a sort of distance there. Without you wanting to distance. But um it's just like a whole can of worms that really you are thinking, "Oh my God, how do I deal with this⁸, without making it a lot worse?"

S2: And I think that is one problem, that staff feel that perhaps they are afraid that they may make it⁹ worse. Also, if they do talk about it, the incident¹⁰ might increase, or become more severe.

Other staff members keep a physical distance from making any contact with a pupil who self-harms, but fulfil their duty of care by passing on their surveillance information to a key staff member who they feel are professionally capable of safeguarding and supporting that pupil (extract 2.4).

7 i.e. the self-harm "incident"

8 i.e. the self-harm

9 i.e. the self-harm

10 i.e. the self-harm "incident"

Staff Group A - Extract 2.4

S2: Schools want a key team of trained staff to deal with teen self-harm.

S1: That's just from talking to teachers who have spotted self-harm. The ones that I've spoken to don't feel they can approach it, but they will phone me, and they say, "do you know?". And I say, "it's fine, they are getting support". ... And they've said, "Oh, I didn't know that¹¹ was rife in school", or something like that. And then they say "thank you for this". Because they don't feel they can broach it¹² with the pupil..... And I've said, "it's fine, it's ...it's¹³ being dealt with".

The behaviour of staff in keeping a distance from the topic of self-harm could be accentuated by some staff's wish to have a key person and/or team with the professional skills and knowledge to work with the topic. Unfortunately this approach limits the rest of the teaching staff from developing their skills and knowledge about adolescent self-harm, and keeps the distance (and topic exclusion) in place. There are inherent qualities that these key staff members are to have, such as the ability to stay calm, but it was difficult for staff to articulate any others, as extract 2.5 demonstrates.

Staff Group B - Extract 2.5

S2: Another thing I feel that is a barrier for school is that ... um ... a few key people perhaps have had adequate training¹⁴, but a huge amount of people haven't. So I think really, that is something else. I think as well that those persons have to be a certain "type" of people um I don't know what the qualities are.... but it has to be somebody who is knowledgeable and calm. And perhaps I suppose this would come with the training it's not, "Oh my God, I've got to DO something!". But we do have to do something about it¹⁵.

By defining the professional as needing to have certain unquantifiable and specialist qualities, which include the ability to be empathetic (such as defined in extract 2.1) which training may or may not be able to equip all school professional with, this begins an "othering" process that defines a pupil with self-harm as different, excluding the person from conventional social norms. Also, if a behaviour is stigmatised, like adolescent self-harm, this negatively impacts empathy (Davis 2015) – there is a social learning aspect that creates an automatic negative appraisal of the stigmatised topic, which accentuates the social exclusion and "othering" processes.

11 i.e. adolescent self-harm

12 i.e. the self-harm

13 i.e. the self-harm

14 i.e. adolescent self-harm training

15 i.e. about the adolescent self-harm

Passing the topic and behaviour of self-harm across to specialist trained staff and external experts is a professional distancing process taking place within the school context. There is a clear acknowledgement of school staff not having the professional skills to work with self-harm (extract 2.6), and the need for this to be provided externally. School staff attempt to access external specialists (which they have to fight for – see extract 2.6), who they perceive are the relevant professionals to work with individual cases of adolescent self-harm (and not schools). In this manner, adolescent self-harm is professionally ring-fenced as a topic and behaviour for the external professional experts (and clinical settings) only, which although understandable given the limitations in school staff's current skills and knowledge, is problematic given that adolescent self-harm resides in a section of the population group within the school context. Some of this population will become visible to school professionals, but the majority will not. The “invisible” population group will have no access to the specialist trained staff and external experts, nor be able to receive support from within the important community context here, given the lack of a whole-school preventative approach to adolescent self-harm.

Staff Group B - Extract 2.6

S3: That's how I approach it¹⁶ now. I go straight to CAMHS. I now find a lot of GPs will bounce it¹⁷ back, so I tend to say now, if I think it's urgent, I ring the mother. I say she needs an appointment with the GP today. I'm concerned about x,y and z. Therefore she needs an urgent referral. And I contact the CAMHS. Again, I'm not specialist trained.

A further issue is the current UK health and social care resource challenges, in particular with Child and Adolescent Mental Health Services (CAMHS), which means “specialists” are in extremely limited supply (British Psychological Society, 2014; House of Commons Health Committee, 2014). Schools may be left in the position of having to provide the support (extract 2.7), working outside of their professional boundaries and expertise, in the absence of external resource availability (with the limited training they have had, as in these two schools). This accentuates staff perceptions of their lack of professional skills in working with the complexity of adolescent self-harm, as they are faced with attempting to deliver care and support, for a student's potentially complex psychosocial situated behaviours. These behaviours may take place across a number of contexts, have a range of complex factors, which are beyond teaching staff's current professional capacities, and for which they also do not have the full legal mandate to work with.

16 i.e. adolescent self-harm

17 i.e. adolescent self-harm

Staff Group B - Extract 2.7

S2: We have a waiting list for our school counselling service. CAMHS have long waiting lists. GPs will often bat back these referrals.

S1: That's right

S3: I've had that happen today at school.

S2: As teachers, I've done some training, you've done some training. I still don't feel that I'm an expert in any stretch of the imagination.

S1: And you really worry about the consequences of...of...¹⁸ of... somebody being brave enough to ... to refer themselves, or to sort of say that there's some kind of a ... an issue¹⁹ ...that they need help with. And then what happens when you say, "well, yes but that help is several months down the line".

Staff carry additional burdens if their attempts to elicit external support are rejected or delayed. Their help seeking behaviours on behalf of their pupils are actively denied by other services. This has the potential to decrease staff's capacity for effective action. If professional requests for help are rejected, and if staff feel they are not trained, it risks incapacitating these school-based professionals.

In sharp contrast, at the same period of time this research study was taking place, the Cabinet Secretary for Health, Well-being and Sport stated that the Welsh Government had "made great strides in recent years to improve and speed up access to services for young people who may present as a result of self-harm or suicidal ideation" (National Assembly for Wales 2017). This perspective is at odds to the picture being described by the core front-line staff in the two schools in Wales within this small-scale study, and also in the recent GW4 study that included over 90 secondary schools in Wales (Evans et al. 2016ab). The GW4 study found that CAMHS have high thresholds in relation to adolescent self-harm, and significant treatment access delays of several months, which are barriers to schools gaining access to specialist services for their pupils (who school-based professionals have judged as needing specialist support, which they do not possess in-house within the educational setting), as well as posing serious health risks to pupils. Schools are left on their own to manage this challenging situation, which they are ill equipped to undertake. **Meaningful community-based consultation and communication to share these differing perspectives between government and school-based staff (as well as including pupils, carers and parents) would be an important first step to understanding this situation clearly, so planning can take place to address it.**

¹⁸ i.e. adolescent self-harm

¹⁹ i.e. adolescent self-harm

School staff may therefore be left in the difficult situation of explaining to pupils why their attempts at gaining support for them have not succeeded. This could mean managing the consequences of this “professionalised” rejection process for a vulnerable pupil, potentially making the initial situation worse. These issues may accentuate staff’s avoidance behaviours.

These themes are reflected in pupils’ experiences when their help seeking behaviours have been rejected (extract 2.8). Furthermore, within this group, these pupils have lived experience of self-harm and suicide attempts. ***The erosion of pupils’ help-seeking behaviours stemming from their experiences within the school context presents risks to their recovery and well-being*** (Rusch et al. 2014).

Student Group B - Extract 2.8

Researcher: So what does that make somebody feel when help is [offered]

P2: [And not] followed up.

P3: Annoyed.

P2: It’s very frustrating.

P3: Like you are kind of stuck. Like your problem doesn’t really matter. So you kind of shy away from asking for help.

P1: Yes.

P2: It puts you off asking for further help when you’ve already asked.

P3: Yes. So then after that happens, when they say, “are you O.K?”, you are like “yeah” when you are really not.

P2: That’s as sometimes as far as it will go. Somebody will just ask you, “are you O.K now?”. If you answer “yes”, even though you are not, they will be like, “O.K they are fine”.

P1: It mirrors my experience. It takes away from, like, you are a person. You have got thoughts and feelings. It doesn’t feel like they acknowledge that.

One reason why the school referrals for support services are being rejected is explained by the current UK restrictions upon health and social care services (House of Commons Health Committee 2016; Welsh NHS Confederation 2015). These service restrictions stem from the “colossal” funding challenges that face health and social care, which have arisen through the recent spending reviews and large budget cuts to these services (House of Commons Health Committee 2016; WLGA and ADSS Cymru 2017). These “austerity measures” have negatively impacted health and social care budgets in England and Wales (Wales Public Services 2017). A few examples of restrictions include: workforce supply issues (and cuts to their training), problems in service reconfigurations (undertaken in an attempt to reduce budgets) and the provision of effective joined-up services; and

people not receiving care because of the significant lack of resources available (House of Commons Health Committee 2016). This may mean even higher criteria thresholds for any school-based referrals, which again means schools are left trying to support pupils with no external services or additional resources available, with their own limitations in capacity. At the same time, there may be rising levels and complexity of self-harming behaviours for schools to work with (extract 2.9).

Staff Group B - Extract 2.9

S1: We are kind of swamped...

S2: And with supporting them. I think self-harm is ...well, I'm not saying it's new, because it's not new. But it's becoming a bigger issue. And because we are becoming aware of more pupils that are doing it as a way of coping with whatever, I think we'd like to have the right answers, wouldn't we?

S3: We deal with self-harm frequently.

S1: Yes.

Researcher: Do you think there has been an increase?

S1: Yes.

S3: And in severity. I am seeing more of it. And I've been Head of Year for years and years now. I am definitely seeing more of it that I used to. And more younger pupils doing it. And anorexia. 11, 12 year olds, to hospitalisation level. Which you just don't think. ... you know ... that wasn't happening, going back six or seven years ago.

School may therefore be overstretched in their support provision, taking the strain due to the issues in the wider system, and the increasing numbers of pupils needing support (extract 2.10).

Staff Group A - Extract 2.10

S3: You can go over there (to the school's pastoral support) and it's absolutely crazy. They are dealing with something like this²⁰, and also with somebody testing for their sugar levels. They are dealing with somebody who needs another print out of their timetable, from one end of the spectrum to the other. And they have had to learn to juggle all of that. And deal with massively sensitive things like this.

This mirrors the recent evidence given to the House of Commons Health Committee (2017, SPR0131) which stated that UK schools are “*facing a ‘perfect storm’ where, despite the growing number of children and young adults who require mental health support, cuts to the funding of both NHS and local authority early intervention services mean that increasing numbers of children are unable to access appropriate and timely support*” (submission by NHS Providers 2016, point 10).

20 i.e. adolescent self-harm

The negative consequences stemming from these issues may include a lack of external support or ability to provide system-level planning to address the need in schools (including the provision of high quality training for all school staff), as well as the school system being overloaded by competing demands. This means school capacity issues and shortages may arise in the face of an increase in student self-harm coming to staff attention. These could be potential explanations for the avoidance behaviours by some professionals, which also include passivity and inaction (seen in extracts 2.11 and 2.12). Pupils posit the reason for these behaviours as being linked to staff being unqualified, and not having the professional competencies to work with self-harm. Some pupils may therefore be unaware of the reasons for this situation in regards to the resource capacity challenges their schools are facing.

Student Group B - Extract 2.11

P2: There's a lot of instances where someone will mention something²¹ to a teacher, and it will be completely dismissed and forgot about. So somebody's thinking that they are waiting for help, but there is nothing going on.

P3: And then they just kind of stop, and like that's it.

Researcher: And then what happens to that person who thinks that they are getting help?

P3: Well they feel worse then they did.

Student Group B - Extract 2.12

The pupils here are reflecting upon the experience of not gaining access to the school counsellor.

P1: I think for this case²², I don't even think it was even brought to the counsellor. To get to the counsellor, you normally tell a teacher, and then they talk to one of the teachers who communicates with the counsellor. I think it only got as far as the communicator.

Researcher: So they didn't make a referral to the counsellor at that point?

P1: No. I went to the GP, but nothing happened....

P2: I find it personally that it can knock you down if you do go to someone for advice and they are like, "No, I can't help you".

P3: Yes.

P2: And I feel that they should advise you to go elsewhere, even if it's a phone number you can call.

Researcher: Why do you think they say they can't help you?

P2: I don't think they have the correct qualifications, or practice to work in certain cases.

21 i.e. adolescent self-harm

22 Pupil is reflecting upon their own historical case, which involved self-harm.

3. The model category of “a judgemental stance”

The third category of the stigma concept is a judgemental stance, which involves the use of negative judgemental behaviours by school professionals and students centred upon adolescent self-harm. It has the following sub-categories: *minimisation*; *negative joking behaviours* (that belittle the seriousness of adolescent self-harm); and *direct negative criticism* (this includes extreme labelling).

When some pupils and staff interact with adolescent self-harm they use a process of minimisation, and also create an artificial measurement system in which rapid dichotomous judgements can be made about the level and reason for self-harm, in regards to its seriousness. This was apparent in extracts 1.6, 3.1 and 3.2 with levels and reason being assigned as: “not serious”, “slight”, “superficial”, “low level”, and “for attention”.

Staff Group A - Extract 3.1

S2: And these two girls were both girls that had “self-harmed”.

At this point the staff member physically made a “quotation marks” gesture with her fingers.

And the one had copied the other one. So we think, and the mum thinks as well. And it's very, very superficial.

Researcher: So when you just said self-harm, and you said it was superficial, you just made two gestures, like quotation marks, to mean that it was “superficial”.

S2: Yes. Very superficial. Hardly scratches.

Staff Group A - Extract 3.2

S3: Because I think something we (that is S1 and S3) have come across, and I am sure teacher Y (S2) has too, there are two distinct groups. Isn't there? There's the group with genuine mental health issues, that do it²³ to help them feel better. And then you've got other groups that do it, I shouldn't say this I suppose because it's not PC, for attention ...for attention seeking, and it's a low level behaviour.

These artificial sorting strategies (centred upon the idea that there is some sort of threshold level of self-harm that makes it “authentic”) have little basis in self-harm psychosocial assessment models (NICE 2013), and demonstrate that school staff are currently working beyond their professional skills and capabilities with adolescent self-harm. A judgement is delivered on the “authenticity” of self-harm. Self-harm for “attention seeking” was not seen as a credible reason, which was separate from self-harm to a “level” which demonstrated distress. This discursive dualism between authentic/non-authentic self-harm is noted in research (Scourfield et al. 2011), and can stem from

23 i.e. self-harm

moral judgements which are stigmatising. It could also negatively impact staff, student and parental help-seeking behaviour for a pupil's potentially complex needs. The consequences of these judgements upon pupils who experience self-harm behaviours mean that they are made to feel worthless, as shown in extracts 3.3 and 3.4 through the use of the analogy of being "brushed off", like a speck of dirt or dust.

Student Group B - Extract 3.3

P2: It's like .. um ... I feel like people are either entirely brushed off, like "oh it's nothing. It's just them, they are doing it²⁴ for attention".... There are people that speak .. I know it's difficult to talk deeply about something .. but there are people who just speak far too light-hearted about it²⁵.

P3: Yes.

P2: As if it's²⁶ not an actual problem. Cos I've had ... (clears throat by two coughs), I've had someone ask me directly about it. Like how I feel about it. And I felt that they were not interested in anything I had to say.

Minimisation also included responding in a shallow manner that ignored the seriousness and actual content of the self-harm disclosure; self-harm was not taken seriously (extract 3.4). Pupils share their experiences and feelings of anger about this:

Student Group B - Extract 3.4

P3: There was an incident²⁷ last year .

P1: Was it last year?

P3: Yes. Where "someone"²⁸ wasn't having a great time. So that someone went to the head of year, had a full blown meltdown, and just said, "I can't do it any more. I'm done". And she literally said, "Oh don't say that, year 10 have it harder" some people don't realise when they feel like that that they've got a problem. But at that point, that person knew [they needed help],

P2: [yes]

P3: Because what they were thinking was not right. They were like, "I can't...". To be brushed off like that...

At this point, P1 physically shifted her position and angrily stretched her whole body and arm across the table, with a clenched fist.

24 i.e. adolescent self-harm

25 i.e. adolescent self-harm

26 i.e. the self-harm

27 The pupil is referring to a historical self-harm and suicide incident.

28 Pupil using third-person mechanism to talk about their historical experiences safely, that was part of the interview safety planning.

P1: It's just reminded me of something. Another "case"²⁹. A student was in a lesson, they were talking to the teacher. And the student had a history of all these things³⁰, she had been through the whole process. They told the teacher that they were seriously going to end their life that day. And the teacher responded with, "is that going to take time away from doing your coursework?"

P3: I that person (in an angry tone) ohhhh(hits the desk in frustration with her hand).

Negative joking behaviours are used to trivialise and belittle the topic of adolescent self-harm, as is shown in the following:

Student Group B - Extract 3.5

P3: I've seen a lot of people joking about it³¹.

P2: Yes.

P3: Which makes me sick. Because obviously ... like... they don't know.

P1: It's people who have not gone through the experience.....

P2: Because obviously our generation, we like to joke about everything. We don't take anything seriously. Um ... but there is like a sort of a line that there is, that is being crossed. And a lot of people don't understand that it is very upsetting.....

P1: It trivialises it, doesn't it? It's not a thing, it's a joke now.

P2: It makes it a topic of comedy when it shouldn't be.

Reasons for the negative joking behaviours are posited by pupils in extracts 3.6 and 3.7, with the second extract drawing attention to the lack of support resources in schools, or joined-up support provision, that staff are fully aware of, placing them in a role of enforced helplessness.

Student Group B - Extract 3.6

P2: I think people tend to make fun of those who self-harm because they can't deal with it themselves. They can't deal with the idea someone would do that. So they try to make it a joke.

Student Group B - Extract 3.7

P2: They (school professionals) are not qualified to cope with it³², and they don't have anyone in the school to refer you to either. So it's not like they can be like, "oh, I am concerned, can you go and talk to ... blah blah". Because there is not even that. Cos ... even at this level ... the most they can do is suggest that you go to see the GP. They've got no promise that you are actually going to do that – they can't check. So I think that the way that they deal with it, they just pretend that it's a joke, like.

29 As footnote 28.

30 i.e. suicide and adolescent self-harm

31 i.e. adolescent self-harm

The existence of minimisation and negative joking behaviours mean that the environment can be primed to deliver direct negative criticism against self-harm, which includes it being termed as "selfish" (extract 3.8), or shameful (extract 3.9), as well as the use of intrusive questioning to deliver assumptive judgements (extract 3.10). Direct criticism also includes judgemental labelling of the behaviour as "extreme" (extract 3.11).

Student Group B - Extract 3.8

P1: There's like a group of people who are connected by this one opinion. Like, if you do it, you are selfish, you are childish.

P2: P3: [yes]

P2: There is a view that it is very selfish. Like, "oh you are only thinking about yourself, how do you think it affects other people?".

Staff Group A - Extract 3.9

S1: I know parents have, out of fear, said "What are you doing? You are bringing shame on the family. What are you doing? You've got everything. Why are you attention seeking?". Those kinds of conversations can actually send a pupil the other way³³.

Student Group A - Extract 3.10

M2: For example, if you are self-harming, they might think that you are trying to get help, but you also get their attention. They've noticed you ... and you get grief for it behind the scenes.

Researcher : When you say "grief behind the scenes", how do you get this?

F1: Some people are just too invested in other people, so they will ask you lots of questions. They will be just too personal. They will be invasive. They will pick it apart, and assume what they think you are going [through].

M2: [Yes]....

M1: People [judge you]. F1. [Yes, judge].

Student Group B - Extract 3.11

P2: People have been told that their cases³⁴ are too extreme so that they are not allowed to have counselling.

P3: Or, if you break down, they say, "you should see the counsellor". But they say "the waiting list is too long, so I wouldn't bother".

P1: There was "a case".

P2: "A case"³⁵ (laughs).

P1: They were told they were "too extreme" for counselling. So the student went to the GP to

32 i.e. adolescent self-harm

33 Euphemism for adolescent suicide.

34 i.e. their historical self-harm behaviours

35 The pupil is making a humorous reference to the "case study" distancing technique, that had been established as part of the interview safety planning, to talk about any historical experiences safely.

get further help. They were referred to the county's mental health team. And the pupil told them what had happened. The team said that they both (that is, the CAMHS and the counselling service) deal with exactly the same thing³⁶, at the exact same level, and that there was no reason the student should have been told they were "too extreme" to go to school counselling.

Personal and social boundaries are compromised as a consequence, as is the individual's social identity within the group social norms, which worst case can lead to a person's human rights-based personal and physical boundaries being transgressed and ignored due to social exclusion. This can lead to an individual being placed in a number of vulnerable situations which potentially heighten the risk of abuse (see extract 3.12); the examples here range from blackmail, unsanctioned public disclosure of highly sensitive information, through to an unauthorised full body search. This also confirms the detrimental impact of public gossip about self-harm within the school context, and that students' worries about this are not unfounded beliefs (see extracts 1.1 and 1.3). This is a mechanism used to "spoil" a student's public social identity (Goffman 1963), the costs of which are high.

Student Group B - Extract 3.12

P2: People can have a tendency to hold it³⁷ against others.

P3: Yes.

P2: To be like, "Oh, I know this about you". It's like if you had a secret, and somebody knew it about you, that does give them power over you. It's very ... um ... I don't know

P3: But like in year 7 ... something happened ... it went round everyone, and she got called in to the office. And literally she got checked all over her body.

P2: It was very invasive.

P3: Um ... and she [was fine]

P2: [She wasn't really]

P3:everything was O.K. Nothing was wrong. But her parents got called. And she was like, "why?". She was happy, but because someone saw like a scratch mark on her

Researcher: So your body language, you are all (there had been a sudden noticeable change in the way the interview participants were holding themselves; the relaxed, casual manner had gone, they were sitting up straight, in a tense manner, watching each other intently) ... that's quite a strong reaction from you all about this situation ... what don't you like about that situation?

P2: It's the idea that they literally went on something a pupil had said, and decided that was the correct course of action [to take].

P3:[Literally] ..

36 i.e. the self-harm

37 i.e. adolescent self-harm

P2: Like, not to like talk to her parents, nor to talk to her about it, or ask her any questions, it was just to go straight in to that.

P3: Even if you'd found that out. You'd be like, "right I need to talk to you". You wouldn't be like, "right lift up your sleeve".

P1:P2: [Yes.]

P3: Do you know what I mean? An 11 year old as well.....

P1: I mean just to search someone who is that young, you have to ask the parents if it's OK to do it.

4. The model category of "exclusion"

This category is the exclusion of the topic of self-harm from the whole school's public discourse. This means that there is no reference to the topic within a school's public environment. The sub-categories of this property centre upon the exclusion of the topic from the whole-school public context and include: *the topic is not taught in the whole-school context* (self-harm is excluded from the curriculum); *training is not delivered in the whole-school context for all staff* (the topic of self-harm is excluded from whole school staff training); and *no public information about the topic is given* (this includes no signposting to help and support).

In both schools, the topic of self-harm was not taught through the PSE curriculum, or any other method (see extracts 4.1 and 4.2), meaning the topic is not taught in the whole-school context to students.

Student Group A - Extract 4.1

Researcher: So have you been taught a module on self-harm?

P1: No.

P2: No. In years 7 to 11 we had a PSE set lesson. But then the introduction of our new timetable didn't leave space for it. So it was then down to registration time. So we had 20 minutes then, and we would go over a topic with the teachers.

Researcher : Did the teachers cover a topic on self-harm?

P1.P2. P3. [No.]

P3: It was more topics like bullying...

P2: Drugs.

Student Group B - Extract 4.2

Researcher: You have done PSE education topics, you have done all about drugs. Have you done one on self-harm?

P1: P2:P3: [no]

P2: No, not explicitly about self-harm itself. There was one about bullying, but it was just a

mention of “people deal with it in this way”. That’s about as far as it goes.

P3: It hardly talks about it at all.

Researcher: So nothing in detail about self-harm?

P1:P2:P3: [no]

Additional structural challenges in regards to teaching any PSE topics are noted in extract 4.1, which highlights the lack of time in the school curriculum for PSE lessons (also extract 4.5); these are squeezed into the registration period, where a teacher may have additional competing duties during this period. PSE appears to hold secondary status beneath the academic disciplines, impacting its curriculum delivery. Also staff may not necessarily be skilled or comfortable in delivering PSE topics (extracts 4.3). These issues with the PSE curriculum mean that even without the stigma model being present as a barrier, if self-harm is perceived to be a challenging and difficult topic, there will be problems within its PSE delivery.

Staff Group B - Extract 4.3

S2: And often ... PSE is an add on to a teacher’s timetable. Rather than something they have a passion about for delivering....You might want to be a history teacher, or a geography teacher, but only a very small minority would say that they wanted to be a PSE teacher. ...And sometimes PSE, you are doing it because ... you have space on your timetable ... not because you are the best person to deliver it.

S3: There are teachers who think about ... when we were doing some of this work this week with the sexual behaviours ... some members of staff were really uncomfortable. And that’s the thing ... you are sort of ...if we are uncomfortable ... like in how far do you say things and take things ...and then there’s the NQTs and inexperienced teachers as well. They all have some PSE lessons to teach, don’t they?

There are a number of reasons staff give for the whole-school context topic exclusion (see extracts 4.4 and 4.5). These reasons centre upon: staff anxiety and apprehension about teaching the topic safely; and staff’s perceptions about the complex characteristics that surround the behaviour (risk of serious physical injury, invisibility and contagion) which would make it difficult for staff to have any control over, or manage safely in a whole-class setting. One staff member shows the high levels of anxiety and apprehension she carries which act as a significant barrier to her teaching the topic (see extract 4.4), through the strong images of self-harm which she says she carries in her head - these images make her feel she could be potentially in “deep water” at any moment, out of her depth. She feels the risks are just too high for her to manage.

Staff Group B - Extract 4.4

S1: It³⁸ is something that I would consider (teaching), but it is something that I am nevertheless quite apprehensive about. Even with kind of having taught PSE for a while. So if I then project that on to maybe someone who hasn't been teaching PSE, how they would feel...And it can lead to a feeling that, I won't go there until I really know the possible ... you know... how things could play out. And that I know how to keep the lesson safe really. So how do you do it, and keep the lessons safe and secure. So I could manage what could come out of it.

Researcher: So again, do you think in a PSE topic ... you are covering sexual health and drugs ... do you think self-harm is different to those types of topics?

S1: I think it can be different because ... um... er....there's such a potential for psychological damage ... you are dealing with an unseen, in a sense. I know substance misuse and sexual behaviour, you can also be dealing with quite deep seated psychological motives that could be harmful. But it just feels as if with self-harm, there's a lot more out there. You've got these images of ... you know ... of self-harm... that are maybe kind of carried in your head...and you are thinking, "If I make a wrong turn here, I could be in really deep water".

Quality system-level support and training could perhaps enable school-based staff to have a platform for a professional dialogue centred upon unpicking their strong fears that surround adolescent self-harm. Furthermore, teaching may or may not be the method used within a whole-school preventative approach, consultation would need to take place upon what schools, staff and pupils feel is both acceptable and feasible for planning the whole-school preventative intervention design. From a public health perspective, it is the school setting that is important, as it potentially facilitates access to the community population group that currently do not (or are unable to) access health services and support.

Extract 4.5 posits small group teaching sessions to manage the perceived risk of contagion, but notes the risks to teaching younger pupils, who are deemed as being too vulnerable to be taught about this topic. However, staff acknowledge that it is precisely these younger pupils in their school who are currently engaging in self-harm who need support. Finding an answer to this dilemma is necessary, given the fact this school highlights the young age of pupils engaging in self-harming behaviour, which they state as complex and varied (see extracts 2.9 and 4.5).

Staff Group B - Extract 4.5

S3: I think it³⁹ is more suited to small focused groups to be honest.....And I think if you did it in a whole class setting, I think you ... you run the risk of getting more children ... almost copying the behaviour.

Researcher: So you think there is a risk of contagion?

S3: Yes... [particularly] with a year 8 group ... they are vulnerable.

38 i.e. a PSE adolescent self-harm topic

Researcher: So they are not ready to be taught about this?

S3: Yes.

S1: The problem with that is that they they don't have any curriculum time to do anything related to this.

S2: But we do have year 8 pupils doing this.

Delivering evidence-based support is necessary, given the issues that are being raised here, to ensure that what is delivered in the school context is both safe and effective to meet the needs of these pupils. Also, contagion behaviours may already exist in the school, stemming from social media (see Appendix), and the increasing visibility and numbers of self-harm in the school context. Simply excluding the topic from the whole school-curriculum is no solution; this leaves students in an exposed position, with no quality school-based support or resources to draw upon to mediate the potential risks, or to learn about the topic and health management behaviours from a responsible, knowledgeable source. Students are currently left on their own to do this, for which they use social media (see extracts 4.9, 4.10, Appendix - extracts 5 and 6), with nothing from school to help act as a barrier to the pro-harm social media sites and graphic images they will inevitably access, which come up automatically on basic google searches.

Furthermore, staff anxiety about having to work individually with the perceived complex characteristics of self-harm, and not being able to do this safely, was accentuated by training not being delivered in the whole-school context for all staff. In both schools only a few key pastoral staff had accessed either self-taught information, or gone on brief low quality training a number of years ago. It was these staff who worked with individual self-harm incidents; other staff passed pupils on to them, which strengthened the exclusion practices within the mainstream setting. Extract 4.6 shows the wish for a knowledgeable team to receive such training, but as extract 4.7 highlights, this specially trained team method could negatively impact a whole school approach. A joined up planning approach (including external support systems) to build school and staff capacity to work with the topic safely, and also respond knowledgeably to self-harm incidents could be a way to manage this tension.

Staff Group B - Extract 4.6

S2: There is a lack of time and adequate training⁴⁰. And at least some mental health training needs to be done at least by one member of staff, done well. I think probably a team of staff need to do that.

39 i.e. the PSE topic for adolescent self-harm

40 i.e. in regards to adolescent self-harm

S3: I think the whole pastoral team should do this.

S2: I've got, "a whole school approach is needed".

S3: I agree.

Staff Group A - Extract 4.7

S2: I think it's key to have a team. We are first response, they will come to us if they have an issue. However, it's still a whole school approach, isn't it? We still all need to be aware of what to look out for, and when to know when to ask for advice and support. So, I am sure we wouldn't create this, but it's still an awareness by everybody. Say S1 is trained, but everyone still needs to know about it⁴¹, don't they? Everyone still needs to be able to recognise (it).....

The final sub-category of the exclusion was the feature of no public information about the topic being given. Individual signposting support was stated at times as being given, but not always (extract 2:12). The reason staff gave for this was due to the stigma that "others" had about the behaviour (but not the staff-members who were speaking), and the consequences and impact this would have on the school (which meant the school acted to protect itself by excluding the topic). Staff did not seem to realise that by this response the school was accentuating, perpetuating and condoning this stigma behaviour (extract 4.8), both within its own setting and the local community. This could also act as barrier against individual help seeking behaviours, as the stigma surrounding the topic is strengthened across two contexts.

Staff Group A - Extract 4.8

S2: I am also thinking every form of communication is of benefit ... such as the school website. (But)... Not ... not anything about self-harm

Researcher : Can I just quickly ask before you leave, about not putting anything to do with self-harm up on the school website. Can I just unpick that a bit? Why would you not do that?

S2: I think it's knowing your audience. As we've said before, we are very rural. We know things happen. But we also feel ..

S3: [It's⁴²] not advertised in the school.

S1: And also, if you put it on there, "we help with self-harm advice", I think [lots of people would say]

S2: [That's like saying we have lots of people who self-harm]

S1: Exactly. "We have an abundance of them here, [look what]"

S2. [when actually],

S3: It's the wrong message.

Researcher: I know you have to go, but you are very clear, you don't want that message to be linked to the school?

S3: Correct.

41 i.e. adolescent self-harm

Researcher: Again, because we are just trying to understand it. Do you know why?

S3: Because of the stigma attached to it in this area.

S1: So just knowing our community, because we are all local people, and we know all the families. I think if you did put those words, ...“Self-harm advice available”, ..they might, you know, it might sensationalise it. It might cause ...unnecessary panic amongst parents thinking, “Oh my goodness, I didn't know they had self-harm at high school”.

Schools may wish to only provide individual support to students who self-harm, but this does not address the public or institutional stigma in the school context (Corrigan and Watson 2002; Pryor and Reeder 2011), nor address the health inequalities that will be stemming from the stigma (Hatzenbuehler 2013). Therefore, any individual examples of working with self-harm are compromised due to the point that individual support is taking place within an institution where stigma is structurally embedded and active through numerous mechanisms. The issue in extract 4.8 also shows how linked social settings can become enmeshed with stigma, perpetuating the behaviour across differing contexts.

A final point is that the impact of this whole-school topic exclusion means that students are not being educated about self-harm in the school context, and use social media to teach themselves (extract 4.9).

Student Group A - Extract 4.9

P2. We have been taught about it⁴³ through social media.

This virtual-based knowledge context includes unmitigated access to graphic pro-harm sites where detailed information is gained by vulnerable pupils, for example, in regards to step-by-step suicide instructions, which students then act on (see extract 4.10).

Staff Group B - Extract 4.10

S3: For example, ... a pupil she had what I call the superficial cuts, but she also had the vertical deep cut, which to me said something else⁴⁴. I haven't got the training to say, it's just what I've picked up from reading and learning, and you know..... She was upset, and couldn't cope with the fact that it didn't work. And how she knew this, is because she watched on YouTube how to do it, to make it work. So pupils have all these tools at their disposal, where they can actually learn very quickly, exactly how to do it, where to do it...

S1: Yes.

S3: ...how to conceal it..

42 i.e. adolescent self-harm

43 i.e. adolescent self-harm

44 Oblique reference to an adolescent suicide attempt.

Staff highlight this could be one area that training could focus upon, to help adults understand the self-harm risks students are facing in their social media⁴⁵ infused world, a world which (according to school staff) adults don't even begin to comprehend.

Staff Group B - Extract 4.11

S3: We need better training. It all comes back to having staff that are competent to tackle these subjects head on, especially the social media aspect. Be honest about chat rooms and the risks. The pop ups on apps that they use. And understanding their world. The biggest problem for most parents and teachers, is that we just don't understand about this. About how different groups access things through apps ...the risks... and they change all the time. Don't they? I would argue that what they see, now with social media and the live streaming, you know, in real face-time, I would argue that they see much, much more than what we know about. We haven't got a clue.

A consequence of this is staff and students feel school pupils have more knowledge about adolescent self-harm than school professionals (extracts 4.12 and 4.13).

Staff Group A - Extract 4.12

S3: I would fully agree with that statement, "teens have more knowledge than professionals about teen self-harm", would you (to S1)?

S1: Yes.

Student Group A - Extract 4.13

P2: But I think it's not just about us being informed, it's the older generation. I would say we are more informed about it⁴⁶ than them.

Students are educating themselves which has the consequences of breaking the silence about self-harm, but not removing the stigma in the school context. This knowledge is not being delivered by the statutory school system, but by students accessing social media. However, the quality of the knowledge that pupils are accessing online can be low (Lewis et al. 2014), and of a graphic nature (Lewis and Baker 2011), within an unsafe environment (*see the Appendix for more extract examples centred on this point*). Therefore excluding the topic from the whole-school context, and not planning a whole school preventative approach to address the topic safely to all students means that there are many negative consequences. Some of these include: perpetuating the stigma; the

45 More detailed extract evidence about social media and student self-harm, including pro-harm sites are given in the Appendix.

46 i.e. adolescent self-harm

inability to safely enable students to learn about how to support themselves and others if they are experiencing self-harm; and not raising awareness of the social media issues and risks that surround self-harm and pro-harm sites, as a means to equip students to protect themselves and others.

5. The model category of “fear and/or danger beliefs”

The final strand of the stigma concept are the fear and/or danger beliefs that stem from the topic, evoking a negative emotional reaction. Dimensions include: *self-harm being a dangerous topic that cannot be taught in schools*; *stigma fear* (an individual’s fear of the associated stigma which surrounds the topic); *panic response* (the topic and behaviour evokes an overwhelming fear) ; and *complexity fear* (the fear of the potential complexity of the behaviour, which includes not being able to manage the complexity safely).

These dimensions of reactive beliefs are evidence of the public stigma about the topic and the behaviour. As Corrigan and Watson state (2002), public stigma is characterised by: stereotypical detrimental beliefs about the topic and/or population group (i.e. too dangerous, too complex to work with); prejudicial reaction (i.e. fear and panic); and discrimination (i.e. excluding the topic from the teaching curriculum, individual avoidance behaviours, judgemental critical behaviours, and public topic exclusion). In the prior sections (1 to 4), there have been numerous examples of these. Four are briefly given here:

1. Fear of self-harm as a dangerous topic (also complexity fear):

Staff Group B (Extract 4.4)

S1: I think it can be different because ... um... er....there’s such a potential for psychological damage ... you are dealing with an unseen, in a sense. I know substance misuse and sexual behaviour, you can also be dealing with quite deep seated psychological motives that could be harmful. But it just feels as if with self-harm, there’s a lot more out there. You’ve got these images of ... you know ... of self-harm... that are maybe kind of carried in your head...and you are thinking, “If I make a wrong turn here, I could be in really deep water”.

2. The stigma fear:

Student Group B - Extract 1.2

P2. There is like, even though more people are talking about it there is still negative ideas surrounding it obviously. Umm.. .. but it’s. it’s very difficult to talk about in school, because it is not talked about.

3. The panic response (also complexity fear):

Staff Group B - Extract 2.3

S1: But um it's just like a whole can of worms that really you are thinking, "Oh my God, how do I deal with this"⁴⁷, without making it a lot worse?".

S2: And I think that is one problem, that staff feel that perhaps they are afraid that they may make it⁴⁸ worse. Also, if they do talk about it, the incident⁴⁹ might increase, or become more severe.

4. The complexity fear:

Staff Group B - Extract 1 (see Appendix B)

S1: That feeling that there's the potential for a lot of harm to be done if the situation isn't handled in a sort of skilled, knowledgeable, confident way. I think that can go for staff as well. Apprehension. What's the best way of supporting this person.

Students, who have lived experiences of self-harm, have given evidence in the interviews of the discriminatory consequences from the public stigma (see extracts 3:11⁵⁰, 3:12⁵¹ and 5:1) to which they are exposed.

Student Group B - Extract 5:1

P3: People are scared of it⁵². And they think, you know, you're a psycho if you do it. They treat you entirely differently, even though nothing has changed about who you were before they knew.

In extract 5:2, a student understands and expresses the point about the prejudice and discrimination surrounding the topic of adolescent self-harm:

Student Group A - Extract 5:2

P3: It used to be, "don't talk about it", for example, like homophobia. With people who were gay, like quite a few, when my mum was younger, if someone was gay, they would try and hide it because people were like, "Oh if you are talking about sexuality and being gay, then more people are just going to become gay". They were really horrible about it. And that sort of applies to this⁵³ I think.

47 i.e. the self-harm

48 i.e. the self-harm

49 i.e. the self-harm "incident"

50 This extract gave the example of the student being told that their self-harm behaviours were "too extreme" for school counselling.

51 This extract gave the example of the unauthorised full body check that stemmed from a staff's fear/danger belief.

When reactive beliefs are not managed responsibly, or challenged appropriately, they accentuate prejudice and stigma, which both lead to discriminatory behaviours (Yang et al. 2017). In staff, this undermines professionalism and leads to poor outcomes when working with adolescent self-harm. Capturing these behaviours to bring them out into the open is an important starting point in planning to address them, **such as through equality training, and anti-oppressive practice**. Some school staff are also working beyond their current professional skills and capacity with adolescent self-harm. Given that these points present multiple risks, for both staff and students, **undertaking further investigation is warranted**. Using a whole county audit process could help begin to address these issues, such as through the mandate of the Local Safeguarding Children Board (LSCB) which has a county-wide safeguarding co-ordination role.

This is the end of PART 1 of the report section, in which the theoretical model of stigma has been explicated in detail, including each of its five main categories with their sub-categories. The extract examples drawn from the qualitative interviews illustrate the model and the context-based analysis.



52 i.e. adolescent self-harm

53 i.e. adolescent self-harm



PART 2: Discussion & Recommendations

This section delivers a discussion centred upon the research project's grounded theory stigma model and its links to wider research. A number of examples of the model's negative consequences for adolescent self-harm within the school context are delineated. Implications for the policy context in Wales are outlined. Future research recommendations are made.

2.1 THE GROUNDED THEORY STIGMA MODEL AND ITS LINKS TO WIDER RESEARCH

The grounded theory stigma model that surrounds adolescent self-harm within the whole-school context means that the topic and behaviour is excluded from the socio-cultural norms of the institutional setting. Unpacking this point through the social and medical model perspectives embedded within the UK's 2010 Equality Act, adolescent self-harm can be a fluctuating condition that may substantially impair ability at times, and is therefore a protected characteristic under the Act. Disability discrimination is illegal in the UK; this includes any treatment that places a person at a disadvantage, and a lack of anticipatory planning to address potential need. With all these issues in mind, it should be understood that **secondary schools reside within a socio-ecological system of wider influences that shape school-based behaviours** (some of which this report has briefly touched upon in Part 1) **which now require further research investigation.**

The model brings to light the ubiquitous nature of stigma within a specific context, a characteristic that is highlighted in public stigma research as the key reason for its damaging impact upon public health (Hatzenbuehler et al. 2013). Tackling stigma in institutional settings can prove to be extremely difficult due to their powerful socio-cultural mechanisms (Pryor et al. 2011; Gronholm et al. 2017). This is why the initial grounded theory stigma model is useful, revealing the specific characteristics of public stigma (Corrigan and Watson 2002) surrounding adolescent self-harm within the two secondary school contexts. To date this is a limited research area (Evans and Hurrell 2016), which the current study contributes to.

This is only a small scale and exploratory project informed by the perspectives of staff and students, and as such its results should be treated cautiously, as further research and testing is required. However, the project's initial findings do align with the wider academic research on this topic (as demonstrated in the following sections) and also delivered new insights.

The GW4 research alliance (the research consortium of Bristol, Cardiff and Exeter universities) demonstrated the whole-school topic exclusion from any adolescent self-harm preventative work (Evans et al. 2016); this was the case in 148 secondary schools (94 in Wales, 54 in England) it surveyed. Its report cited that the reason schools gave for this whole-school topic exclusion was their worry about the potential “social contagion” behaviour stemming from teaching the topic; they felt they could not teach the topic safely (*see 2.6 within this report section for further discussion*). A systematic review similarly reflected the theme of marginalisation and of adolescent self-harm being “rendered invisible” (Evans and Hurrell 2016) in the whole-school context, noting the research paucity on the institutional-level factors impacting adolescent self-harm.

The results from the current research project found the same exclusion behaviour in two schools in Wales (these schools were purposefully sampled from the GW4 study sample in Wales), and offers more detail regarding this aspect: the “contagion belief” is situated within public stigma (Corrigan and Watson 2002) and stems from a potentially discriminatory response. Evidence of the stigma and social exclusion that surrounds adolescent self-harm, at an institutionalised level, is delivered through this project’s grounded theory stigma model.

Given the current research project mirrors the whole-topic exclusion findings of the GW4 study, this also means that potentially the stigma and social exclusion could be widespread across many secondary schools in England and Wales. **Exploration of the school-based contextual influences, including their risk and protective factors upon self-harm, is warranted.** This work could incorporate **larger scale testing of the grounded theory stigma model**, to refine it, and to confirm or refute the working hypothesis of the stigma model being widespread in UK secondary schools. For example, the visual representation of the model (*see page 4*) uses the theme of “**permeation**” to give an idea of how the socio-cultural behaviours are permeated or infused by the model, in relation to the topic and behaviour of adolescent self-harm within the secondary school context. This means (after further exploratory work has been completed) that perhaps the analogy of “permeation” could be taken forward, to develop a measurable characteristic, such as its “concentration gradient” within a secondary school context. This would enable the concept of “variability” to be developed within the stigma model – its “concentration gradient” will be stronger or weaker in different settings, but still present. Its various constituents, their specific strength or dosage, and their interactions, could therefore be closely monitored and analysed, as well as more detail and understanding gained about outcomes.

The grounded theory stigma model in this project demonstrates that adolescent self-harm is a powerful stigma marker (Lopez-ibor 2002), which levers differentiation and the resulting negative behaviours within the school context. Shared themes from the academic field of stigma research resonate with the research project's model. These include: Goffman's concept of stigma as a social identity that is "spoiled" by society due to its association with a socially disapproved characteristic (Goffman 1963), which in the research project's model is adolescent self-harm; stigma occupying the socio-cultural context, influencing the dynamics within this setting (Hebl and Dovidio 2005); public consensus maintaining the devaluation of the disapproved characteristic (Corrigan et al. 2004) and institutions legitimizing this within their professional practices resulting in structural stigma (Pryor and Reeder 2011).

The project's grounded theory stigma model, with its specific properties and dimensions that have been built "from the interview ground" upwards, through the grounded theory constant comparative approach (based on the line-by-line raw interview data) aligns with the public stigma model posited in wider research (Corrigan and Watson 2002).

2.2 THE PUBLIC STIGMA MODEL

Corrigan and Watson's public stigma model (2002) has three main categories. The first is *stereotyping*, which involves holding stereotypical negative beliefs about a population group. The second is *prejudice*, which is the negative emotional reaction stemming from the negative beliefs. The third is *discrimination*, which is the behavioural response to the prejudice and is characterised by avoidance, including negative interactions and a lack of support.

Briefly applying the grounded theory stigma model to these public stigma categories we can see the similarities between them, for example:

- *stereotyping* (e.g. holding stereotypical negative beliefs about the adolescent self-harm population group and behaviours, such as adolescent self-harm being "too dangerous, too complex to work with") is evidenced in the grounded theory model's main category of "fear/ danger beliefs";
- *prejudice* (e.g. the negative emotional reaction stemming from the negative beliefs about the adolescent self-harm population group and behaviours) is again evidenced in the grounded theory model category of "fear/ danger beliefs"; these include fear-based emotional reactions that the grounded theory stigma model's sub-categories expound, such as "the panic response" and the "fear of contagion";

- *discrimination (e.g. the behavioural response to the prejudice against the adolescent self-harm population group and behaviours)* is evidenced in the grounded theory model categories of “avoidance”, “taking a judgemental stance” and “public exclusion”. Furthermore, “word tabooing” is a learned social avoidance behaviour.

Table 1:

Comparisons between the Public Stigma Model and the Grounded Theory Stigma Model (use of Main Categories)

Public Stigma Model (PSM) (from Corrigan and Watson 2002) These are the MAIN CATEGORIES of the PSM	Public Stigma Model Definition of the Main Categories	Grounded Theory Stigma Model Main Categories
Stereotyping	Stereotypical Detrimental Beliefs <i>e.g. too dangerous, too complex to work with</i>	Main Category: Fear and Danger Beliefs
Prejudice	Agreement with negative beliefs, and/or negative emotional reactions <i>e.g. anger, fear</i>	Main Category: Fear and Danger Beliefs <i>e.g. the topic evokes a negative emotional response</i>
Discrimination	Behaviour Response to Prejudice <i>e.g. avoidance(and negative interactions), does not provide support</i>	Main Categories: Avoidance (Individual) A Judgemental Stance Exclusion (Public) (Word Tabooing is also a learned social avoidance behaviour)

The concrete details delivered within the project’s grounded theory stigma model reveal the specific constellation of public stigma within the secondary school context. Its negative consequences, which include the potential social exclusion and health inequalities (World Health Organization 2017a), are likely to be severe at times for the adolescent self-harm population group. These could negatively impact young people’s health trajectories at critical times, and pose a serious risk of harm, including accidental death and suicide. **Exploration of the school-based contextual influences, including their risk and protective factors upon self-harm, is urgently warranted.**

2.3 DISCRIMINATION, AVOIDANCE BEHAVIOURS AND “ INSTITUTIONALISED” STIGMA

As highlighted by the public stigma model, discrimination stems from an avoidance behavioural response, correlating with an emotional arousal centred upon stereotypical negative beliefs, which means a non-neutral response to stimuli that have been appraised as negative (Janschewitz and MacKay 2011). This leads to behaviours designed to limit any contact with the stimuli, such as moving away or keeping a distance (Feltman and Elliot 2010). This response is a socially learned behaviour, linked to a mental concept that has been structured through social learning from within an individual's culture (Barrett 2017). It is therefore a goal-directed behaviour (Daw and Shohamy 2008), with concept labelling of the stimuli delivered by the categorisation processes of the brain (Barrett 2017), all of which have been developed and learned from within each individual's socio-cultural environment.

The issue here is the pervasive and situated nature of these behaviours, which are delivered within the institutional context of the school setting towards a specific group (i.e. the self-harm population group). There is a social structure within this setting, which is permeated with these negative behaviours, and, if these individual behaviours are left unaddressed, they remain dynamically in operation (Henry 2010). These types of negative and judgemental interactions permeated both schools' social contexts, and therefore contributed to bias operating at an institutional level (Dovidio et al. 2010). The powerful institutional setting (powerful in that it has an organisational agency and dynamism due to its own socio-cultural structures, mechanisms and methods of operating) condones the avoidance, as it both creates and maintains the social normality/reality within its own system (Martin et al. 2008), that is, the “normative expectations” (Goffman 1963), and influences the surrounding micro-system. For example, avoidance had a covert nature within the social setting of the two schools, hidden behind a method of operating that provided a barrier or distance between the person and the topic of adolescent self-harm. These points may offer an explanation regarding why tackling the organisational discrimination and the structural stigma, which are both legitimised by the institutional setting (Pryor and Reeder 2011), as evidenced within these two school contexts, can prove to be extremely difficult (Gronholm et al. 2017).

Another specific reason posited for failings in programmes to tackle public stigma is that only broad stigma modelling has been used, instead of context specific and detailed modelling (Schulze 2008; Stuart 2008; Bos et al. 2013). Undertaking an evaluation of the explicit components of stigma within a specific context means they can be brought to light, so that public health planning can take place about what the next steps are to take to address the stigma. **The initial grounded theory**

stigma modelling from within this small-scale project should continue to be developed for public health planning to address the school-based stigma. Also within other settings where stigma has been demonstrated to exist in relation to adolescent self-harm, such as primary health care services (Timson et al. 2012).

2.4 THE GROUNDED THEORY STIGMA MODEL AND THE POTENTIAL NEGATIVE CONSEQUENCES FOR ADOLESCENT SELF-HARM

The negative consequences that stem from the research project's grounded theory stigma model are likely to be critical at times for the adolescent self-harm population group. For example, in the use of the minimisation strategies by staff and pupils within the school context, which included value-laden appraisals of the authenticity of the self-harm (such as "superficial"). These subjective-based judgements correlate to beliefs centred upon the idea that there is perhaps a level that can be used for measurement purposes (and therefore risk assessment), which for self-harm has little meaning (House of Commons Health Committee 2017). As a behaviour, self-harm requires a holistic assessment approach, using a psychosocial framework (NICE 2013). Focusing purely on the external or internal injury is a first-aid emergency response. However the injury is just one aspect of the behaviour. It is also not necessarily easily visible as cutting is only one form utilised within a range of self-harm behaviours (NHS Choices 2015).

In using a swift and artificial "level" approach (without a detailed and knowledgeable assessment process), and correlating the seriousness of the behaviour to this "scale", school staff are demonstrating their lack of knowledge about working with adolescent self-harm. This means they have not received quality training. Self-harm is a complex behaviour. From a clinical perspective, until a psychosocial and in depth self-harm assessment takes place by professionals with expertise in adolescent self-harm, the knowledge and understanding of the self-harming behaviour is extremely limited. Adolescent self-harm requires a biopsychosocial understanding across a number of interweaving domains which include environmental, biological, cognitive, affective and behavioural (Walsh 2014). Adolescent self-harm may also be part of an emerging psychiatric condition, such as Borderline Personality Disorder (NICE 2013), or it could be a response to abuse (Hawton et al. 2015). There is the additional factor of needing to understand the intent behind the self-harm, which could be suicidal; light "scratches" can be part of the practise for a planned suicide attempt. The use of risk assessment centred solely upon low or high levels of "lethality", or in

correlating a “level” of self-harm injury with suicide intent, is perilous and potentially unsafe (Chan et al. 2016; Oquendo and Bernanke 2017); there can also be deeper injuries on non-visible parts of the body, which the young person has not disclosed.

Problematically, stigma behaviours are not just confined to the school context. For example, in relation to psychosocial assessment for adolescent self-harm delivered in primary health care services, research has demonstrated that stigma exists within these settings (Mackay and Barrowclough 2005; McDaid 2008; Timson et al. 2012), leading to negative outcomes for the adolescent self-harm population group, which include (amongst others) these young people disengaging from clinical and health services support (McCann et al. 2006; Mental Health Foundation 2006; Taylor et al. 2009). The potential for stigma behaviours being present in health services need to be taken into account in regards to the UK’s current health policy recommendations (House of Commons Health Committee 2017) which mandate that every individual with self-harming behaviours should receive a quality psychosocial assessment and a safety plan (NICE 2014); “quality” is likely to be undermined, and the process likely to be negative, due to stigma.

From this report’s perspective it means research investigation and analysis centred upon fully understanding the stigma that also exists in primary health care services, similar to the concrete detail delivered by the grounded model of stigma within this small scale study.

Taking this point forward logically, and thinking about the support settings/systems that surround schools, the question arises whether stigma also exists in secondary health services, such as Child and Adolescent Mental Health Services (CAMHS). There is some historical evidence to support this point (Nixon 2011; National Collaborating Centre for Mental Health 2012). One of the recommendations in the self-harm guidance commissioned by the National Institute for Health and Clinical Excellence (NICE) due to the presence of stigma in professionals is for all health and social care professionals to be educated about the stigma surrounding self-harm (National Collaborating Centre for Mental Health 2012). Therefore, although the grounded theory stigma model gives detailed evidence of the specific stigma behaviours in the school context which surround adolescent self-harm, which professionals can now be educated about, this does not address the potential stigma in other settings. Up to date research information to deliver the detail about potential stigma within CAMHS would give further input upon this issue, to help meet the NICE training guidelines for staff working with adolescent self-harm. This work would contribute to [understanding the socio-ecological system of wider influences that shape school-based behaviours regarding adolescent self-harm, which is one of the core research recommendations of this report](#). One key problem that surrounds working with adolescent self-harm effectively is the lack of quality evidence (Hawton et

al.2015), which negatively impacts the ability to deliver evidence-based knowledge, which in turn weakens service delivery and support (such as training professionals in the evidence-based knowledge base to work with adolescent self-harm). **It is posited here that the lack of evidence-based knowledge compromises professional behaviours, with could be one reason for widespread stigma across numerous contexts.**

An additional issue for children and young people is when adults may take decisions that unlawfully restrict access to public service support and provision (for whatever reasons, whether service criteria thresholds, public stigma, or due to lack of knowledge). There may also be other issues here due to tensions in public health service provision with young people who are not adults. For example: in the ability for young people to make informed decisions in treatment care which are tempered by age and legal capacity; in what services they actually want; by safeguarding protocols that limit confidentiality for the young person; also in having access to services that are “young people friendly” - one small example being access to services that mean not missing school for appointments which can lead to young people being made to share information about absences that they do not wish to, let alone in them gaining access to services on their own if they wish it. For an individual who discloses self-harm, the first point of contact they have with any one about this behaviour shapes their future help seeking and health management (Hunter et al. 2012; Klineberg et al. 2013). Responses that deliver rejection, or highly charged emotion, or any of the grounded theory stigma model expounded in this report, or additional stigma behaviours, are harmful to these processes.

Adding to these aforementioned points are the current problems in quality service provision for adolescent health needs. The World Health Organization has issued guidelines to improve health services for adolescent health focussing upon a rights-based approach to health (which for Wales, given its right-based legislative framework for children and young people, is a directive for action to address these issues), as it states “services for adolescents are highly fragmented, poorly coordinated and uneven in quality” (WHO 2018). WHO outlines eight global quality standards for quality healthcare services for adolescents (*see Table 2*). The extract below (*Evidence Extract A*) is just one example of why there is work to be done in Wales currently, in regards to improving quality standards for adolescent self-harm.

EVIDENCE EXTRACT A:

ISSUES IN WALES (& ENGLAND) WITH ACCESS TO CHILD AND ADOLESCENT MENTAL HEALTH SERVICES & SUPPORT FOR ADOLESCENT SELF-HARM

At the same period of time this research study was being completed, the Cabinet Secretary for Health, Well-being and Sport stated that the Welsh Government had “*made great strides in recent years to improve and speed up access to services for young people who may present as a result of self-harm or suicidal ideation*” (National Assembly for Wales 2017). This perspective is at odds to the picture being described by the core front-line staff in the two schools within this small-scale study, and also in the recent GW4 research alliance (the research consortium of Bristol, Cardiff and Exeter universities) work that included over 90 secondary schools in Wales (Evans et al. 2016). The GW4 study found that Child and Adolescent Mental Health Services (CAMHS) in both England and Wales have high thresholds in relation to adolescent self-harm, and significant treatment access delays of several months, which are barriers to schools gaining access to specialist services for their pupils (who school-based professionals have judged as needing this specialist support), as well as posing serious health risks to pupils. Schools are left on their own to manage this challenging situation, which they are ill equipped to undertake. **Meaningful community-based consultation and communication to share these differing perspectives between government and school-based staff (as well as including pupils, carers and parents) would be an important first step to understanding the situation clearly, so planning can take place to address it.**

THIS EXTRACT INFORMATION IS DRAWN FROM PAGE 13 OF THIS REPORT

TABLE 2: *The World Health Organization's recommendations for improvements to the quality of health-care services so that adolescents find it easier to obtain the health services that they need to promote, protect and improve their health and well-being (TABLE SOURCE, WHO 2015 p. 4).*

GLOBAL STANDARDS FOR QUALITY HEALTH-CARE SERVICES FOR ADOLESCENTS

Eight global standards define the required level of quality in the delivery of services as shown in the table below. Each standard reflects an important facet of quality services, and in order to meet the

needs of adolescents all standards need to be met. This section presents each of these standards and its criteria, categorized as input, process and output criteria.

Adolescents' health literacy	Standard 1. The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
Community support	Standard 2. The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.
Appropriate package of services	Standard 3. The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach. ¹
Providers' competencies	Standard 4. Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both health-care providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.
Facility characteristics	Standard 5. The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
Equity and non-discrimination	Standard 6. The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.
Data and quality improvement	Standard 7. The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.
Adolescents' participation	Standard 8. Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

¹ Service provision in the facility should be linked, as relevant, with service provision in referral level health facilities, schools and other community settings.

Additional factors to consider are how to access the high number of young people within community settings who do not come into contact with any health services or support (Hawton et al. 2012; Geulayov et al. 2018). Their viewpoints are important, including what they think is useful, how they wish services to be delivered to them, and what types of services. **Working in partnership with the community-based adolescent self-harm population group is one way forward, to answer these questions**, taking planning to address some of the logistical challenges this entails in completing research outside of traditional public health research structures using participatory methods. *Finding out the type and range of support, and its delivery locations, that are both acceptable and feasible to the community-based adolescent self-harm population group, would be a good opening discussion.*

Picking up the narrative thread raised in the opening of this discussion about judgement centred on the “authenticity” of self-harm, and looking at this point in more detail, it is a form of emotional invalidation. This is when an individual’s emotional responses and cognitive perspectives undergo rejection, avoidance and critical negative judgement (Krause et al. 2003; Crowell et al. 2009) by the other person within an interpersonal situation. Invalidation is a core characteristic of an emotionally abusive response (Krause et al. 2003; Westphal et al. 2016). It means that, for example, an adult individual (such as a teacher) is unable to react appropriately to the emotional content delivered within an interpersonal dimension (from a student), which levers the emotional invalidation response from the adult individual, which in turn increases the emotional reactivity of the student (Shenk and Fruzzetti 2011). School staff may themselves be under pressure, including having mental health needs themselves which may negatively impact their ability to respond appropriately to pupils in this situation. A 2015 education sector health survey stated 84% of school staff suffering mental health issues, of which 81% cited the workload as the core problem (Education Support Partnership 2016). More than half of these staff were not engaged in any help seeking behaviours for their own mental health needs.

The well documented high level of work-related stress experienced in the teaching profession (Health and Safety Executive 2017) is likely to have a negative impact upon professional capacity to work effectively with adolescent self-harm within schools. Additionally this study has shown that adolescent self-harm evokes an accentuated stress response in school staff, which may act as a significant barrier to support provision, and the health and well-being needs of both staff and students. Therefore school staff may be under considerable strain. All of these issues could impair staff abilities to respond appropriately to adolescent self-harm.

The additional dimension of the relationship self-harm has with emotional distress (i.e. the student may already be experiencing high levels of emotional distress) means additional risks within an invalidation response, which may have negative repercussions for the student. For example, given that a subset of individuals who self-harm as a consequence of Borderline Personality Disorder (BPD) will exist in the school context, emotionally invalidating environments are a risk factor in the full psychopathology development of BPD (Kaufman et al. 2017). Also clinical-based data posits self-harm on a risk spectrum that includes suicide (Hawton et al. 2012; Hawton et al. 2015; Arensman et al. 2018; Geulayov et al. 2018); invalidation as a response may lead to an increase in the interpersonal and environmental stresses which may elevate the suicide risks, especially for individuals experiencing mental illness (Mars et al. 2014).

There is a much higher incidence of self-harm and suicide within specific youth population groups (Ferrara et al. 2012), such as:

- youth BPD (Pompili et al. 2005);
- anorexia (Kostro et al. 2014);
- gender dysphoria (Aitken et al. 2016);
- bipolar disorder (Iorfino et al. 2016).

Therefore the grounded theory stigma model could negatively impact young people's health trajectories into mental health illness. The results of this type of discrimination is the marginalisation of a minority group in the school context; this is termed social exclusion and gives rise to health inequalities (WHO 2017c). The conclusion here is the repeated warning about the serious health risks that stem from these issues, which are woven throughout this discussion section and report: *for adolescent self-harm, these aforementioned points could lead to serious risk of harm to students, which include unintended injuries, accidental death and suicide. Schools need to receive support in assessing the risks within their setting, in taking steps to address them, and in ensuring they are managed appropriately.*

2.5 THE GROUNDED THEORY STIGMA MODEL AND ITS IMPLICATIONS FOR THE EDUCATIONAL POLICY CONTEXT IN WALES

The public exclusion of the topic of adolescent self-harm from a whole-school preventative approach is at odds with the Welsh legislative framework centred upon young people's rights and well-being. For example, in Wales, there are a number of policies in place to support a rights-based

approach to students' emotional and mental health within the school context. These reside within the overarching framework of the United Nations Conventions on the Rights of the Child (OHCHR 1989), enshrined in Welsh law through the Rights of Children and Young Persons (Wales) Measure (2011). In Wales, children and young people have active participation rights within their society, without discrimination, so that marginalised groups like the adolescent self-harm population group are not excluded (UNICEF 2007). Participation includes all matters that relate to the young person. This includes giving young people the information they require to be able to make informed decisions, in all of the societal contexts they are part of, such as the school context (UNICEF 2007). Excluding the topic of adolescent self-harm from the school's public arena, which a recent systematic review and meta-ethnography demonstrated is also evident within other school settings (Evans and Hurrell 2016), is potentially discriminatory practice as it acts as a barrier to participation rights.

Additional criticism to this whole-school topic exclusion can be drawn from the fact that a whole-school approach is posited by the Welsh Government to promote students' emotional health and well-being. This includes formal teaching on emotional and mental health issues that are relevant to students, and a whole-school approach to health promotion. In the emotional health and well-being school policy document, "Thinking Positively" (Welsh Assembly Government 2010) adolescent self-harm is defined as a common mental health issue, and a number of examples of a whole-school approach to working preventively with adolescent self-harm are outlined, but these require strategic planning and joined-up support across a range of contexts (such as the Local Authority, CAMHS and local health services) for this to take place. These services are under considerable strain at the present moment, which could negatively impact this strategic service vision. Also a linear "systems thinking" perspective (Welsh Assembly Government 2008) as part of the School Effectiveness Framework is advocated as an approach to achieving this "joined-up support" for students' well-being, using it to plan support within and across the interrelated systems that schools are part of (such as a Local Authority and the Welsh Government). Although having good intentions and aspirations to achieve system-level positive outcomes (Welsh Assembly Government 2008), its linear systems approach is too limited and will not yield the results required: its linear modelling approach across four complex systems with multiple interactive mechanisms is fundamentally flawed (Shalizi 2006; The Health Foundation 2010).

All schools have a statutory duty (Education Act 2002, s.175) to safeguard and protect young people in their care. Adolescent self-harm resides within child safeguarding and protection duties and procedures within schools. Current statutory safeguarding policy for all schools states that an

early help approach is to be used in schools to safeguard and promote the welfare of children. This includes a preventative services approach in Wales (Social Services and Well-being (Wales) Act 2014). Within this statutory framework, safeguarding and promoting the welfare of children is defined as: protecting children from maltreatment; preventing impairment of children's health or development; ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best outcomes. Section 16 (1) (c) of the Social Services and Well-being Wales 2014 Act requires a local authority in Wales to promote the involvement of persons (for whom care and support or preventative services are to be provided) in the design and operation of that provision (Welsh Government 2017).

The Suicide and Self-Harm Prevention Strategy for Wales 2015-2020 (Welsh Government 2015) states that “*self harm reduction must be cross-governmental, cross-sectoral and collaborative, with shared responsibility at all levels of the community, if it is to have a chance of success*”, and specifically includes school settings. The Equality Act 2010, the 1989 United Nations Convention on the Rights of the Child (specifically articles 2⁵⁴, 19⁵⁵, 23⁵⁶, 24⁵⁷) and the All Wales Child Protection Procedures (2008) framework would give a legal mandate to completing this work, to investigate the social exclusion that surrounds adolescent self-harm within the school context, and the potentially unlawful discrimination.

2.6 NAVIGATING IATROGENIC RISKS WITHIN THE SECONDARY SCHOOL CONTEXT

The grounded theory stigma model offers detail about the socio-cultural behaviours within the secondary school context in relation to adolescent self-harm. It is recommended here that one intervention strand should focus upon reducing and extinguishing these responses from staff and students. ***Reducing stigma responses does not in any way mean the normalising of adolescent self-harm within the secondary school context. The practical application of the model in this study would be for it to be used to remove the stigmatising reactions/behaviours in regards to adolescent self-harm, to inform the planning of whole-school preventative support delivered within the secondary school context.***

54 UNCRC - section 2 – children's rights to no discrimination, on ANY grounds, including mental health.

55 UNCRC – section 19 -appropriate legislative, administrative, social and educational measures are in place to protect the child from abuse, harm, neglect and negligent treatment from ANY person who has care of the child (this includes schools, who have a duty of care).

56 UNCRC section 23 – this cites the right of a child with mental health needs to actively participate within the community, and his/her dignity to be respected.

57 UNCRC section 24 – the right of the child to the highest standards of health and access to quality health services, and to not be deprived of access to these.

This report is not focused upon the issue of teaching pupils about adolescent self-harm, as this is a separate investigation – it is concerned with **addressing stigmatising responses to adolescent self-harm within the school context**. A whole-school preventative approach needs to be undertaken, but this requires further exploratory work and research to develop what this will be, including consulting with pupils and staff in Wales, and the local and national infrastructures that support and interlink with secondary schools in Wales. Teaching may or may not be an appropriate part of this future intervention design, but it is not necessarily **the** method that would be used within a whole-school preventative approach in schools. Obviously, one of the core activities in school is teaching, which is why school staff focus on this and have a strong opinion centred upon the teaching of adolescent self-harm, as teaching is the familiar and foremost activity within their setting. But from a public health perspective in relation to adolescent self-harm, and a whole-school preventative approach, there may be additional methods to use within the secondary school setting. **It is the community context and adolescent population group that is of interest here, and the ability to gain access to the “invisible” community-based adolescent self-harm group** that don’t interact with traditional health services and support. Innovative and critical thinking is needed, centred upon the aforementioned points, being mindful that schools are politically and historically influenced institutions, and also have their own strong climate of socio-cultures, routines and traditions, which may be barriers to incorporating change.

In regards to teaching about adolescent self harm within the secondary school setting, the following section briefly reflects upon a few issues that future research could take further.

Currently there is no quality evidence that has captured the outcomes of a whole-school approach to teaching about adolescent self-harm, including the potential iatrogenic risks. Specific school-based programmes targeting self-harm exist in other countries. For example, a US school-based study tested the Signs of Self-Injury (SOSI) programme, and found no iatrogenic effects (Meuhlenkamp et al. 2009; Heath et al. 2014), but the US school system is very different to the UK model, as the US system has specialist services within schools to deliver support (and a distinctive health model and funding system). Transferring what appear to be effective programmes from international contexts to the UK is not a straightforward solution, due to the differing socio-cultural contexts, and institutional mechanisms.

A literature review centred on the risk of contagion in US school programmes posited that the careful design of psycho-education programmes centred upon self-harm being an unhealthy coping behaviour could decrease social contagion, but that quality research was needed on this point (Jarvi

et al. 2013). Planning to fulfil this quality research process would be one way forward, that could eventually lead to a randomised control trial model, given the complexities that surround this issue in an education setting context due to concerns about pupils' safety, and the potential iatrogenic risks. A process evaluation component would need to be utilised alongside this work, for example, to demonstrate how the specific outcomes were achieved within the context. Initial exploratory research would need to be first completed to fully define the context and problem in specific detail.

This evidence-based work could be completed as a key strand in addressing the public exclusion of the topic from the whole-school context. It would need to include examining potential iatrogenic risks in whole-school or group based adolescent self-harm discussion (Heath et al. 2014). This would be able to give school staff a quality evidence-base to draw their perspectives from in regards to their perceived complex characteristics of self-harm.

Research centred upon clinical and institutional medical settings has demonstrated the potential for multifaceted causal pathways to the social contagion aspect of adolescent self-harm (Nock and Prinstein 2004; Walsh 2014) within these specific clinical contexts. There is limited research on social contagion within community settings, such as schools (Walsh 2014). Virtual-based experiences of contagion, where the use of social media is the contagion site, are a growing phenomenon (Lewis et al. 2011b; Walsh 2014). In inpatient settings, social learning theory, direct modelling and peer influences are posited as influencing social contagion (Jacobson and Batejan 2014; Walsh 2014). Given these points, in particular to the lack of current research in UK school contexts, delivering whole-school or group-based teaching about self-harm in a school setting, without first gaining the quality evidence-base centred upon understanding the social contagion aspects, is a potential risk. Furthermore, to undertake this work, all schools would need to have effective self-harm school protocols in place, which includes external support pathways; these may be currently compromised given the current UK health and social care resource challenges. A system level safety perspective should inform the planning of this work, to ensure support is in place across a number of system levels, and also that it is fully understood how the elements within these systems interact in regards to quality, safety and support (Emanuel et al. 2011; Rubenfeld and Scheffer 2014). A complex systems perspective could therefore be useful here, to capture the potential non-linear aggregate activity of the multiple components.

One final point made here is that the correlating of adolescent self-harm and contagion by school staff also resides within a spectrum of potentially stigmatising behaviours. This is a dimension that needs to be carefully appraised, to ensure that it is not a stigmatising reaction to adolescent self-

harm that is informing this response. Although fear of contagion appears at first to be a “rational” explanation for the exclusion of self-harm from a whole-school approach, it does reside within a spectrum of the fear and danger beliefs, that are hallmarks of public stigma. Further research is needed to explore this point, as there is a lack of transparency. Managing complexity is part of working with young people; any contagion behaviours will not be a simplistic linear model, and it is argued here that with the pro-harm social media aspects, all students who use social media to explore adolescent self-harm are potentially at risk of contagion behaviours, which they can then bring into their school social network. Understanding the mitigating and mediating factors surrounding contagion behaviours would be a more useful starting point, otherwise it risks a paralysis, which leads to “doing nothing”. Risk management guidance and safety protocols could be designed, to support professionals to manage the complexity of adolescent self-harm safely within the school context, which are currently lacking. However, without a whole-school approach and quality training, this could not work, as the grounded theory stigma model would still be active throughout the institutional context. Any support intervention would need to target the specific grounded theory stigma behaviours as part of the intervention design.

2.7 INITIAL RESEARCH RECOMMENDATIONS

The concluding points of this report section provide research recommendations to take the initial work from this small-scale research project further.

- The stigma model requires further testing and modelling, on a larger scale.
- Institutional factors impacting adolescent self-harm in the secondary school context in Wales should continue to be investigated, including an exploration of the school-based contextual influences in regards to their risk and protective factors upon adolescent self-harm.
- Secondary schools reside within a socio-ecological system of wider influences that shape school-based behaviours regarding adolescent self-harm which require further research. This includes the potential for stigma to be present in primary and secondary health care services, such as Accident and Emergency Departments, and Child and Adolescent Mental Health Services.
- The research agenda should include consulting with school-based staff and pupils about viable support and interventions for adolescent self-harm within the secondary school context. Participatory research methods would facilitate this process.

- Adolescent self-harm is a complex health behaviour; any preventative intervention in schools centred upon this topic and behaviour needs to stem from a complex public health intervention approach. This work should take place within public health bodies who work in this way, who have the research resources and expertise to develop and fully evaluate these types of complex interventions (such as DECIPHER⁵⁸ and the GW4 research alliance⁵⁹).
- The stigma model (if widespread), is likely to negatively impact any adolescent self-harm intervention programme in schools. The practical application of the model in this study would be for it to be used to address the stigmatising reactions/behaviours in regards to adolescent self-harm, to inform the planning of whole-school preventative support delivered within the secondary school context. Complex intervention design and research could take this initial work further.

58 Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement.

59 The research consortium of Bristol, Cardiff and Exeter universities.

APPENDIX: INTERVIEW EXTRACT EVIDENCE ABOUT SOCIAL MEDIA AND STUDENT SELF-HARM.

This includes student access to pro-harm social media sites.

Topic extract 1 makes reference to the impact of social media.

Staff Group B - Extract 1

S1: There's some desperate situations where parents have been aware of the impact of social media on their child, and they're struggling to deal with the situation. It's very serious, and very stressful. And they feel a total helplessness in the face of what can be found out there, in terms of extreme kind of the more to do with ... er ... with self-harm maybe around eating disorders, and stuff like that as well. The absolute lack of control.... Almost like wishing the whole ...you know ... that they could whisk their child away from any access to social media. It's that lack of control. That feeling that there's the potential for a lot of harm to be done if the situation isn't handled in a sort of skilled, knowledgeable, confident way. I think that can go for staff as well. Apprehension. What's the best way of supporting this person.

Topic extracts 2 and 3 make reference to contagion behaviour.

Staff Group B - Extract 2

S2: I also think that social media has a huge huge influence. It seems to be a large part of informing and influencing pupils. And copycat copycat, particularly for the younger ones. In the recent weeks there seems to be, quite a lot of our younger pupils self-harming. But very very superficially. But it still comes under the umbrella of self-harm.

S1: Self-harm, yes.

S2: I am talking about minor, minor scratches perhaps.

Researcher: What year are these pupils?

S2: These are Year 8 pupils. And I've been told on two occasions these pupils were copying another pupil.

Researcher: So, in some specific instances, sometimes they are copying a pupil that they know?

S2: Yes.

Researcher: And are there any instances where they are copying from the social media aspect, from people they don't know?

S2: In the instance I am thinking about, two pupils copied another pupil. The first pupil had seen things on social media.

Staff Group B - Extract 3

S2: Talking to your friends, everything is instant. If they don't instantly have a reply, they feel slighted. Or ignored.

S1: Yes.

S2: Or as if they are being left out. One pupil's quarrel last week with another girl had started because one pupil had sent 47 messages in one evening. And this girl hadn't replied because she was doing something else. So she was worried when she came in to school. I

tried to explain that 47 messages is an awful lot. ...she was wanting something back, and she wasn't getting something, was she? Well I had to fire-fight that first thing in the morning. Because she was aggrieved that the other girl hadn't replied, and thought that they weren't talking. But it was all in her head! It was nothing like that at all. And these two girls were both girls that had self-harmed. And the one had copied the other one. So we think, and the mum thinks as well. And it's very, very superficial

Topic extracts 4 makes reference to pro-harm sites framed as "challenges".

Student Group A - Extract 4

P1: Yes, they may use social media. There's all these types of challenges and stuff on social media, like this. Obviously it's different with self-harm when you are doing it because you are upset. But there's these challenges. *P1 then asked himself*, "Oh what challenges have there been?", *then said*: There's stuff with the salt and ice challenge, for example. Where you've got salt. You put a small amount of salt, and you put ice on your skin, and you time it. You see how long you can do it. And obviously it burns into your skin. It's a form of bodily harm, isn't it? It's bodily harm.

Topic extracts 5 and 6 make reference to pro-harm sites and the graphic images pupils have accessed.

Staff Group A - Extract 5

S1: You know, they are all experimenting with different things. Unfortunately with social media, things are advertised. A girl came to me the other day and said she was lured into a website. And she is a very sensible girl. But then got frightened with the images that she saw, and couldn't get them out of her head. And she said, "I didn't mean to go on to that website". But these websites have clever ways of drawing you in.

Researcher: Do you know what type of website that was?

S1: Erm

Researcher: What was the content?

S1: It wassuicide. She is a very clever, very able, very lovely family. But got frightened because she was just being inquisitive. But those images are in her head, and it's really affecting her. And she is going over and over, "I don't want to kill myself, I don't".

Student Group B - Extract 6

P2: The problem is having visual representation of self-harm.

Researcher: Do you mean for visual, do you mean graphic examples?

P2: Yes.

P3: With you know what you said about how you can go from watching that (the Netflix programme) and doing it. There was an incident back in the day ...

P2: "Back in the day" ... during [the war].... (laughs)

P1: [during the war]

P3: Um ... someone found their secret instagram account.

P2: Oh yes ...

P3: About ... you know ...that. And the name of it was like "suicide" or something like that. But there was pictures, graphic pictures. But there were comments on the pictures from 13

year olds ..

P2: Very young kids.

P3: 13 year olds saying, "I want to be like you". "I'm going to ... you knowdo all this ...to be like you " It was kind of an anorexia thing as well... as well as the self-harm situation. That wasn't exactly great, because there were some people in this school were seeing it. It made me feel very uncomfortable.

Topic extracts 7 make reference to the use of live streaming to deliver graphic images of a pupil's self-harming behaviour to other pupils

Staff Group B - Extract 7

S3: It's so very complex. I've been dealing with a really complicated one over the last couple of days. This is a child who, again in year 8, so for me, that's the classic age. That's where we see it. Much more so than any other year group. And ... um.... She.... She had done some significant self-harm. But told me reasons why she did it. Um and opened up quite a bitand we went through lots of different pieces. Then when she went to her mum, her mum took her to CAMHS, she told them a completely different story. So breaking that down, "unpicking it", that's what they say in CAMHS, isn't it? Unpicking everything, it's time consuming. It took me about four hours just to write the report. Because it was: this was said, then this was said, then this was said, and then this version. That was particularly unpleasant, because you had children she was self harming in front of through video clips, in "face time", in front of others. It was really really complicated. This was a young child, mixed up in gender identity and all sorts of things. The real time streaming of it causes trauma to the other children. So what was happening was that she was then saying she didn't have any friends to her mum. Mum was interpreting that as the child being bullied, picked on and isolated. Actually what was, the friends were friends of hers, but they got scared. They didn't know how to deal with it. They didn't know how to ... you know ... erm ... cope. Actually they backed off because they hadn't got the maturity or skills set to be able to deal with it.

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