

This is a pre-publication version of the following article: **McGeechan, G.J.**, Swainston, K., & O'Neill, C. (2021). Young people's experiences of a targeted community intervention for self-harm. *BPS North of England Bulletin*, 3, 21-34.

## **Abstract**

Deliberate self-harm is a major public health concern, mostly emerging in adolescence and is associated with future suicidal ideation. Most studies relating to interventions involve clinical samples and as such less is known about the effectiveness of community delivered interventions. The present study is a qualitative evaluation of a school-based targeted intervention aimed at reducing stigma around self-harm. Two focus groups were conducted with 11 participants, with data analyzed using a framework analysis approach. Young people reported several positive aspects of the service; enjoying the relaxed atmosphere, the lack of pressure to share personal information and the variety of available resources. However, the targeted approach of the intervention led to some stigma from peers. Furthermore, there is a provision gap when the time limited service ends, risking relapse. This suggests a need for more effective signposting once a service comes to an end.

## **Introduction**

There is some debate in the literature regarding a definitive definition for deliberate self-harm (DSH). However, most scholars agree that it is a deliberate act of self-injury without clear suicidal intent (Muehlenkamp, Claes, Havertape, & Plener, 2012; O'Carroll et al., 1996; Silverman, Berman, Sanddal, O'Carroll, & Joiner Jr, 2007), with some definitions stipulating that the injury must be severe enough for tissue damage to occur (Gratz, 2001). However, such definitions may exclude the ingestion of substances which is above the recommended dose, but not at such a level as to cause risk to life (De Leo & Heller, 2004). Despite this debate concerning the definition of DSH it is clear from the literature that self-injury is a serious public health concern, which tends to emerge in adolescence and if not addressed can be a significant risk factor for future suicidal ideation (Byrne et al., 2008; Laye-Gindhu, 2005; O'Connor & Rasmussen, 2009). However, recent longitudinal research suggests that the majority of individuals who engage in DSH do not go on to attempt suicide (Mars et al., 2019).

Recent evidence suggests that the number of recorded incidents of DSH amongst young people (aged under 18), in the United Kingdom (UK) is rising (Morgan et al., 2017), and is amongst the highest in Europe (Harrington, 2001). For example, the National Health Service (NHS) reports that the number of young girls who received hospital treatment for injuries related to self-harm has almost doubled over the past 20 years. Rising from 7,300 in 1997/98 to 13,500 in 2016/17 (National Health Service, 2018) and is amongst the top five reasons for acute medical admissions (Madge et al., 2008). However, not all incidents of self-harm will result in treatment, suggesting that the number of young people engaging in this behavior is likely to be much higher. Indeed, research suggests that more than 110,000 children aged 14 and under currently self-harm in the

UK (The Childrens Society, 2018), whilst 1/3 of people aged 16-25 in the UK admit to having self-harmed at one stage of their lives (YouGov, 2018).

Various psychological models have considered the etiology and functions of DSH (Nock, 2014; Nock & Cha, 2009). However, evidence appears to be converging around two primary functions; emotion regulation and interpersonal effects, for example expressing distress (Taylor et al., 2018).

A number of reasons have been postulated as to why young people engage in DSH, with the most common self-reported reasons being to escape, to obtain relief, and to die (Scoliers, 2009). These reasons were reinforced by one of the largest studies conducted looking at incidences of DSH in a community sample of young people. Over 30,000 young people across seven countries were asked a number of questions related to DSH including their reasons for engaging in this behavior. The most common reasons cited were to escape a terrible state of mind, and to die. Furthermore, this study concluded that most young people only decided to engage in DSH about an hour before doing so, and most did not attend hospital for their injuries (Madge et al., 2008).

In addition to the self-reported reasons why young people engage in DSH it is also important to consider what risk factors may be associated with future engagement in this behavior. A distinction can be drawn between distal risk factors (early experiences) and proximal risk factors (experiences nearer to illness onset) (Fliege, Lee, Grimm, & Klapp, 2009). Several distal risk factors have been proposed which may be related to future risk of DSH such as parental separation or death (Hawton, Saunders, & O'Connor, 2012), emotional neglect, and physical and psychological abuse, especially sexual abuse (Gratz, Conrad, & Roemer, 2002). Proximal risk factors can include perceived stress (Fliege et al., 2006), depression and anxiety (O'Connor, Rasmussen, & Hawton, 2010) and recent self-harm by friends (Hawton, Rodham, Evans, & Weatherall, 2002).

More recently, researchers have been investigating the links between social media/internet use and DSH in young people. There is some evidence to suggest that there can be a correlation between internet and social media/internet use and population level suicide rates. Indeed, there has been a growth in pro-suicide websites which encourage people to engage in such behavior and may even provide how to guides (Luxton, June, & Fairall, 2012). However, such studies have been criticized for poor methodological quality and there has been a call for more robust research in this area to better understand the links. One such study conducted in the UK was one of the first to look specifically at the role between social media/internet use in DSH behavior in young people. The authors found that 20% of participants who had self-harmed revealed that social media/internet was a causal factor in their decision to engage in this behavior. With issues such as cyber-bullying, peer pressure, and imitating others online being quoted as some of the online activities driving DSH (O'Connor, Rasmussen, & Saunders, 2014). Whilst a lot of research has focused on the negative aspects of social media/internet use in triggering DSH behavior it has to be noted that some research has shown that social media/internet use can be a positive source of support for young people (Daine et al., 2013). A recent systematic review highlighted that social media/internet forums provide a sense of community and can provide advice to young people on how to access formal and informal support (Dyson et al., 2016). Whilst evidence may not provide a robust link between social media/internet use and DSH, it appears that social media/internet use has the potential to be a supportive tool or a hazardous environment for young people.

Given the prevalence of DSH within this population there have been numerous interventions which have been implemented with the aim of reducing engagement in this behavior. Evidence is however mixed on the most efficacious approach to such interventions. For example, whilst there have been positive results shown for group therapy which focused on problem solving skills when

assessed as part of a randomized controlled trial (Wood, Trainor, Rothwell, Moore, & Harrington, 2001), these results do not often translate well into routine practice when replicated on a larger scale (Hazell et al., 2009). Other studies have utilized theory-based interventions such as brief motivational interviewing (MI). MI is an intervention underpinned by a client-centered and directive theoretical approach which aims to strengthen and elicit motivation to change behavior by reducing resistance to change, and using goal setting which is articulated by the client (Miller & Rollnick, 2009). Most studies however have demonstrated limited effectiveness of MI at reducing engagement in self-harm when compared to usual care (Crawford et al., 2010; Van Voorhees et al., 2009). Whilst there have been numerous interventions looking at ways of reducing DSH these have tended to be conducted with clinical samples. As stated above most instances of DSH may never be reported or result in clinical treatment, therefore there is a need to understand what interventions may lead to reduced engagement in this behavior in community samples (The Childrens Society, 2018).

A recent Cochrane review of interventions for self-harm (Hawton et al., 2015) in young people listed only one study testing a psychosocial intervention with a community sample (Rossouw & Fonagy, 2012). Further, research which has been conducted with community samples suggest that interventions may be more effective if delivered outside of a clinical setting where clients can become dependent on clinical care and may be less motivated to change their behavior (James, Taylor, Winmill, & Alfoadari, 2008). The present study was part of a larger evaluation looking at the effectiveness of a community delivered partnership approach to addressing self-harm amongst vulnerable young people. Due to the limited research looking at interventions in community samples it is important to gain an in-depth understanding of the positive and negative aspects of such interventions to inform future studies.

Therefore, the aim of the present paper was to qualitatively explore young people's views of a targeted, community delivered program for raising awareness of self-harm issues and relevant support.

## **Methods**

### *Study Design*

A qualitative study exploring the views of young people receiving a targeted, community delivered intervention aimed at raising awareness of self-harm issues and relevant support in the UK.

### *Intervention*

The service which was evaluated as part of this study was designed to ensure access to self-harm support services was available to all young people in participating schools, to raise awareness of self-harm amongst all young people, and to reduce stigma. This was delivered through a partnership approach involving primary care, social services, schools, and third sector support services. The intervention used a lead provider model, whereby a single organization took the lead in delivering the service within high schools and signposted to other partner organizations to increase the scope of the service.

### *Recruitment*

All young people who had engaged with the service were eligible to take part in a focus group with their peers. Members of staff within schools acted as gatekeepers and organized the time and date for the focus groups which were conducted by CO and KD.

### *Ethical Considerations*

A parental consent form, and study information sheet was sent to all eligible participants, and only those who returned a completed parental consent form were eligible to take part in a focus group. Participants then completed a subsequent consent form prior to the focus group commencing. Ethical approval for this study was granted by REDACTED FOR REVIEW (SSSBLEC258).

### *Data Collection*

Two focus groups were conducted with young people who had engaged with the service. Topic guides were prepared in advance of the focus groups which aimed to uncover barriers and facilitators to the successful delivery of the service. All focus groups were held on school premises and were chaperoned by a member of school staff.

### *Data Analysis*

All focus groups and interviews with participants were audio recorded to aid with analysis. A framework analysis (Ritchie & Spencer, 1994; Srivastava & Thomson, 2009) approach was used to analyze the data with a pre-existing coding framework developed from the secondary analysis of existing data provided by the service providers (not detailed here). Two researchers (GM and KD) analyzed the data and assigned codes based on the existing framework, in instances where data did not fit the framework then new codes were created, and the framework was adapted accordingly. In order to increase reliability and validity of the findings, the wider research team reviewed the emergent themes which were then adapted through discussion for the final framework.

## **Results**

In total two focus groups were conducted with young people from two schools in the UK, with a total of 11 participants. Focus groups with young people lasted an average of 41 minutes. In total we identified two major themes, each with several sub-themes. The findings are summarized below, with illustrative quotations provided in Table 1.

### Positive aspects of the service

#### *Benefits of a partnership approach*

Participants discussed several different aspects which they felt encouraged their engagement with the service. Participants spoke about the people who facilitated the service within the school and how they shared their own experiences. Young people seemed to appreciate this approach as it put the facilitator on the same footing as them, and showed them that they were not alone in their experiences:

Well (facilitator) you wouldn't just tell her stuff, she would tell us stuff about when she was a kid and that in school... yeah so, we didn't feel like it was only us, she like discusses some of her like worries when she was in school and that, and her home life (FG2)

A further benefit of the partnership approach was that participants had access to a variety of resources which could be used in conjunction with, or instead of attending the group sessions. Participants demonstrated an awareness that these different approaches are needed to ensure that support is accessible to as many young people as possible:

If you do it more like in assembly then people can come out and just joke with it like with their friends. But when it is like an app, they can like see it privately and actually think about it instead of just making remarks about it (FG1).

### *Peer support*

A primary aim of the service was to provide a peer support network for young people so that they could share their learning with others in the school and raise awareness around mental health issues. Whilst this was not formally achieved by the service providers it appears that an element of peer support emerged organically amongst participants. They spoke about the supportive nature of the group, and that they had gained confidence to speak to their peers about mental health, even with those who had not engaged with the support group. “It was good because obviously when I had stuff going on at home it was like, it was just me and then when I went to the group it wasn’t just me (FG2).”

Someone who I know like who was self-harming when he was going through a tough time with like his mam [sic] being in hospital and his nanna dying and that, like just telling him that it’s okay to talk to someone (FG2).

As young people moved on from the service, they formed an informal support group and offered advice to younger pupils who were going through similar issues:

Even like little (name) like I see him all the time now in school he’s only like in Year 8 and he’s like hi (name) and just like it is nice to know that they do look up to you because I was here when it was like loads of, not last year but the year before and I kind of had that relationship with them as well so it was kind of like nice to have that

relationship with other kids because I know how comfortable I felt around them (previous cohort) and I could go to them (FG1).

### *Safe and supportive environment*

The provision of a safe and supportive environment provided young people with the confidence that they could speak openly within the group and know that what they said in the room was private due to the ground rules which had been put in place. “Yeah, we had rules that, we had rules in the first or second week when (facilitator) came in like how private stuff needed to be within the group (FG2).”

The facilitators of the service viewed as key in fostering a safe and supportive environment. Participants appreciated that they were non-judgmental and perhaps because they were not staff within the school, they felt more comfortable opening up to them.

I mean it does help I think it's an outlet like when (name) came in we didn't actually feel like forced to talk or have that discussion. You know sometimes we would just be sat talking like usual and I'd be like maybes sitting doing revision and just have like a relaxed conversation. It's nice when you don't have that pressure from someone (FG1).

The safe and supportive environment fostered within the group setting then allowed young people to open up and discuss mental health in other settings. This increased confidence can then help reduce stigma around mental health issues and hopefully improve access to mental health services for young people. For example, one participant spoke about reduced anxiety and their confidence

to speak to counsellors at a skin cancer charity which they were receiving support from, and with their teachers at school.

Right now, like since I've been (attending) and I've met all these people I am not like afraid of anxiety, I can't do this or... I like on Mondays basically I go to my counsellors, like MelanomaMe, and like they do counselling (inaudible). I'm not that bothered to say because it is my life and I can't like hide it, cause when I did hide it a lot of teachers like used to always think I couldn't do anything, I was too scared but now like that they know I've got anxiety like we won't try and push your limits we won't push you to a point where you're crying (FG1).

#### Aspects of the service which could be improved

Whilst the feedback from the young people who took part in the focus groups was mostly positive it is important to acknowledge areas of concern which could potentially limit the impact of the service.

#### *Stigma associated with accessing support*

One important aspect which arose from participants related to stigma from peers about accessing support for mental health. Whilst some of the analysis above describes increased confidence in discussing mental health with others, this was not the case for everyone. Some participants felt that they could not tell their friends that they were accessing support, afraid that they would be treated differently or that it would lead to uncomfortable conversations about mental health.

I think that's why I didn't tell my friendship group as well, in case they tret [sic] me differently. In case they were like 'oh we can't do this because of her' or 'we can't do this because of her' (FG1).

Because people might think it is like a label (inaudible) people might be scared to get diagnosed because it is a label and then when you tell people they think that makes them completely different from the person they were before. Like you don't want to be treated different (FG1).

### *Schools could do more to reduce stigma*

The targeted nature of recruitment to the group could then be seen to single people out within the school, and act as a barrier to future recruitment if young people do not want to receive that sort of attention from their peers. Targeted recruitment could also at times mean that young people were taking part in the service without feeling fully informed about its purpose. "I was kind of confused about why I had to do it [join group] (FG2)".

Additionally, some participants discussed that more could be done to raise awareness of the struggles faced by young people with mental health difficulties. It was hoped that this would make their peers less likely to make jokes at the expense of others or make hurtful comments if they knew what it was like to be a sufferer.

I just want more people to see the reality of it because obviously I wouldn't wish it on like anyone but I would like people to at least know how it feels for just like five seconds just so they can like understand it more. Then they may not be as nasty about it if they understood (FG1).

Other participants opined that most teachers were lacking in understanding of mental health issues faced by young people, and sometimes think it is just an excuse. There was a suggestion that more training would help teachers better support young people and reduce strain on services.

It would be nice for more of the teachers to understand because yes, we have a few teachers who understand but not all of them do, and some of them probably do think that people use it [anxiety] as an excuse. It would be nice for them to have a training day for people to understand it more and if you have more teachers to speak to (FG1).

#### *Gap in provision once service ends*

Finally, whilst the service was viewed positively by students, as it was a time limited service, there is a gap in provision once the service ends. Therefore, in order to maintain the positive impacts for students there is a need for services like this to continue in the long-term, or for another service to take its place. “Cause when you are in the group like your confidence is boosted then kinda [sic] we stopped and like some people didn’t have any confidence anymore they didn’t have the support the needed.” FG2

Whilst some students discussed the positives of a partnership approach and access to other avenues of support, there is a need for face-to-face support and once this ends people may revert to previous behavior. “I think that there should be more groups and [service] should access the school more to help put students like worries aside.” FG2

## **Discussion**

The above study aimed to evaluate the impact of a community delivered and targeted partnership approach to reducing stigma around self-harm and raising awareness of support services. To the

best of our knowledge this is the first such study to explore the experiences of young people taking part in such a school-based service. The results outlined above provide insights into the positive aspects of a targeted community intervention for self-harm, whilst also introducing issues which could impact on the acceptability and effectiveness of such interventions.

Within the UK, Public Health England has launched local suicide prevention planning. As part of this guidance it is recommended that a multi-agency partnership approach is adopted, led by public health, primary care and mental health services, to reduce the burden of suicide and self-harm (Public Health England, 2016). The partnership approach was a key component of this service, and this appears to have been well received by participants. Participants enjoyed the environment which was fostered by an external facilitator during the group discussions, alluding to the relaxed atmosphere and that there was no pressure to share experiences if they did not want to. However, when they did choose to share their experiences, they found the facilitator easy to talk to. Evidence suggests that the relationship between a facilitator and client can have a positive impact on reducing self-harming behavior (Dunster-Page, Haddock, Wainwright, & Berry, 2017). Therefore, it is essential in services such as this that a good level of rapport is developed and that young people feel that they are being listened to and understood if they choose to share (Storey, Hurry, Jowitt, Owens, & House, 2005).

Another benefit of the partnership approach was that young people were given a variety of options when it came to support around self-harm. This included whole school assemblies to raise awareness and reduce stigma, to the actual group itself and the use of a website and a mobile phone application (app) to support young people. Previous literature has highlighted that the internet can be a source of support for young people in relation to self-harm or a toxic environment which facilitates, or in some cases actively encourages self-harm (Daine et al., 2013; Luxton et al., 2012).

However, the young people in this study felt that the variety of options, including the website and app, were a positive thing and meant that there would always be an option available for them to access support.

However, despite the positive experiences outlined by participants there were some areas of concern which were highlighted which should be considered by future providers. For example, whilst overall young people appeared to enjoy taking part in the service, the targeted nature of the intervention meant that some felt that they were taking part without being fully informed of the purpose of the service. Previous research of mental health services delivered in schools has highlighted that targeted interventions can lead to stigma from peers, and this appears to have been an issue for some participants in this study (McGeechan, Richardson, Wilson, Allan, & Newbury-Birch, 2019). Whilst a universal approach to delivering such services may reduce this stigma (Kuyken et al., 2013), it is often the case that when piloting services such as this that providers, and schools will select individuals that they feel would benefit most, rather than implementing a school wide service for which they have no evidence of effectiveness (McGeechan et al., 2019).

Furthermore, participants raised concerns about the lack of focus on mental health issues within their school and were concerned that once the service finished then things would regress to how they were before. Whilst there is little evidence on self-harm remission following community interventions (Hawton et al., 2015), evidence from clinical samples suggests that young people, and especially young females with a history of self-harm, are at most risk of being admitted to hospital within 12-months following discharge from treatment (Gunnell et al., 2008). This suggests that despite the benefits of the service, as outlined by participants, some may be at risk of harm if, and when that service is withdrawn.

## **Limitations**

One of the limitations of this study was that interviews took place during school time, this limited the amount of time available for researchers to speak to participants as there was a desire not to keep students out of class for too long. Furthermore, as the school acted as gatekeepers for recruitment to the study, we were unable to measure uptake to the study and are unaware of how many people declined to take part. Finally, as the study was a service evaluation of a commissioned service, we are not able to generalize our findings to wider community based self-harm interventions. However, as already highlighted there is a paucity of research in this area, and as such future studies should look to measure effectiveness on a larger scale (Hawton et al., 2015).

## **Conclusion**

In summary, the partnership approach to a targeted community service addressing self-harm was well received by participants. They felt that the facilitators fostered a safe and secure environment where they felt comfortable sharing if they wanted to. Furthermore, due to the partnership approach there were numerous resources which young people could access if they were not comfortable talking about issues in schools. Of interest was the mobile phone application which students could access in their own time, which many felt would provide added benefit to services. However, whilst extra resources are available the students seemed to enjoy working directly with service providers. This suggests that extra resources may be useful but cannot directly replace face-to-face support.

## **Declaration of Conflicting Interests**

KS is the chair of the ethics committee which approved this study however was not involved in reviewing this application. The remaining authors have declared that they have no competing or potential conflicts of interest

**Funding:** The study was funded by Sunderland City Council as part of a wider service evaluation.

**Acknowledgements:** The authors would like to acknowledge the contribution of Karen Dodsworth (KD) who was involved in data collection and analysis for this study but who was not involved in producing the final manuscript.

## References

- Byrne, S., Morgan, S., Fitzpatrick, C., Boylan, C., Crowley, S., Gahan, H., . . . Guerin, S. (2008). Deliberate Self-harm in Children and Adolescents: A Qualitative Study Exploring the Needs of Parents and Carers. *linical child psychology and psychiatry*, 13(4), 493-504. doi:10.1177\_1359104508096765
- Crawford, M. J., Csipke, E., Brown, A., Reid, S., Nilsen, K., Redhead, J., & Touquet, R. (2010). The effect of referral for brief intervention for alcohol misuse on repetition of deliberate self-harm: an exploratory randomized controlled trial | Psychological Medicine | Cambridge Core. *Psychological medicine*, 40(11), 1821-1828. doi:doi:10.1017/S0033291709991899
- Daine, K., Hawton, K., Singaravelu, V., Stewart, A., Simkin, S., & Montgomery, P. (2013). The Power of the Web: A Systematic Review of Studies of the Influence of the Internet on Self-Harm and Suicide in Young People. *PloS one*, 8(10), e77555. doi:10.1371/journal.pone.0077555
- De Leo, D., & Heller, T. S. (2004). Who are the kids who self-harm? An Australian self-report school survey. *Medical Journal of Australia*, 181(3), 140-144. doi:10.5694/j.1326-5377.2004.tb06204.x
- Dunster-Page, C., Haddock, G., Wainwright, L., & Berry, K. (2017). The relationship between therapeutic alliance and patient's suicidal thoughts, self-harming behaviours and suicide attempts: A systematic review. *Journal of Affective Disorders*, 223, 165-174. doi:<https://doi.org/10.1016/j.jad.2017.07.040>
- Dyson, M. P., Hartling, L., Shulhan, J., Chisholm, A., Milne, A., Sundar, P., . . . Newton, A. S. (2016). A Systematic Review of Social Media Use to Discuss and View Deliberate Self-Harm Acts. *PloS one*, 11(5), e0155813. doi:10.1371/journal.pone.0155813
- Fliege, H., Kocalevent, R. D., Walter, O. B., Beck, S., Gratz, K. L., Gutierrez, P. M., & Klapp, B. F. (2006). Three assessment tools for deliberate self-harm and suicide behavior: evaluation and psychopathological correlates. *Journal of psychosomatic research*, 61(1), 113-121. Retrieved from <http://dx.doi.org/>
- Fliege, H., Lee, J. R., Grimm, A., & Klapp, B. F. (2009). Risk factors and correlates of deliberate self-harm behavior: A systematic review. *Journal of psychosomatic research*, 66(6), 477-493. Retrieved from <http://dx.doi.org/>
- Gratz, K. L. (2001). Measurement of Deliberate Self-Harm: Preliminary Data on the Deliberate Self-Harm Inventory. *Journal of psychopathology and behavioral assessment*, 23(4), 253-263. doi:10.1023/A:1012779403943
- Gratz, K. L., Conrad, S. D., & Roemer, L. (2002). Risk Factors for Deliberate Self-Harm Among College Students - Gratz - 2002 - American Journal of Orthopsychiatry - Wiley Online Library. *American journal of Orthopsychiatry*, 72(1), 128-140. doi:10.1037/0002-9432.72.1.128
- Gunnell, D., Hawton, K., Ho, D., Evans, J., O'Connor, S., Potokar, J., . . . Kapur, N. (2008). Hospital admissions for self harm after discharge from psychiatric inpatient care: cohort study. *The British Medical Journal*, 337, a2278. doi:10.1136/bmj.a2278 %J BMJ
- Harrington, R. (2001). Depression, suicide and deliberate self-harm in adolescence. *British Medical Bulletin*, 57(1), 47-60. doi:10.1093/bmb/57.1.47
- Hawton, K., Rodham, K., Evans, E., & Weatherall, R. (2002). Deliberate self harm in adolescents: self report survey in schools in England. *British Medical Journal*, 325(7374), 1207-1211. doi:10.1136/bmj.325.7374.1207
- Hawton, K., Saunders, K. E. A., & O'Connor, R. C. (2012). Self-harm and suicide in adolescents. *The Lancet*, 379(9834), 2373-2382. Retrieved from <http://dx.doi.org/>
- Hawton, K., Witt, K. G., Salisbury, T. L. T., Arensman, E., Gunnell, D., Townsend, E., . . . Hazell, P. (2015). Interventions for self-harm in children and adolescents. *Cochrane database of systematic reviews*(12).

- Hazell, P. L., Martin, G., McGill, K., Kay, T., Wood, A., Trainor, G., & Harrington, R. (2009). Group therapy for repeated deliberate self-harm in adolescents: failure of replication of a randomized trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 48(6), 662-670. Retrieved from <http://dx.doi.org/>
- James, A. C., Taylor, A., Winmill, L., & Alfoadari, K. (2008). A Preliminary Community Study of Dialectical Behaviour Therapy (DBT) with Adolescent Females Demonstrating Persistent, Deliberate Self-Harm (DSH). *Child and Adolescent Mental Health*, 13(3), 148-152. doi:10.1111/j.1475-3588.2007.00470.x
- Kuyken, W., Weare, K., Ukoumunne, O. C., Vicary, R., Motton, N., Burnett, R., . . . Huppert, F. (2013). Effectiveness of the Mindfulness in Schools Programme: non-randomised controlled feasibility study. *The British Journal of Psychiatry*, 203(2), 126-131.
- Laye-Gindhu, A., Schonert-Reichl, K.A. (2005). Nonsuicidal Self-Harm Among Community Adolescents: Understanding the “Whats” and “Whys” of Self-Harm | SpringerLink. *Journal of Youth and Adolescence*, 34(5), 447-457. doi:10.1007/s10964-005-7262-z
- Luxton, D. D., June, J. D., & Fairall, J. M. (2012). Social Media and Suicide: A Public Health Perspective. <https://doi.org/10.2105/AJPH.2011.300608>, 102, S195-S200. doi:10.2105/AJPH.2011.300608
- Madge, N., Hewitt, A., Hawton, K., Wilde, E. J. D., Corcoran, P., Fekete, S., . . . Ystgaard, M. (2008). Deliberate self-harm within an international community sample of young people: comparative findings from the Child & Adolescent Self-harm in Europe (CASE) Study - Madge - 2008 - Journal of Child Psychology and Psychiatry - Wiley Online Library. *The Journal of Child Psychology and Psychiatry*, 49(6), 667-677. doi:10.1111/j.1469-7610.2008.01879.x
- Mars, B., Heron, J., Klonsky, E. D., Moran, P., O'Connor, R. C., Tilling, K., . . . Gunnell, D. (2019). What distinguishes adolescents with suicidal thoughts from those who have attempted suicide? A population-based birth cohort study. *Journal of child psychology and psychiatry*, 60(1), 91-99.
- McGeehan, G. J., Richardson, C., Wilson, L., Allan, K., & Newbury-Birch, D. (2019). Qualitative exploration of a targeted school-based mindfulness course in England. *Child and Adolescent Mental Health*, 24(2), 154-160.
- Miller, W. R., & Rollnick, S. (2009). Ten Things that Motivational Interviewing Is Not. *Behavioural and Cognitive Psychotherapy*, 37(2), 129-140. doi:doi:10.1017/S1352465809005128
- Morgan, C., Webb, R. T., Carr, M. J., Kontopantelis, E., Green, J., Chew-Graham, C. A., . . . Ashcroft, D. M. (2017). Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care. *British Medical Journal*, 359, j4351. doi:10.1136/bmj.j4351
- Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health*, 6(1), 10. doi:doi:10.1186/1753-2000-6-10
- National Health Service, N. D. (2018). Hospital admission for self poisoning or self harm in young people. Retrieved from <https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2018-supplementary-information-files/hospital-admissions-for-self-poisoning-or-self-harm-in-young-people>
- Nock, M. K. (Ed.) (2014). *Comprehensive theoretical models of nonsuicidal self-injury*. New York, NY: Oxford University Press.
- Nock, M. K., & Cha, C. B. (Eds.). (2009). *Psychological models of nonsuicidal self-injury*. Washington DC, USA: American Psychological Association.
- O'Carroll, P. W., Berman, A. L., Maris, R. W., Moscicki, E. K., Tanney, B. L., & Silverman, M. M. (1996). Beyond the Tower of Babel: a nomenclature for suicidology. *Suicide and Life-Threatening Behavior*, 26(3), 237-252.

- O'Connor, R. C., Rasmussen, S., & Hawton, K. (2010). Predicting depression, anxiety and self-harm in adolescents: The role of perfectionism and acute life stress. *Behaviour research and therapy*, 48(1), 52-59. Retrieved from <http://dx.doi.org/>
- O'Connor, R. C., & Rasmussen, S., Miles, J., Hawton, K. (2009). Self-harm in adolescents: self-report survey in schools in Scotland | The British Journal of Psychiatry | Cambridge Core. *The British Journal of Psychiatry*, 194(1), 68-72. doi:doi:10.1192/bjp.bp.107.047704
- O'Connor, R., Rasmussen, S., & Saunders, K. E. (2014). Adolescent Self-harm: A school based study in Northern Ireland. *Journal of Affective Disorders*, 159, 46-52. Retrieved from <http://dx.doi.org/>
- Public Health Engalnd. (2016). *Local Suicide Prevention Planning: A local resource*. Retrieved from [https://www.nspa.org.uk/wp-content/uploads/2016/10/PHE\\_LA\\_guidance-NB241016.pdf](https://www.nspa.org.uk/wp-content/uploads/2016/10/PHE_LA_guidance-NB241016.pdf)
- Ritchie, J., & Spencer, L. (Eds.). (1994). *Qualitative data analysis for applied policy research*. New York, NY: Routledge.
- Rossouw, T. I., & Fonagy, P. (2012). Mentalization-based treatment for self-harm in adolescents: a randomized controlledtrial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 51(12), 1304-1313.
- Scoliers, G., Portzky, G., Madge, N., Hewitt, A., Hawton, K., De Wilde, E. J., Ystgaard, M., Arensman, E., De Leo, D., Fekete, S., van Heeringen, K. (2009). Reasons for adolescent deliberate self-harm: a cry of pain and/or a cry for help? | SpringerLink. *Social Psychiatry and Psychiatric Epidemiology*, 44(8), 601-607. doi:10.1007/s00127-008-0469-z
- Silverman, M. M., Berman, A. L., Sanddal, N. D., O'Carroll, P. W., & Joiner Jr, T. E. (2007). Rebuilding the tower of Babel: a revised nomenclature for the study of suicide and suicidal behaviors part 2: suicide-related ideations, communications, and behaviors. *Suicide and Life-Threatening Behavior*, 37(3), 264-277.
- Srivastava, A., & Thomson, S. (2009). Framework Analysis: A Qualitative Methodology for Applied Policy Research. 4 *Journal of Administration and Governance*, 72. Retrieved from <https://ssrn.com/abstract=2760705>
- Storey, P., Hurry, J., Jowitt, S., Owens, D., & House, A. (2005). Supporting young people who repeatedly self-harm. 125(2), 71-75. doi:10.1177/146642400512500210
- Taylor, P. J., Jomar, K., Dhingra, K., Forrester, R., Shahmalak, U., & Dickson, J. M. (2018). A meta-analysis of the prevalence of different functions of non-suicidal self-injury. *Journal of Affective Disorders*, 227, 759-769.
- The Childrens Society. (2018). The Good Childhood Report 2018. Retrieved from <https://www.childrensociety.org.uk/what-we-do/resources-and-publications/the-good-childhood-report-2018>
- Van Voorhees, B. W., Fogel, J., Reinecke, M. A., Gladstone, T., Stuart, S., Gollan, J., . . . Bell, C. (2009). Randomized Clinical Trial of an Internet-Based Depression Prevention Program for Adolescents (Project CATCH-IT) in Primary Care: Twelve-Week Outcomes. *J Dev Behav Pediatr*, 30(1), 23-37. doi:10.1097/DBP.0b013e3181966c2a
- Wood, A., Trainor, G., Rothwell, J., Moore, A. N. N., & Harrington, R. (2001). Randomized trial of group therapy for repeated deliberate self-harm in adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40(11), 1246-1253. Retrieved from <http://dx.doi.org/>
- YouGov. (2018). New survey shows more than a third of young people have self-harmed.

