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Towards an understanding of the self-harming behaviours of vulnerable young people

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Word Count

Thesis Section	Text	Abstracts, References, Tables and Appendices	Total
Thesis Abstract	290	-	290
Literature Review	7,973	8,668	16,641
Research Paper	7,939	10,692	18,631
Critical Appraisal	3,739	749	4,488
Ethics Section	4,022*	9,573	13,595
Total	**23,963**	**29,682**	**53,645**

*Word count excludes all word printed words on NHS ethics forms as per guidance

Claire Smith-Gowling, May 2016

Thesis Abstract

Relatively little is known about the factors associated with young people's engagement in self-harm. Given the existing vulnerabilities associated with being looked-after, the first section of this thesis aimed to examine and synthesise the empirical literature investigating the psychosocial risk factors associated with self-harm and suicide among looked-after children (LAC). Systematic appraisal of fourteen studies highlighted several demographic, socio-environmental and psychological factors thought to place LAC at an increased risk of self-harm and suicidal behaviour. The findings have significant implications for intake assessment, treatment planning, service delivery, and staff training to address the complex emotional and behavioural needs of LAC.

Given the potential risk that exposure to the self-harm of others might have on engagement in self-harm, the second section of this thesis aimed to explore, using Interpretative Phenomenological Analysis (IPA), how adolescents made sense of the self-harm of others, and how, if at all, the self-harm of others influenced their own behaviour and well-being. Eight young people, resident at one of two adolescent inpatient units, were interviewed and five themes emerged from the interview data: 'Exposure to self-harm', 'An unpleasant environment', 'Helper vs helped', 'Separation from the attention seekers', and 'Competing for authenticity'. Self-harm prevention efforts aimed towards reducing the social transmission and stigma surrounding self-harm were discussed.

The final section of the thesis adopts a critical and reflective stance to consider the decision-making processes regarding the thesis topic including the rationale for the study and the chosen methodology, and the practical and procedural challenges encountered during the course of the research, such as ethics approval processes and recruitment difficulties. The appraisal then goes onto review the researchers' clinical reflections on the applications of the thesis findings, and the impact of the research on her journey through doctoral training.

Declaration

This thesis reports research undertaken between January 2015 and July 2016 as a requirement of the Doctorate in Clinical Psychology at Lancaster University. The work presented here is my own except where reference is made. The work has not been submitted for the award of any higher degree elsewhere.

Claire Smith-Gowling, July 2016

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Contents

Appendices

Section 1: Thesis Literature Review

Running head: SELF-HARM AND SUICIDAL BEHAVIOUR IN LAC

Self-harm and suicidal behaviour in looked-after children: A systematic review

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Abstract

Background: The number of emotional, social and behavioural problems of looked-after children (LAC) has been consistently shown to be substantially higher than that of children and adolescents living with their families, however there has been little research that has explored self-harm and suicidal behaviour in LAC. The current paper aims to review quantitative research studies exploring potential risk factors associated with self-harm and suicidal behaviour in LAC.

Method: Searches of electronic databases including PsycINFO, Web of Science, PubMed and CINHAL were conducted using explicit inclusion and exclusion criteria. A total of 490 publications were identified, and following a thorough selection process, fourteen quantitative studies were included.

Results: Systematic appraisal of these studies highlighted several demographic, socio-environmental and psychological factors thought to place LAC at an increased risk of self-harm and suicidal behaviour.

Conclusions: The review findings represent the first steps toward identifying factors associated with self-harm and suicidal behaviour among LAC, and have substantial implications for intake assessment, treatment planning, service delivery and staff training to address the complex emotional and behavioural needs of LAC.

Keywords: Systematic review; looked-after children; risk factors; self-harm; suicidal behaviour.

The reported increase in prevalence of self-harming behaviour among adolescents is concerning. In 2002, a comprehensive UK survey by Hawton, Rodham, Evans, and Weatherall (2002) found that 13% of children and adolescents reported self-harm. Such findings are not unique to children and adolescents in the UK, with several international studies highlighting similar concerns (Laye-Gindhu & Schonert-Reichl, 2005; Muehlenkamp, Claes, Havertape, & Plener, 2012; Nock, 2010). Moreover, the actual rate of self-harm has been estimated at much higher than this due to the often private nature of this behaviour (Hawton et al., 2002; Madge, Hewitt, Hawton, Wilde, Corcoran, & Fekete et al., 2008; National Institute for Health & Care Excellence [NICE], 2004). Research suggests that levels of self-harm in adolescence are continuing to increase, with 19% of adolescents now reporting self-harm (Mars, Heron, Crane, Hawton, Lewis, & Macleod et al., 2014). Suicide has been shown to be one of the leading causes of death among young people, and research has shown that adolescents who self-harm are at a much greater risk of suicide (50-100 times more likely) than those who do not self-harm (NICE, 2013). Consequently, researchers began to explore possible risk factors for self-harm and suicidal behaviour in the general adolescent population (Fliege, Lee, Grimm, & Klapp, 2009; Hawton, Saunders, & O'Connor, 2012).

Self-harm and suicidal behaviour

Self-harm is a term which captures a variety of behaviours in which an individual intentionally inflicts harm to their body without obvious suicidal intent (NICE, 2011), however, a universal definition for self-harm has yet to be established (Hawton, Harris, Simkin, Bale, & Bond, 2003). Many current researchers use the NICE quality standards for self-harm (NICE, 2013) definition, which is any act of self-poisoning or self-injury carried out by an individual irrespective of motivation or suicidal intent. Common presentations of self-harm among adolescents include skin cutting and scratching, burning, interfering with wound healing, hair pulling, and self-poisoning (Klonsky, 2007; Skegg, 2005). There are several important exclusions that the term self-harm is not intended to cover. These include accidental harm to self, excessive consumption of alcohol or recreational drugs, and starvation or overeating (NICE, 2013).

Although much of the research in this area groups self-harm with suicidal behaviour, some researchers and clinicians distinguish the two (Nock & Kessler, 2006; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006), with the key difference being the intent to end one's life (Muehlenkamp, 2005). Although research suggests that people who self-harm are at a greater risk of considering and/or attempting suicide (Andover & Gibb, 2010; Hukkanen, Sourander, & Bergroth, 2003; Muehlenkamp & Kerr, 2010), self-harm is more widely understood as a coping strategy (Holm & Severinsson, 2010; Meltzer, Lader, Corbin, Singleton, Jenkins, & Brugha, 2000) and not necessarily an indication of suicidal intent (Hall & Place, 2010). However, the risk of accidental death from self-harm, such as cutting too deep or tying ligatures too tight, continues to be of concern (Zahl & Hawton, 2004).

Although there have been convincing empirical differences highlighted between people who self-harm and people who attempt suicide (Muehlenkamp & Gutierrez, 2004), regrettably, evaluating intent and distinguishing between these behaviours is often difficult in clinical practice and research. As a result, researchers exploring this topic area continue to group self-harm with suicidal behaviour. Moreover, most studies focus on suicide attempts as the outcome of interest, however suicidal ideation is an important outcome to consider when addressing the suicidal behaviour of young people (Bridge, Goldstein, & Brent, 2006).

Risk factors associated with self-harm and suicidal behaviour in the general population

Globally, suicide is one of the leading causes of death for young people (World Health Organisation [WHO], 2014). A number of individual and interpersonal factors may influence child suicidality, including age, gender, self-efficacy, history of maltreatment, peer relationships, social support and separation from family (Johnson, Wood, Gooding, Taylor, & Tarrier, 2011; Kleiman, Riskind, & Schaefer, 2014; Rubin, O'Reilly, Luan, & Localio, 2007; Taussig, Clyman, & Landsverk, 2001; Waldrop, Hanson, Resnick, & Kilpatrick, 2007; Wasserman, Cheng, & Jiang, 2005). In the UK, since evidence suggests that the prevalence of suicide and suicidal behaviour is rising for young males (Department of Health [DoH], 2015b; Richardson, Clarke, & Fowler, 2013), government policy has focused on the need to reduce suicide rates (DoH, 2012; 2015a). Although research has highlighted the need to prevent the repetition and consequential escalation of self-harming and suicidal behaviour (Hawton, Fagg, Simkin, Bale, & Bond, 1997), there has been less focus on the prevention and understanding of the associated risk factors (Webb, 2002).

Although self-harm and suicide are not considered to be diagnosable mental health problems in their own right, research has shown a considerable overlap between the psychological and environmental risk factors associated with developing mental health difficulties and those factors associated with developing self-harming and suicidal behaviour (Hawton, Saunders, & O'Connor, 2012). Self-harm and suicidal behaviour have been shown to be associated with a range of psychological difficulties including anxiety, impulsivity, low self-esteem and substance use problems (Jacobson, Muehlenkamp, Miller, & Turner, 2008; Klonsky, 2007; Nock et al., 2006). More specifically, depression and hopelessness have been highlighted as major features of self-harm and suicidal behaviour among children and young people (Harrington, Kerfoot, Dyer, McNiven, Gill, et al., 1998; Kingsbury, Hawton, Steinhardt, & James, 1999).

However, since self-harm and suicidal behaviour can occur in the absence of any mental health difficulties, it is important to consider other psychosocial stressors that may place adolescents at increased risk. For example, a substantial amount of research in recent decades has established that childhood adversities such as physical and/or sexual abuse (McLaughlin, Greif Green, Gruber, Sampson, Zaslavsky & Kessler, 2012; Mills, Scott, Alati, O'Callaghan, Najman, & Strathearn, 2013), witnessing domestic violence or family conflict (Meltzer et al., 2000), and having a parent with mental health difficulties (Groholt, Ekeberg, Haldorsen, 2000), are all important risk factors for the development of self-harm and suicidal behaviour in adolescence. Moreover, Rubenstein and colleagues' (Rubenstein, Halton, Kasten, Rubin, Stechler, 1998) survey of high school students also found worries about sexuality, academic pressure and failure, and having friends who self-harm to be associated with self-harm and suicidal behaviour.

More recently, there is a growing amount of literature showing that poly-victimisation (exposure to more than one type of adversity) increases the risk of suicidal behaviour and self-harm (Afifi, MacMillan, Boyle, Taillieu, Cheung, & Sareen, 2014, Chan, 2013; Finkelhor, Ormrod & Turner, 2007; Ford, Grasso, Hawke, & Chapman, 2013). Thus looked-after children (LAC) within the child welfare system should be a cause for concern since this vulnerable population is known to have been exposed to many of the psychosocial risk factors highlighted as being risk factors for self-harm and suicidal behaviour (Hukkanen, Sourander, Bergroth, & Piha, 1999).

Risk factors associated with self-harm and suicidal behaviour in LAC

The term 'looked-after' was introduced in the Children Act (1989) and refers to children and young people under the age of 18, who live away from their parents or family, and are supervised by a social worker from the local authority (Department of Education [DoE], 2014). However, the LAC population is complex and heterogeneous, with some young people living in kinship care or at home under social care supervision where others live in out-of-home foster care or in residential care homes. This heterogeneity can leave research pertaining to LAC difficult to interpret as some findings may reflect these different sub-populations of LAC. Over the past seven years, the number of children who are looked-after in the UK has increased and is now higher than at any point since 1985 (DoE, 2015). In 2015, there were 69,540 LAC in the UK, an increase of 6% since 2011; the majority of which are looked-after by the local authority due to abuse or neglect (61%). Most LAC are placed in foster care (75%), with 10% cared for in residential care and secure units.

Since many LAC come from disadvantaged backgrounds, their prior exposure to a number of socio-environmental risk factors mean that they are already vulnerable to developing mental health problems by the time they become looked-after (Mental Health Foundation, 2002). While each looked-after child has a unique story with a different set of circumstances leading to their placement in care, research provides compelling evidence of several adverse outcomes for children and young people who are looked-after (Cousins, Taggart, & Milner, 2010; Meltzer, Lader, Corbin, Goodman, & Ford, 2004; Pecora, White, Jackson, & Wiggins, 2009; Scott & Malcolm, 2006). LAC are disproportionately more likely to have lower academic achievement, a history of emotional and physical abuse and neglect, and difficulties fitting in with others and establishing meaningful relationships (Childline Case Notes, 2009; DoE, 2014; Harkess-Murphy, MacDonald, & Ramsay, 2013; Jackson & McParlin, 2006). Moreover, the DoH reported LAC were at five-fold increased risk of all childhood mental, emotional and behavioural problems, and almost seven times more likely to have conduct disorders (DoH, 2012). Also concerning is that children and young people in care are at increased risk of sexual exploitation, as recent high-profile media cases have identified (Simkiss, Spencer, Stallard, & Thorogood, 2012).

In 2003, the first national survey of the mental health of looked-after young people in England was completed (Meltzer, Corbin, Gatward, Goodman, & Ford, 2003). The sample comprised 1039 LAC drawn from 134 local authorities across England. Children in care were shown to have significantly higher rates of diagnosed mental health difficulties, such as depression, anxiety or conduct disorder, than the general child population (49% compared to 11%), and also to have high levels of risk-taking behaviours such as smoking, and alcohol and drug misuse. Furthermore, children in residential care were much more likely to have a diagnosable mental health difficulty than those in foster care (72% compared with 40%).

LAC in the UK are also almost five times more likely to engage in self-harm (DoH, 2012), and their risk of suicide is double the national average for general adolescent populations (Baker, Kurland, Curtis, Alexander, & Papa-Lentini, 2007; Hurley, Trout, Chmelka, Burns, Epstein, & Thompson et al., 2009). Similar evidence of increased prevalence in rates of psychological difficulties for LAC also exists in the USA (Kerker & Dore, 2006), Australia (Tarren-Sweeney, 2008), and Denmark (Tine & Mett, 2009). In light of the many vulnerabilities associated with being a looked-after child (Chavira, Accurso, Garland, & Hough, 2010; Devaney, Bunting, Davidson, Hayes, Lazenbatt, & Spratt, 2012; Spratt, 2012), the risk of self-harm and suicidal behaviour is clearly a major concern for those working with LAC.

Rationale for current review

Whilst it is clear that young people in care have higher levels of actual self-harm and suicidal behaviour, there is a concerning lack of studies investigating the risk factors for suicidality and self-harm among LAC (McAuley & Davis, 2009; O'Connor, Rasmussen, Miles, & Hawton, 2009). Of the limited research in this area, there have been some exploratory cross-sectional studies which have investigated potential risk factors associated with self-harm and suicidal behaviour amongst this population. However, these studies have yet to be systematically reviewed. As yet, the only reviews in this field have predominantly focused on the best treatment approaches for LAC with mental health difficulties (Leenarts, Diehle, Doreleijers, Jansma, & Lindauer, 2013; Turner & Macdonald, 2011), or investigated the impact of transition to/from care upon a child's mental health (Everson-Hock, Jones, Guillaume, Clapton, Duenas, & Goyder et al., 2011).

Understanding the psychosocial risk factors associated with self-harm and suicide risk among LAC is especially important given the existing vulnerabilities associated with being looked-after (Hukkanen et al, 2003). This paper aims to review the current quantitative research base investigating the possible risk factors associated with self-harm and suicidal behaviour amongst children and young people in looked-after settings. In doing so, the review aims to achieve a broader understanding of the psychosocial risk factors associated with LAC who self-harm in comparison with those who do not.

Method

Search strategy

A systematic literature search of publication databases including PsycINFO, Web of Science, PubMed and CINHAL was conducted using the following search strategy: (Adolescents OR young people OR youth OR children) AND ("Looked after" OR "residential care" OR "foster care" OR "child welfare" OR "children in care" OR "group home*") AND ("self-harm*" OR "suicid*" OR "self-injur*" OR "self-mutilat*"). Other potential articles were identified by using further internet searches using Google Scholar and citation pearls. All titles and abstracts were examined and those studies that met the inclusion criteria were retrieved as full-text and further examined for relevance. The reference lists of papers that met the inclusion criteria were then hand searched for any additional articles.

Selection criteria

The inclusion criteria for studies were as follows: (i) participants must be children and young people in LAC settings (including residential care and foster care); (ii) articles must report original quantitative research; (iii) there must be a focus on exploring the risk factors associated with self-harm or suicidal behaviour; and (iv) only studies from peer-reviewed journals were included since these are considered more credible and of higher quality than other publications. The term ‘looked-after’ was used to include children and young people who are cared-for in non-medical or secure settings, thus studies were excluded if their sample consisted of young people from youth offending, inpatient or other residential specialist treatment settings. Studies without a measure of self-harm or suicidal behaviour or focusing solely on the function of self-harm were also excluded because this review focused on risk factors associated with self-harm and suicidal behaviour. All quantitative papers that met these inclusion and exclusion criteria were considered for the review. A summary of the flow of papers through the review is shown in figure 1 (see appendix 1-A).

Assessment of quality

To assess the methodological quality of the studies under review, the quality assessment tool for quantitative studies developed by the Effective Public Health Practice Project (EPHPP; 1998) was used. This tool allows quantitative research papers to be rated on several components including selection bias, study design, confounders, blinding, data collection methods, withdrawals and dropouts. This tool has been found to have strong content and initial construct validity and inter-rater reliability (Thomas, Ciliska, Dobbins, &

Micucci, 2004). Each study was rated as “strong,” “moderate,” or “weak” on each of the quality assessment criteria and then assigned an overall score. In order for a study to be rated as “strong”, at least four of the criteria had to be rated as strong, with no weak ratings. A rating of “moderate” was achieved if only one criterion was rated weak. The Quality Assessment Tool Dictionary (see appendix 1-D) provides further guidance on how to make judgments about study quality.

Analyses

The participants, risk factors and outcome measures were too diverse to integrate the results statistically as a meta-analysis. In order to analyse the studies systematically, the quality assessment and general characteristics of the studies under review were qualitatively examined. Findings were then grouped based upon child demographics, socio-environmental factors and psychological factors.

Results

Search results

The search strategy identified 490 publications, 147 of which were duplicates. Of the 343 articles screened, a further 304 were removed on the basis of their title and abstract. The remaining 39 papers were obtained in full text and assessed for eligibility, with 25 articles rejected on the basis that they did not satisfy the inclusion/exclusion criteria. Following a thorough selection process, fourteen studies were included in the review. Table 1 (see appendix 1-B) provides a description of the studies’ characteristics and key findings.

Participant characteristics

The 14 studies included in this review comprised a total of 11,471 LAC, with a median number of 165 participants per study.Of the studies providing demographic information pertaining to gender (n=13), 6075 participants were male (53%), indicating similar representation of gender across all the studies in total. The mean ages of the samples were reported only in seven of the studies; with an average participant age of 13.7 years across those studies reporting age.

The majority of the studies were conducted either in North America (n=7) or Europe (n= 6), with only one study conducted elsewhere (Asia). Children and young people from a variety of looked-after settings (including residential homes and foster care both within and outside of the family) were included in the majority of studies (n=8); whereas other studies recruited young people solely from residential children's homes (n=6).

Study design

All fourteen studies included in this review used a cross-sectional design to explore and investigate relationships between self-harm and suicidal behaviour and particular demographic and psychosocial characteristics of LAC. Some of the studies included within this review used data collected from larger epidemiological study datasets (n=8). Of these studies, two used data collected by the social work administrative database (SOSCARE: Cousins et al., 2010; Cousins, McGowan, & Milner, 2008), two used data collected by the Christian Aid Society of Toronto (CAS-T: Grenville, Goodman, & Macpherson, 2011; Cheung & Goodman, 2007), and two used data collected as part of the UK National Survey of Child and Adolescent Well-Being (NSCAW: Anderson, 2011; Heneghan, Stein, Hurlburt, Zhang, Rolls-Reutz, & Fisher, 2013). Although some studies shared data from the same larger epidemiological studies, within this review they will be treated as separate studies since the data is used to explore different research questions (see Table 1 for study research questions and main findings).

Outcome measures

The majority of studies utilised psychometric assessments (n=9), where other studies used data from larger epidemiological studies. Of the studies using primary outcome measures, a variety of psychometric assessments were administered, with 21 different measures in total. Of these measures, the majority focused upon the emotional, behavioural and social outcomes for the child, such as depression, anxiety, PTSD, alcohol/substance misuse, and exposure to abuse or neglect. The most popular of these outcome measures was the Child Behaviour Checklist (CBCL; Achenbach & Rescorla, 2001). Across half of the studies (n=7), self-harm and suicidal behaviour were measured by reviewing young peoples' case files and serious incident reports. Other studies used psychometric items within the assessments (n=5), whereas others relied upon self-report (n=2). The psychometric assessments used across studies are presented in Table 1.

Statistical analyses

All of the fourteen studies included in the review used cross tabulation, chi-squared statistics or Pearson's correlation coefficients to record the frequency of participants that have specific characteristics and highlight any possible relationships between variables. Four of the fourteen studies included in the review used t-tests and two used ANOVA to identify whether there were significant differences in the outcome data between groups. Building upon these statistics, nine studies used regression analysis and multi-level modelling to predict whether certain demographic information and outcomes predicted self-harm and suicidal behaviour.

Quality assessment

The assessments of methodological quality are presented in Table 2 (see appendix 1-C). One of the components of EPHPP rates studies on their blinding, however this was omitted as a quality criterion in the current review since this was not thought to be applicable to cross-sectional designs. The overall methodological quality of the studies was moderate. Nine were rated as moderate quality and five as methodologically weak (Cheung & Goodman, 2007; Cousins et al., 2010; Cousins et al., 2008; Hamilton, Taylor, Killick, & Bickerstaff, 2015; Hurley, Wheaton, Mason, Schnoes, & Epstein, 2014). No studies achieved a "strong" rating. In general, studies were rated moderate-strong quality for study representativeness and use of reliable and valid outcome measures, and moderate quality for control of confounding variables.

Key findings: Youth Demographics

Of the studies investigating gender as a risk factor for self-harm and suicidal behaviour, the majority reported that females were more likely than males to express thoughts of suicide, and more likely to engage in self-harm than males. Hurley et al. (2014) also found that females were considered at greater risk of suicide (x^2 = 33.61, p<0.001) than males. Furthermore, when exploring the association between gender and type of behaviour with frequency of self-harm, Grenville et al. (2011) found females were more likely than males to self-harm than threaten self-harm (AOR=1.34, ACI= 0.79-2.27), and females with more than one self-harm incident were significantly more likely to have repeat incidents of self-harm in the future than males (AOR=2.55, ACI=1.08-6.02). Conversely, Harkess-Murphy et al. (2013) reported no significant gender differences in self-harm incidences (x^2 (1) = 3.104, p= 0.078).

Only two studies investigated age as a risk factor. Of these studies, Heneghan et al. (2013) found rates of suicidal behaviour to be higher among younger teens than older teens, whereas Hurley et al. (2014) found no significant age differences between high and low suicide risk groups. Three of the fourteen studies reviewed considered ethnicity as a risk factor for self-harm and suicidal behaviour. Of these studies, Hurley et al. (2014) found that Caucasian youth had a significantly higher representation in the high suicide risk history group (x^2 = 60.48, $p<0.001$) than other ethnicities. Conversely, Cheung and Goodman (2007) found that minority and non-minority LAC did not differ in the number of self-harming attempts or threats reported, suggesting no ethnic differences in the amount of self-harm. However, when compared to minority LAC, non-minority LAC were more likely to engage in cutting behaviours when attempting to self-harm (Cheung & Goodman, 2007), suggesting differences in the type of self-harm used and not the frequency.

Key findings: Socio-environmental factors

The number and types of looked-after placements were investigated by four studies as possible risk factors for self-harm and suicidal behaviour. Hamilton et al. (2015) found that the number of placements since coming into care and number of suicide attempts had a significant positive correlation ($r = 0.157$, $p<0.05$), with higher numbers of placement moves associated with higher numbers of suicide attempts. Likewise, Anderson (2011) found that the number of LAC placements since entering the study at baseline was significantly associated with subsequent suicide ideation, adjusting for age, gender and ethnicity. An odds ratio of 1.68 ($p<0.05$) indicated that the likelihood of suicide ideation increased by 68% with each placement breakdown (Anderson, 2011).

In terms of the type of placement, Hamilton et al. (2015) found children in foster care placements made no suicide attempts, and that rates of self-harm and suicidal behaviour were also lower amongst this group. Anderson (2011) also found a significant association between type of LAC placement and suicide ideation. Among young people in an LAC placement, those living in residential care were 7.25 times more likely to have suicide ideation compared to those living in kinship care with a family member ($p<0.01$). Although Cousins et al. (2010) found no significant differences in levels of self-harm and attempted suicide across young people in foster care and residential care placements, young people in residential care were significantly more likely ($p<0.005$) to present with challenging behaviour.

Across studies investigating history of abuse as a risk factor, levels of reported abuse and maltreatment among LAC were high (Gearing, Brewer, Elkins, Ibrahim, MacKenzie, & Schwalbe, 2015; Greger, Myhre, Lydersen, & Jozefiak, 2015; Hukkanen et al., 2003). Of these studies, Greger et al. (2015) reported that 40.8% of looked-after females had experienced sexual abuse, and 46.4% reported having been a victim of family violence. In addition, Harpin and colleagues (Harpin, Kenyon, Kools, Bearinger, & Ireland, 2013) found young people residing in LAC placements reported greater numbers of suicide attempts (x^2= 70.58, $p<0.001$), and sexual (x^2 = 113.3, $p<0.001$) and physical abuse (x^2 = 189.7, $p<0.001$) than those living at home. Moreover, Gearing et al. (2015) found that young people with a history of abuse were 4 times more likely to present with suicidality than young people who did not report abuse; and self-harm was also found to be more common among young people with a history of abuse (Hukkanen et al., 2003).

Key findings: Psychological factors

Several studies explored participant mental health and psychological wellbeing as risk factors for self-harm and suicidal behaviour. Heneghan et al. (2013) suggested LAC had odds

2.29 times higher of reporting a mental health problem (95% CI=1.38-3.81) than those living at home. Overall, 42.7% of young people reported having at least one mental health problem (Heneghan et al., 2013), of which 9% reported depression, 13.9% suicidality, 23% substance use/abuse, 13.5% anxiety, and 18.6% ADHD. Similar, yet more conservative results, were also found by Hamilton et al. (2015) who reported that 13% of young people in looked-after care had a mental health diagnosis. In addition, Hamilton et al. found a significant positive correlation between mental health diagnosis and number of suicidal thoughts ($r = 0.263$, $p<0.01$).

Among young people in an LAC placement, Anderson (2011) reported that those in residential care were 4.6 times more likely to have clinically significant depressive symptoms than those in kinship care. Moreover, Anderson (2011) reported a statistically significant effect of number of LAC placements on prior or current depressive symptoms (OR=1.62, $p<0.05$), supporting the role of depressive symptoms as a mediator of the relationship between number of LAC placements and subsequent suicide ideation. Furthermore, Gearing et al.'s (2015) study found depression to be most endorsed mental health problem among LAC (45%). However, a quarter of participants (24%) also met criteria for PTSD, and suicidality was identified in 27% of the sample. Young people with PTSD were found to be 2.6 times more likely to report suicidality than those without PTSD, and for young people with depression, there was a 3.5 times greater likelihood of reporting suicidality than for those without depression (Gearing et al., 2015).

Hurley et al. (2014) reported significant differences between low and high suicide risk history groups on mental health diagnoses, with young people in the high-risk group being more likely to have one or more diagnosis. Moreover, a large majority of young people in residential care were found by Hurley et al. (2014) to have a history of alcohol and/or substance use (69.9%). Hamilton et al. (2015) and Hurley et al. (2014) reported that young people with a history of alcohol and/or drug misuse presented with a higher incidence of self-harm and suicidal behaviour.

Several studies included in the present review include psychometric outcomes to assess various individual and interpersonal characteristics that may influence risk of self-harm and suicidal behaviour in LAC. For example, Cousins et al. (2008) found that 49.6% of young people in care scored within the abnormal range of the SDQ total difficulties score. Scores on the CBCL for LAC with high suicide risk history were also shown to be significantly higher than those in the low risk group ($F=18.36$, $p<0.001$; Hurley et al., 2014). In a study by Hukkenen et al. (2003), regression analysis found self-harming behaviour, low CGAS level and violence were associated with suicidality in LAC. Half of children with suicidality had shown self-harming behaviour during the past 6 months. Children with suicidality also had significantly higher CBCL scores, and significantly higher symptom levels on anxious-depressive and aggressive syndrome scales.

When compared with peers who did not self-harm, Harkess-Murphy et al. (2013) found that young people in the self-harm group reported significantly fewer reasons for living ($t(46) = -5.787$, $p <0.001$) and significantly lower academic self-esteem ($t(100) = -3.838$, $p<0.001$). Self-harming participants were found to perceive their problems as significantly more difficult to cope with ($t(38) = 4.424$, $p<0.001$) than non-self-harmers. Furthermore, Harkess-Murphy et al. (2013) found that as levels of self-criticism increased, the odds of engaging in self-harm increased by 5.2 times ($p<0.001$), suggesting self-criticism as a risk factor for self-harm in LAC.

Key findings: Protective factors

Of particular interest are studies highlighting factors which may be protective against risk of self-harm and suicidal behaviour. For example, Gearing et al. (2015) highlighted self-efficacy and close peer relationships as protective factors. For every unit increase in general self-efficacy, the odds of depression decreased by 65%. Moreover, the odds of depression for young people who reported having close peer relationships were 88% lower than the odds of depression for young people without close peer relationships. Gearing et al. (2015) also found that young people reporting close peer relationships had 93% lower odds of having PTSD than those without.

Harpin et al. (2013) found that care from a parent ($t=19.33$, $p<0.001$), care from other adults ($t=16.47$, $p<0.001$), connection to school ($t=15.27$, $p<0.001$), and a high grade point average ($t=21.01$, $p<0.001$) were also significantly more frequent among young people living at home, than for LAC, and that these factors were significantly correlated with emotional distress for LAC ($F=230.0$, $p<0.001$). Moreover, parental caring ($\beta= -0.11$) and school connectedness ($\beta= -0.12$) were correlated with decreased mental health distress in young people living out-of-home, thus may be important protective factors for LAC.

Discussion

Summary of main findings

To date, little is known about the risk factors for self-harm and suicidal behaviour in LAC. This review examined studies which have explored the association between various demographic, social and psychological factors which may place children and young people at an increased risk of self-harm and suicidal behaviour. In relation to demographic factors, female LAC were generally found to be more likely to express thoughts of suicide (Hamilton et al., 2015), to engage in self-harm (Grenville et al., 2011), and to be at a greater risk of suicide (Hurley et al., 2014) than males. These findings largely replicate previous research findings that females account for a greater proportion of self-harm incidents and expressions of suicidal ideation (O'Connor, Rasmussen, & Hawton, 2009; Whitlock, Eckenrode, & Silverman, 2006). However, Hurley et al.'s (2014) finding that females are at a greater risk of suicide is divergent from epidemiological research which has shown that actual levels of suicide are higher for adolescent males (Bertolote & Fleischmann, 2015); with male suicide reported to be at 2.6 times that of females (Wasserman, Cheng, & Jiang, 2005). These findings may have implications for further research to disentangle the relationship between self-harm, suicidal behaviour, and actual rates of suicide.

Of the few studies investigating age and ethnicity as risk factors for self-harm and suicidal behaviour, there were mixed findings. For example, where Heneghan et al. (2013) found rates of suicidal behaviour to be higher among younger LAC (aged 12-14) than older LAC (aged 15-18), Hurley et al. (2014) found no significant age differences between high and low suicide risk groups. The variability in finding with regards to age is also reflected in the wider adolescent research literature, with some studies identifying increased self-harm between 12-15 years of age (Muehlenkamp, Williams, Gutierrez, & Claes, 2009; Sourander, Aromaa, Pihlakoski, Haavisto, Rautava, & Helenius et al., 2006), where others find comparable levels across adolescents of all ages (Hilt, Nock, Lloyd-Richardson, & Prinstein, 2008; Latzman, Gratz, Young, Heiden, Damon, & Hight, 2010). This highlights another area for future research to clarify any differences in rates of self-harm and suicidal behaviour across age for both LAC and general adolescent populations.

With regards to ethnicity as a risk factor, although Hurley et al. (2014) found that Caucasian children had a significantly higher representation in the high suicide risk group, Cheung and Goodman (2007) found no ethnic differences in the number of self-harming attempts or threats reported. Interestingly, ethnic differences in the type of self-harm used was reported by Cheung and Goodman (2007), who found non-minority children in care were more likely to engage in cutting behaviours than minority children. However, it is difficult to draw any meaningful conclusions about ethnicity from the studies currently under review since most of the studies were conducted in North America and Europe, with only one other study conducted elsewhere (Asia). While an understanding of some risk factors discussed here may be drawn across nationalities, other risk factors are more likely to be culturally determined and differ significantly between countries, making it difficult to generalise the findings.

Health services and social care provision, and indeed people's experience of being a member of a particular ethnic group, are all likely to vary significantly between different countries (Holland, Faulkner, & Perez-del-Aguila, 2005). For example, a study in the USA showed that African-American children were taken into care, even after controlling for socio-economic status and level of risk, at a threshold much lower than Caucasian children (Rivaux, James, Wittenstrom, Baumann, Sheets, Henry & Jeffries, 2008). Moreover, African-American children are over represented in the USA public care system after adjusting for age and gender, income and childhood abuse (Lau, McCabe, Yeh, Garland, Hugh, & Landsverk, 2003). In light of these differences, the generalisability of findings must be critically considered if evidence from the wider international literature is used in the development of LAC guidance for specific countries. For example, evidence from North America may not be generalisable for LAC in Asia.

Of the socio-environmental factors investigated, the number and type of looked-after placements were identified as possible risk factors for self-harm and suicidal behaviour. Higher numbers of placement moves were associated with higher numbers of suicide attempts (Hamilton et al., 2015) and higher levels of suicidal ideation (Anderson, 2011), suggesting a significant detrimental effect of multiple placement moves on LAC wellbeing. This is perhaps unsurprising given the psychological impact that separation and loss will have upon levels of distress and attachment behaviours (Bowlby, 1998). Furthermore, Anderson (2011) also found a significant association between type of out-of-home placement and suicide ideation, with residential care placing LAC at a much greater risk of self-harm and suicidal behaviour than those in foster care.

Although the research evidence has thus far indicated that being a LAC places young people at an increased risk of self-harm and suicidal behaviour, it feels important to consider these findings in relation to cause and effect. For example, children who self-harm might be at an increased risk of being taken into care in the first place, due to parent/carer difficulties keeping them safe at home. Moreover, an alternative explanation for residential care placing LAC at a greater risk of self-harm and suicidal behaviour might be that the young people in residential settings are placed there because they already have behaviours that are too risky to be managed in foster care. Further research is needed to explore whether the type of LAC placement is a risk factor for future self-harm and suicidal behaviour, and/or whether the risky behaviours of a child (including self-harm and suicidal behaviour) predict a placement in care in the first place.

Within this review, several adverse childhood experiences (ACES; Felitti, Anda, Nordenberg, Williamson, Spitz, & Edwards et al., 1998) were shown to place LAC at a greater risk of self-harm and suicidal behaviour (Gearing et al., 2015; Greger et al., 2015; Hukkanen et al., 2003). Hukkenen et al. (2003) found significantly greater reports of historical abuse among young people who had self-harmed or attempted suicide. These findings were also more recently supported by Gearing et al. (2015), who found that young people with a history of abuse were 4 times more likely to present with suicidal behaviour than those who did not report abuse.

The studies currently under review also support the wider research literature suggesting that ACES place individuals at an increased risk of developing mental health difficulties (Heneghan et al., 2013; Schilling, Aseltine, & Gore, 2007). Of the mental health difficulties explored in LAC, depression was the most common reported difficulty (Gearing et al., 2015) and the diagnosis found to be most commonly associated with suicide ideation (Anderson, 2011). Furthermore, Hurley et al. (2014) reported that young people in the high-risk group were more likely than their peers to have one or more mental health diagnosis. However, it is also important to consider the possible over-diagnosing of LAC due to the amount of screening assessments and contact with professionals. Indeed, there may well be a danger that behaviours stemming from attachment disruption and developmental trauma among LAC are misdiagnosed (e.g. hypervigilance diagnosed as ADHD). Together these findings are unsurprising given the strong emerging association between exposure to ACES and negative outcomes such as mental health difficulties, suicidal behaviour and self-harm among the general population (Chapman, Dube, & Anda, 2007; Zetterqvist, Lundh, & Svedin, 2012). Since LAC are a population that are especially vulnerable to poly-victimisation and ACES (Skegg, 2005), it is crucial that high risk behaviours such as self-harm and suicidal ideation are regularly screened and assessed to safeguard LAC.

Several other risk factors were identified among the studies reviewed which may be useful to consider when screening for self-harm and suicidal behaviour in LAC. In addition to screening for ACES and mental health difficulties of LAC, psychometric data might also be helpful for assessing risk of self-harm and suicidal behaviour. For example, high scores on the SDQ (Cousins et al., 2008) and CBCL (Hurley et al., 2014) and low scores on the CGAS (Hukkenen et al., 2003) were found to be associated with increased levels of self-harm and suicidal behaviours in LAC. Furthermore, a consideration of alcohol and substance misuse may also be helpful given the current reviews findings that there is a higher incidence of self-harm and suicidal behaviour amongst young people with a history of alcohol and/or drug misuse (Hamilton et al., 2015; Hurley et al., 2014). With access to LAC case files, much of this routinely collected data could be made available for care professionals to make provisional risk assessments for LAC with regards to self-harm and suicidal behaviour. However, such assessments may be limited since they would be dependent of the availability and accuracy of a limited amount of data.

The studies under review also highlighted several factors which may be protective against risk of self-harm and suicidal behaviour, such as having a caring parent, feeling connected to their school (Harpin et al., 2013), and having greater self-efficacy and close peer relationships (Gearing et al., 2015). Therefore, in addition to a review of LAC case files, it may also be helpful for care professionals to supplement such assessments with a clinical interview to facilitate a qualitative exploration of other risk and protective factors unique to each LAC. The relationships between demographic factors (age, gender and ethnicity), socio-environmental factors (type of placement, number of placement moves and abuse histories) and psychological factors (mental health difficulties, drug/alcohol misuse, self-esteem and self-criticism) and self-harm and suicidal behaviour are complex, and although this review is but a brief exploration of which may constitute significant risk factors for LAC, it hoped that it will provide future research with an evidence-base upon which it can build.

Methodological limitations

Although several significant associations between various psychosocial risk factors and self-harm and suicidal behaviour among LAC have been identified, a number of methodological limitations mean the robustness of these findings should be carefully considered. All fourteen studies were cross-sectional in nature, reflecting the early stage of the research in this area. Since the EPHPP tool considers cross-sectional designs to be methodologically weak, the highest rating the studies being reviewed could achieve using this tool was "moderate". Although cross-sectional designs limit the ability to determine causal relationships, and have inherent methodological limitations, these studies allow for the early assessment of outcomes and risk factors for large populations. Thus, despite such studies being methodologically limited, they offer a valuable first contribution to the evidence base and help to suggest directions for future research.

A further limitation across studies arises from the representativeness of the data. Due to the variability of different LAC settings by country, type, size or provider, the results from these studies may not be generalisable to other settings or services. Moreover, some studies only reviewed existing data from child case files and may therefore be subject to reporter bias since it relies entirely on the accuracy and quality of the service provider's documentation. It is also possible that there might be substantial under-reporting of sensitive issues, first due to the private nature of self-harm and suicidal behaviour, and second, because of vague definitions and poor levels of understanding of self-harm amongst care professionals. Of the studies that did use formal outcome measures, these were administered voluntarily, with few studies reporting the percentage of the total sample of participants providing this data. Therefore, there may be significant differences among young people who completed these measures and those that did not, also leading to difficulties generalising these findings for all LAC.

Perhaps the biggest limitation of the research in this area to date is the grouping of self-harm with suicidal behaviour. Previous research has suggested that self-harm and suicidal behaviours are differentiable by the presence or absence of suicidal intent (Muehlenkamp, 2005), however because suicidal intent is often difficult to ascertain, such differentiation is rarely commented on within studies. Grouping these behaviours together without measuring suicidal intent may compromise the generalisability of the risk factors identified within these studies, as some risk factors may be more salient for self-harm without intent than with and vice versa. Therefore, future research is needed to clarify whether there are any differences between risk factors for self-harm with intent and self-harm without intent.

Implications for clinical practice

Findings from the studies under review show how the adversity faced by LAC may place them at an increased risk of self-harm and suicidal behaviour. Much of this adversity occurs before their removal into care. However, of particular concern are children’s experiences since being placed in looked-after care that may contribute to risk of self-harm and suicidal behaviour. For example, number and type of LAC placement has been shown by several studies under review to be associated with increased self-harm and suicidal behaviour among young people. This has several implications. First, since greater numbers of placement moves and breakdowns are associated with a greater risk of self-harm and suicidal behaviour, then it is essential that welfare services match LAC placements to the individual needs of the children and that professionals working into these services promote placement stability for LAC. Therapeutic professionals, such as clinical psychologists, could utilise their knowledge and understanding of the therapeutic needs of young people to help support the placement matching process. In doing so, this may help to reduce the inappropriate placement of children and reduce the subsequent number of placement breakdowns which have been shown to place young people at a greater risk of self-harm and suicidal behaviour.

Secondly, it is important for welfare services to be aware of the risks associated with type of placement. The common pathway for young people to enter residential care is following multiple foster care placement breakdowns. Since young people in foster care placements are associated with a reduced risk for self-harm and suicidal behaviour when compared to their peers in residential care, this further supports the need for placement stability. Moreover, in 2010, the National Institute for Health and Clinical Excellence and Social Care Institute for Excellence (NICE & SCIE, 2010), and the Department of Education (Department for Education and Skills 2010) published guidance emphasising care planning and placement stability as key factors for improving care and promoting psychological wellbeing among LAC. Considerations such as offering additional support for foster carers and placement providers, contributing towards clear therapeutic plans and having access to consultations with clinical psychologists to respond efficiently to any difficulties that may arise, may all contribute towards maintaining placement stability for LAC.

As an alternative to residential care for LAC, several Multi-Dimensional Treatment Foster Care (MDTFC) programmes have been established across the UK. Originally developed in the USA (See Chamberlain & Reid, 1998), MDTFC delivers intensive support for LAC based on the principles of Social Learning Theory (Bandura, 1986). Although many LAC have been exposed to several ACES, few will have been given the opportunity to access appropriate therapeutic support. Without therapeutic support, LAC difficulties can manifest significant behavioural challenges which can lead to the inappropriate/emergency placing of

LAC and subsequent placement breakdowns (McAuley & Davis, 2009). In response to this need for therapeutic support, and indeed a need for placement stability, MDTFC advocates placing LAC within a single family placement with trained foster carers who support LAC to build on their strengths, improve their social relationship skills, and problem solving abilities. However such placements are resource intensive, thus it remains to be seen whether such placements can provide a realistic alternative to residential care for some LAC. Perhaps therapeutic parenting programmes such as Dyadic Developmental Psychotherapy (DDP) and the PACE attachment model (Becker-Weidman & Hughes, 2008), which consider the impact of early trauma on the developing brain, represent efficient and cost-effective alternatives.

Thirdly, placing children in LAC placements may also expose them to the self-harm and suicidal behaviour of other LAC. This exposure may act to trigger, normalise and/or reinforce self-harm and suicidal behaviours in LAC. Social contagion is the term that refers to these epidemic-like patterns of self-harm, particularly in hospital and inpatient settings (Yates, 2004), and more recently via social media (Whitlock, Powers, & Eckenrode, 2006). Since a child’s living environment can impact upon their experiences of social support, peer influence and emotional stability, a child living in a group home with others who self-harm may, therefore, be more likely to develop similar behaviours. Therefore, it is necessary that services work towards developing appropriate policies for managing children’s exposure to the self-harm and suicidal behaviour of others within LAC settings.

The studies under review consistently show increased levels of self-harm and suicidal behaviour in LAC. Given the serious risk associated with these behaviours, it is of critical importance that researchers and clinicians work towards the development and implementation of a screening tool for the risk of self-harm and suicidal behaviour, which can help professionals working with these vulnerable children to identify those that are at high risk of these behaviours. If risk can be quantified prior to and throughout the duration of care, social workers, foster carers and other care professionals will be in a better position to prevent future incidents by directing additional support and supervision to those who need it most, and able to contain the impact of exposure to self-harm and suicidal behaviour for other LAC.

Implications for future research

The studies included within this review have highlighted several risk factors that warrant further attention using more methodologically robust methods. In order for research in this area to progress, future studies should utilise more comprehensive psychometric assessments, develop a longitudinal element in order to examine how exposure to various psychosocial risk factors might impact upon a child's behaviour throughout their time in care, and adopt qualitative research methods to incorporate the actual voices and experiences of the young people. Moreover, it would also be important for future studies to consider that self-harm can occur along a continuum with or without suicidal intent, and take steps to measure these differences.

The findings from this review also have substantial implications for intake assessment, treatment planning, service delivery and staff training to address the complex emotional and behavioural needs of LAC. Research towards the development of a risk assessment tool, specifically for LAC, would be particularly useful for the early identification of those who may be at an increased risk of self-harm and suicidal behaviour. Although it remains unclear as to the motives underlying self-harm and suicidal behaviour in LAC, results from this review also underscore the importance of further exploring how these behaviours are conceptualised by LAC. Qualitative research is required to understand the links between self-harm and suicidal behaviour in LAC. For example, which LAC engage in self-harm and suicidal behaviour and why, and what factors do they believe contribute to these behaviours. Moreover, given the potential risk associated with exposure to the self-harm and suicidal behaviour of others, investigating the impact of social contagion among LAC could also be an important avenue for future research.

Conclusions

Removing children from environments that do not meet their physical and emotional needs is essential to protect young people from harm. However, without understanding self-harm and suicidal behaviour within the child-welfare system, services are not able to provide the level of protection and support these children need. Despite several limitations, some of which are inherent to cross-sectional studies, the findings from this review represent the first steps toward identifying factors associated with self-harm and suicidal behaviour among LAC. Collectively, these studies have highlighted various demographic, psychological and environmental factors that may place LAC at a greater risk of self-harm and suicidal behaviour, and support the need for continued research in this area.

References

**Reviewed studies are marked with an asterisk*

Achenbach, T. M., & Dumenci, L. (2001). Advances in empirically based assessment: Revised cross-informant syndromes and new DSM-oriented scales for the CBCL, YSR, and TRF: Comment on Lengua, Sadowski, Friedrich, and Fisher. *Journal of Consulting and Clinical Psychology*, 69(4), 699–702. doi:10.1037/0022-006x.69.4.699

Afifi, T. O., MacMillan, H. L., Boyle, M., Taillieu, T., Cheung, K., & Sareen, J. (2014). Child abuse and mental disorders in Canada. *Canadian Medical Association Journal,* 186(9), E324–E332. doi:10.1503/cmaj.131792

* Anderson, H. D. (2011). Suicide Ideation, Depressive Symptoms, and Out-of-Home Placement Among Youth in the U.S. Child Welfare System. *Journal of Clinical Child & Adolescent Psychology*, 40(6), 790–796. doi:10.1080/15374416.2011.614588

Andover, M., & Gibb, B. (2010). Non-suicidal self-injury, attempted suicide, and suicidal intent among psychiatric inpatients. *Psychiatry Research, 178,* 101-105. doi.org/10.1016/j.psychres.2010.03.019

Baker, A., Kurland, K., Curtis, P., Alexander, G., & Papa-Lentini, C. (2007). Mental health and behavioral problems of youth in the child welfare system: Residential treatment centers compared to therapeutic foster care in the Odyssey Project population. *Child Welfare*, *86*(3), 97–123.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Prentice-Hall, USA.

Becker-Weidman, A., & Hughes, D. (2008). Dyadic Developmental Psychotherapy: an evidence-based treatment for children with complex trauma and disorders of attachment. *Child & Family Social Work*, 13(3), 329–337. doi:10.1111/j.1365-2206.2008.00557.x

Bertolote, J., & Fleischmann, A. (2015). A global perspective in the epidemiology of suicide. *Suicidologi*, *7*(2). 6-8. doi:10.5617/suicidologi.2330

Bowlby, J. (1998). *Attachment and loss (Volume 3): Loss, sadness and depression*. Pimlico London.

Bridge, J., Goldstein, T., & Brent, D. (2006). Adolescent suicide and suicidal behavior. *Journal of Child Psychology and Psychiatry*, *47*, 372–394.doi:10.1111/j.1469-7610.2006.01615.x

Chamberlain, P., & Reid, J. B. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology*, 66(4), 624–633. doi:10.1037/0022-006x.66.4.624

Chan, K. (2013). Victimization and poly-victimization among school-aged Chinese adolescents: Prevalence and associations with health. *Preventive Medicine, 56*(3–4), 207–210. .doi.org/10.1016/j.ypmed.2012.12.018

Chapman, D., Dube, S., & Anda, R. (2007). Adverse childhood events as risk factors for negative mental health outcomes. *Psychiatric Annals*, *37*(5), 359-364.

Chavira, D., Accurso, E., Garland, A., & Hough, R. (2010). Suicidal behaviour among youth in five public sectors of care. *Child and Adolescent Mental Health, 15*, 44–51. doi:10.1111/j.1475-3588.2009.00532.x

*Cheung, C., & Goodman, D. (2007). The effects of self-harming behaviours of youth in child welfare care. *First Peoples Child & Family Review*, *3*(2), 37-42.

Childline Casenotes. (2009). *Looked after children talking to Childline*. Retrieved from http://www.nspcc.org.uk/Inform/publications/casenotes/clcasenoteslookedafterchildren_wdf80622.pdf

Children Act. (1989). London: Her Majesty's Stationary Office.

*Cousins, W., McGowan, I., & Milner, S. (2008). Self-harm and attempted suicide in young people looked after in state care. *Journal of Children's and Young People's Nursing, 2*(2), 51–53.doi:10.12968/jcyn.2008.2.2.28195

*Cousins, W., Taggart, L., & Milner, S. (2010). Looked after or overlooked? An exploratory investigation of the mental health issues of adolescents living in state care in Northern Ireland. *Psychology, Health & Medicine, 15*(5), 497-506. doi:10.1080/13548506.2010.487110

Department for Education. (2015). *Outcomes for Children Looked After by Local Authorities in England, as at 1 October 2015.* Office for National Statistics. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/464756/SFR34_2015_Text.pdf. Accessed 5th December 2015.

Department for Education. (2014). *Outcomes for Children Looked After by Local Authorities in England as at 31 March 2014.* Office for National Statistics. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384781/Outcomes_SFR49_2014_Text.pdf. Accessed 5th December 2015.

Department for Education. (2010). *Promoting the Educational Achievement of Looked After Children Statutory Guidance for Local Authorities.* Office for National Statistics. Retrieved from https://www.gov.uk/government/uploads/system/uploads/ attachment_data/ file/276468/educational_achievement_of_looked_after_children. pdf. Accessed 20th February 2016.

Department of Health. (2015a). *Preventing suicide in England Two Years on: Second report on the cross-government outcomes strategy to save lives.* HMSO: London.

Department of Health. (2015b). *Statistical update on suicide.* HMSO: London.

Department of Health. (2012). *Preventing suicide in England: A cross-government outcomes strategy to save lives.* HMSO: London.

Devaney, J., Bunting, L., Davidson, G., Hayes, D., Lazenbatt, A., & Spratt, T. (2012). *Still vulnerable: The impact of early childhood experiences on adolescent suicide and accidental death.* Northern Ireland Commissioner for Children and Youth: Belfast.

Effective Public Health Practice Project. (1998). *Quality Assessment Tool for Quantitative Studies*. Effective Public Health Practice Project. Available from: http://www.ephpp.ca/index.html (accessed 12 January 2016).

Everson-Hock, E., Jones, R., Guillaume, L., Clapton, J., Duenas, A., Goyder, E., & ... Swann, C. (2011). Supporting the transition of looked-after young people to independent living: A systematic review of interventions and adult outcomes. *Child: Care, Health and Development*, *37*(6), 767-779. doi:10.1111/j.1365-2214.2011.01287.x

Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., ... & Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, *14*(4), 245-258. doi:10.1016/s0749-3797(98)00017-8

Finkelhor, D., Ormrod, R., & Turner, H. (2007). Poly-victimization: A neglected component in child victimization. *Child abuse & neglect*, *31*(1), 7-26. doi:10.1016/j.chiabu.2006.06.008

Fliege, H., Lee, J., Grimm, A., & Klapp, B. (2009). Risk factors and correlates of deliberate self-harm behavior: A systematic review. *Journal of Psychosomatic Research*, *66*(6), 477-493. doi:10.1016/j.jpsychores.2008.10.013

Ford, J., Grasso, D., Hawke, J., & Chapman, J. (2013). Poly-victimization among juvenile justice-involved youths. *Child Abuse & Neglect*, *37*(10), 788-800. doi:10.1016/j.chiabu.2013.01.005

*Gearing, R., Brewer, K., Elkins, J., Ibrahim, R., MacKenzie, M., & Schwalbe, C. (2015). Prevalence and correlates of depression, posttraumatic stress disorder, and suicidality in Jordanian youth in institutional care. *Journal of Nervous and Mental Disease, 203*(3), 175-181. doi:10.1097/NMD.0000000000000267

*Greger, H., Myhre, A., Lydersen, S., & Jozefiak, T. (2015). Previous maltreatment and present mental health in a high-risk adolescent population. *Child Abuse & Neglect, 45,* 122-134. doi:10.1016/j.chiabu.2015.05.003

*Grenville, J., Goodman, D., & Macpherson, A. (2012). Characteristics of Self-harm Behaviour among Identified Self-harming Youth in Care. *International Journal of Mental Health & Addiction, 10*(5), 646-659. doi:10.1007/s11469-011-9361-2

Groholt, B., Ekeberg, O., Haldorsen, T. (2000). Adolescents hospitalised with deliberate self-harm: the significance of an intention to die. *European Journal of Child and Adolescent Psychiatry, 9*, 244–54. doi:10.1007/s007870070027

Hall, B. & Place, M. (2010). Cutting to cope – a modern adolescent phenomenon. *Child Care, Health and Development*, *36*, 623-629. doi.org/10.1111/j.1365-2214.2010.01095.x

*Hamilton, D. J., Taylor, B. J., Killick, C., & Bickerstaff, D. (2015). Suicidal ideation and behaviour among young people leaving care: Case-file survey. *Child Care in Practice, 21*(2), 160-176. doi:10.1080/13575279.2014.994475

*Harkess-Murphy, E., MacDonald, J., & Ramsay, J. (2013). Self-harm and psychosocial characteristics of looked after and accommodated young people. *Psychology, Health & Medicine, 18*(3), 289-299. doi:10.1080/13548506.2012.712706

*Harpin, S., Kenyon, D., Kools, S., Bearinger, L., & Ireland, M. (2013). Correlates of Emotional Distress in Out-of-Home Youth. *Journal of Child & Adolescent Psychiatric Nursing, 26*(2), 110-118. doi:10.1111/jcap.12030

Harrington, R., Kerfoot. M., Dyer. E., McNiven. F., Gill. J., Harrington. V., Woodham. A., & Byford S. (1998). Randomized trial of a homebased family intervention for children who have deliberately poisoned themselves. *Journal of the American Academy of Child Adolescent Psychiatry, 37*, 512–518. doi:10.1016/s0890-8567(14)60001-0

Hawton, K., Fagg, J., Simkin, S., Bale, E., & Bond A. (1997). Trends in deliberate self-harm in Oxford, 1985–1995. *British Journal of Psychiatry, 171*, 556–560. doi:10.1192/bjp.171.6.556

Hawton, K., Harriss, L., Hall, S., Simkin, S., Bale, E., & Bond, A. (2003). Deliberate self-harm in Oxford, 1990-2000: a time of change in patient characteristics. *Psychological medicine*, *33(6),* 987-995. doi.org/10.1017/s0033291703007943

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.org/10.1136/bmj.325.7374.1207

Hawton, K., Saunders, K., & O'Connor, R. (2012). Self-harm and suicide in adolescents. *The Lancet*, *379*(9834), 2373-2382. doi:10.1016/s0140-6736(12)60322-5

*Heneghan, A., Stein, R., Hurlburt, M., Zhang, J., Rolls-Reutz, J., Fisher, E.,... & Horwitz, S. (2013). Mental health problems in teens investigated by US child welfare agencies. *Journal of Adolescent Health*, *52*(5), 634-640. doi:10.1016/j.jadohealth.2012.10.269

Hilt, L., Nock, M., Lloyd-Richardson, E., & Prinstein, M. (2008). Longitudinal study of nonsuicidal self-injury among young adolescents rates, correlates, and preliminary test of an interpersonal model. *The Journal of Early Adolescence*, *28*(3), 455-469. doi:10.1177/0272431608316604

Holland, S., Faulkner, A., & Perez-del-Aguila, R. (2005). Promoting stability and continuity of care for looked after children: a survey and critical review. *Child & Family Social Work,* 10, 29–41. doi:10.1111/j.1365-2206.2004.00339.x

Holm, A., & Severinsson, E. (2010). Desire to survive emotional pain related to self-harm: A Norwegian hermeneutic study. *Nursing and Health Sciences, 12,* 52-57. doi.org/10.1111/j.1442-2018.2009.00485.x

*Hukkanen, R., Sourander, A., & Bergroth, L. (2003). Suicidal ideation and behavior in children's homes. *Nordic Journal of Psychiatry, 57*(2), 131. doi.:10.1080/08039480310000969

Hukkanen, R., Sourander, A., Bergroth, L., Piha, J. (1999). Psychosocial factors and adequacy of services for children in children’s homes. *European Journal of Child and Adolescent Psychiatry, 8,* 268–75. http://dx.doi.org/10.1007/s007870050101

*Hurley, K., Trout, A., Chmelka, M., Burns, B., Epstein, M., Thompson, R., & Daly, D. (2009). The changing mental health needs of youth admitted to residential group home care comparing mental health status at admission in 1995 and 2004. *Journal of Emotional and Behavioral Disorders*, *17*(3), 164-176. doi:10.1177/1063426608330791

*Hurley, K., Wheaton, R., Mason, W., Schnoes, C., & Epstein, M. (2014). Exploring suicide risk history among youth in residential care. *Residential Treatment for Children & Youth, 31*(4), 316-327. doi:10.1080/0886571X.2014.958377

Jackson, S., & McParlin, P. (2006). The education of children in care. *The Psychologist, 19*, 90–93.

Jacobson, C., Muehlenkamp, J., Miller, A., & Turner, J. (2008). Psychiatric impairment among adolescents engaging in different types of deliberate self-harm. *Journal of Clinical Child & Adolescent Psychology*, *37*(2), 363-375. http://dx.doi.org/10.1080/15374410801955771

Johnson, J., Wood, A., Gooding, P., Taylor, P., & Tarrier, N. (2011). Resilience to suicidality: The buffering hypothesis. *Clinical Psychology Review, 31*, 563–591. http://dx.doi.org/10.1016/j.cpr.2010.12.007

Kandel, D., Raveis, V., & Davies, M. (1991). Suicidal ideation in adolescents: depression, substance use, and other risk factors. *Journal of Youth and Adolescence, 20*, 289–309. http://dx.doi.org/10.1007/bf01537613

Kerker, B., & Dore, M. (2006). Mental health needs and treatment of foster youths: Barriers and opportunities. *American Journal of Orthopsychiatry, 76*(1), 138-147. doi:10.1037/0002-9432.76.1.138

Kerkhof, J. (2000). *Attempted suicide: patterns and trends.* In The International Handbook of Suicide and Attempted Suicide (K. Hawton & K. van Heeringen ed.). John Wiley & Sons: Chichester.

Kingsbury, S., Hawton K., Steinhardt, K. & James, A. (1999). Do adolescents who take overdoses have specific psychological characteristics? A comparative study with psychiatric and community controls. *Journal of the American Academy of Child Adolescent Psychiatry, 38*, 1125–1131. http://dx.doi.org/10.1097/00004583-199909000-00016

Kleiman, E. M., Riskind, J. H., & Schaefer, K. E. (2014). Social support and positive events as suicide resiliency factors: examination of synergistic buffering effects. *Archives of Suicide Research*, *18*(2), 144-155. http://dx.doi.org/10.1080/13811118.2013.826155

Klonsky, E. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review, 27*, 226-239. doi.org/10.1016/j.cpr.2006.08.002

Lau, A. S., McCabe, K. M., Yeh, M., Garland, A. F., Hugh, R. L. & Landsverk, J. (2003). Race/ethnicity and rates of self-reported maltreatment among high-risk youth in public sectors of care. *Child Maltreatment,* 8, 183–194. http://dx.doi.org/10.1177/1077559503254141

Laye-Gindhu, A., & Schonert-Reichl, K. (2005). Nonsuicidal self-harm among community adolescents: Understanding the “whats” and “whys” of self-harm. *Journal of Youth and Adolescence*, *34(5),* 447-457. doi.org/10.1007/s10964-005-7262-z

Leenarts, L., Diehle, J., Doreleijers, T., Jansma, E., & Lindauer, R. (2013). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. *European Child & Adolescent Psychiatry*, *22*(5), 269-283. http://dx.doi.org/10.1007/s00787-012-0367-5

Madge, N., Hewitt, A., Hawton, K., Wilde, E. J., 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. *Journal of Child Psychology and Psychiatry, 49,* 667-677. doi.org/10.1111/j.1469-7610.2008.01879.x

Mars, B., Heron, J., Crane, C., Hawton, K., Lewis, G., Macleod, J., ... & Gunnell, D. (2014). Clinical and social outcomes of adolescent self-harm: population based birth cohort study. *British Medical Journal*, *349*, g5954. doi.org/10.1136/bmj.g5954

McAuley, C. & Davis, T. (2009). Emotional well-being and mental health of looked after children in England. *Child and Family Social Work, 14,* 147–155. doi:10.1111/j.13652206.2009.00619.x

McCann, J., James, A., Wilson, S., Dunn, G. (1996). Prevalence of psychiatric disorders in young people in the care system. *British Medical Journal, 313*, 1529–30. http://dx.doi.org/10.1136/bmj.313.7071.1529

McLaughlin, K., Greif Green, J., Gruber, M., Sampson, N., Zaslavsky, A., & Kessler, R. (2012). Childhood adversities and first onset of psychiatric dis-orders in a national sample of US adolescents. *Archives of General Psychiatry, 69*(11), 1151–1160. http://dx.doi.org/10.1001/archgenpsychiatry.2011.2277

Meltzer, H., Corbin, T., Gatward, R., Goodman, R., & Ford, T. (2003). *The Mental Health of Young People Looked After by Local Authorities in England*. The Stationary Office: London.

Meltzer, H., Lader, D., Corbin, T., Goodman, R., & Ford, T. (2004). *The mental health of young people looked after by local authorities in Scotland.* The Stationery Office: Edinburgh.

Meltzer, H., Lader, D., Corbin, T., Singleton, N., Jenkins, R., & Brugha, T. (2000). *Non-fatal suicidal behaviour among adults aged 16 to 74*. The Stationery office: Great Britain.

Mental Health Foundation. (2002). *The Mental Health of Looked After Children – Bright Futures: Working with Vulnerable Young People*. Mental Health Foundation: London.

Mills, R., Scott, J., Alati, R., O'Callaghan, M., Najman, J., & Strathearn, L. (2013). Child maltreatment and adolescent mental health problems in a large birth cohort. *Child Abuse and Neglect*, 37(5), 292-302. http://dx.doi.org/10.1016/j.chiabu.2012.11.008

Muehlenkamp, J. (2005). Self-injurious behavior as a separate clinical syndrome. *American Journal of Orthopsychiatry*, *75*(2), 324. http://dx.doi.org/10.1037/0002-9432.75.2.324

Muehlenkamp, J., Claes, L., Havertape, L., & Plener, P. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health*, *6*(10), 1-9. doi.org/10.1186/1753-2000-6-10

Muehlenkamp, J. & Gutierrez, P. (2004). An investigation of differences between self-injurious behaviour and suicide attempts in a sample of adolescents. *Suicide and Life-Threatening Behaviour, 34,* 12-23. http://dx.doi.org/10.1521/suli.34.1.12.27769

Muehlenkamp, J., & Kerr, P. (2010). Untangling the self-harm web: How non-suicidal self-injury and suicide attempts differ. *Prevention Research, 17*, 8-10. doi.org/10.1037/e515372010-002

Muehlenkamp, J., Williams, K., Gutierrez, P., & Claes, L. (2009). Rates of non-suicidal self-injury in high school students across five years. *Archives of Suicide Research*, *13*(4), 317-329. http://dx.doi.org/10.1080/13811110903266368

NICE & SCIE (2010). *Promoting the quality of life of looked-after children and young people,* Public Health guidance 28. National Institute for Health and Clinical Excellence.

NICE (2004). Self-harm: the Short-term Physical and Psychological Management and Secondary Prevention of Self-harm in Primary and Secondary Care. *NICE Clinical Guideline 16*. London: NICE. Retrieved from https://www.nice.org.uk.

NICE (2013). Quality standard for Self-harm. *NICE Quality Standard 34*. London: NICE. Retrieved from https://www.nice.org.uk.

Nock, M. (2010). Self-injury. *Annual Review of Clinical Psychology,* 6, 339-63. doi.org/10.1146/annurev.clinpsy.121208.131258

Nock, M., Joiner, T., Gordon, K., Lloyd-Richardson, E., & Prinstein, M. (2006). Nonsuicidal self-injury among adolescents: diagnostic correlates and relation to suicide attempts. *Psychiatry Research*, *144*, 65-72. doi:10.1016/j.psychres.2006.05.01

Nock, M., & Kessler, R. (2006). Prevalence of and risk factors for suicide attempts versus suicide gestures: analysis of the National Comorbidity Survey. *Journal of Abnormal Psychology*, *115*(3), 616. http://dx.doi.org/10.1037/0021-843x.115.3.616

O'Connor, R., Rasmussen, S., Miles, J., & Hawton, K. (2009). Deliberate self-harm in adolescents: Self-report survey in schools in Scotland. *British Journal of Psychiatry, 194*, 68–72. http://dx.doi.org/10.1192/bjp.bp.107.047704

Pecora, P., Jenson, P., & Romanelli, L. (2009). Mental health services for children placed in foster care: An overview of current challenges. *Child Welfare, 88*(5), 5-26.

Pfeffer, C., Klerman, G., Hurt, S., Kakuma, T., Peskin, J., Siefker, C. (1993). Suicidal children grow up: Rates and psychosocial risk factors for suicide attempts during follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*, 106–13. http://dx.doi.org/10.1097/00004583-199301000-00016

Renaud, J., Brent, D., Birmaher, B., Chiappetta, L., Bridge, J. (1999). Suicide in adolescents with disruptive disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 846–51.

Richardson, N., Clarke, N., & Fowler, C. (2013). Young men and suicide project: A report on the All-Ireland Young Men and Suicide Project. Dublin: Health Service Executive.

Rivaux, S., James, J., Wittenstrom, K., Baumann, D., Sheets, J., Henry, J. & Jeffries, V. (2008). The intersection of race, poverty, and risk: understanding the decision to provide services to clients and to remove children. *Child Welfare*, 87, 151–168.

Rubenstein, J., Halton, A., Kasten, L., Rubin, C., Stechler, G. (1998). Suicidal behavior in adolescents: Stress and protection in different family contexts. *American Journal of Orthopsychiatry, 68,* 274–84. http://dx.doi.org/10.1037/h0080336

Rubin, D., O'Reilly, A., Luan, X., & Localio, A. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics, 119*, 336–344. http://dx.doi.org/10.1542/peds.2006-1995

Schilling, E., Aseltine, R., & Gore, S. (2007). Adverse childhood experiences and mental health in young adults: a longitudinal survey. *BMC public health*, *7*(1), 30. http://dx.doi.org/10.1186/1471-2458-7-30

Scott, J., & Malcolm, H. (2006). The health of looked after and accommodated children and young people in Scotland, messages from research. Edinburgh: Social Work Inspection Agency.

Simkiss, D., Spencer, N., Stallard, N., Thorogood, M. (2012). Health service use in families where children enter public care: a nested case control study using the General Practice Research Database. *BMC Health Services Research*, *12*, 65. doi:10.1186/1472-6963-12-65

Skegg, K. (2005). Self-harm. *Lancet*, *366:* 1471–83. doi.org/10.1016/s0140-6736(05)67600-3

Sourander, A., Aromaa, M., Pihlakoski, L., Haavisto, A., Rautava, P., Helenius, H., & Sillanpää, M. (2006). Early predictors of deliberate self-harm among adolescents. A prospective follow-up study from age 3 to age 15. *Journal of Affective Disorders*, *93*(1), 87-96. http://dx.doi.org/10.1016/j.jad.2006.02.015

Spratt, T. (2012). Why multiples matter: Re-conceptualizing the population referred to child and family social Workers. *British Journal of Social Work, 42*, 1574–1591. doi:10.1093/bjsw/bcr165

Tarren-Sweeney, M. (2008). The mental health of children in out-of-home care. *Current Opinion in Psychiatry*, *21*(4), 345-349. doi.10.1097/YCO.0b013e32830321fa

Taussig, H., Clyman, R., & Landsverk, J. (2001). Children who return home from foster care: A 6-year prospective study of behavioural health outcomes in adolescence. *Pediatrics, 108*(1), E10. http://dx.doi.org/10.1542/peds.108.1.e10

Thomas, H., Ciliska, D., Dobbins, M., & Micucci, S. (2004). A process for systematically reviewing the literature: Providing the research evidence for public health nursing interventions. *Worldviews on Evidence-Based Nursing, 1,* 176-184. doi: 10.1111/j.1524-475x.2004.04006.x

Tine, E., & Mette, L. (2009). Prevalence of mental health problems among children placed in out-of-home care in Denmark. *Child & Family Social Work, 14*(2), 156–65. http://dx.doi.org/10.1111/j.1365-2206.2009.00620.x

Turner, W., & Macdonald, G. (2011). Treatment foster care for improving outcomes in children and young people: A systematic review. *Research on Social Work Practice*, 21(5), 501–527. doi:10.1177/1049731511400434

Waldrop, A., Hanson, R., Resnick, H., & Kilpatrick, D. (2007). Risk factors for suicidal behaviour among a national sample of adolescents: implications for prevention. *Journal of Traumatic Stress, 20*(5), 869–879. http://dx.doi.org/10.1002/jts.20291

Wasserman, D., Cheng, Q., & Jiang, G. (2005). Global suicide rates among young people aged 15–19. *World Psychiatry, 4*(2), 114–120.

Whitlock, J., Eckenrode, J., & Silverman, D. (2006). Self-injurious behaviors in a college population. *Pediatrics*, *117*(6), 1939-1948. http://dx.doi.org/10.1542/peds.2005-2543

Whitlock, J., Powers, J., & Eckenrode, J. (2006). The virtual cutting edge: the internet and adolescent self-injury. *Developmental Psychology*, *42(3*), 407. doi.org/10.1037/0012-1649.42.3.407

World Health Organisation. (2014). *Preventing suicide: A global imperative.* World Health Organisation.

Yates, T. (2004). The developmental psychopathology of self-injurious behaviour: Compensatory regulation in posttraumatic adaptation. *Clinical Psychology Review, 24*, 35-74. doi.org/10.1016/j.cpr.2003.10.001

Zahl, D. & Hawton, K. (2004). Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11,583 patients. *The British Journal of Psychiatry*, *185*(1), 70-75. doi.org/10.1192/bjp.185.1.70

Zetterqvist, M., Lundh, L., & Svedin, C. G. (2012). A comparison of adolescents engaging in self-injurious behaviors with and without suicidal intent: Self-reported experiences of adverse life events and trauma symptoms. Journal of Youth and Adolescence, 42(8), 1257-72. doi:10.1007/s10964-012-9872-6.

Zlotnick, C., Donalson, D., Spirito, A., & Pearlstein, T. (1997). Affect regulation and suicide attempts in adolescent inpatients. *Journal of the American Academy of Child and*

Adolescent Psychiatry, 36, 793–8. http://dx.doi.org/10.1097/00004583-199706000-00016

Appendix 1-A

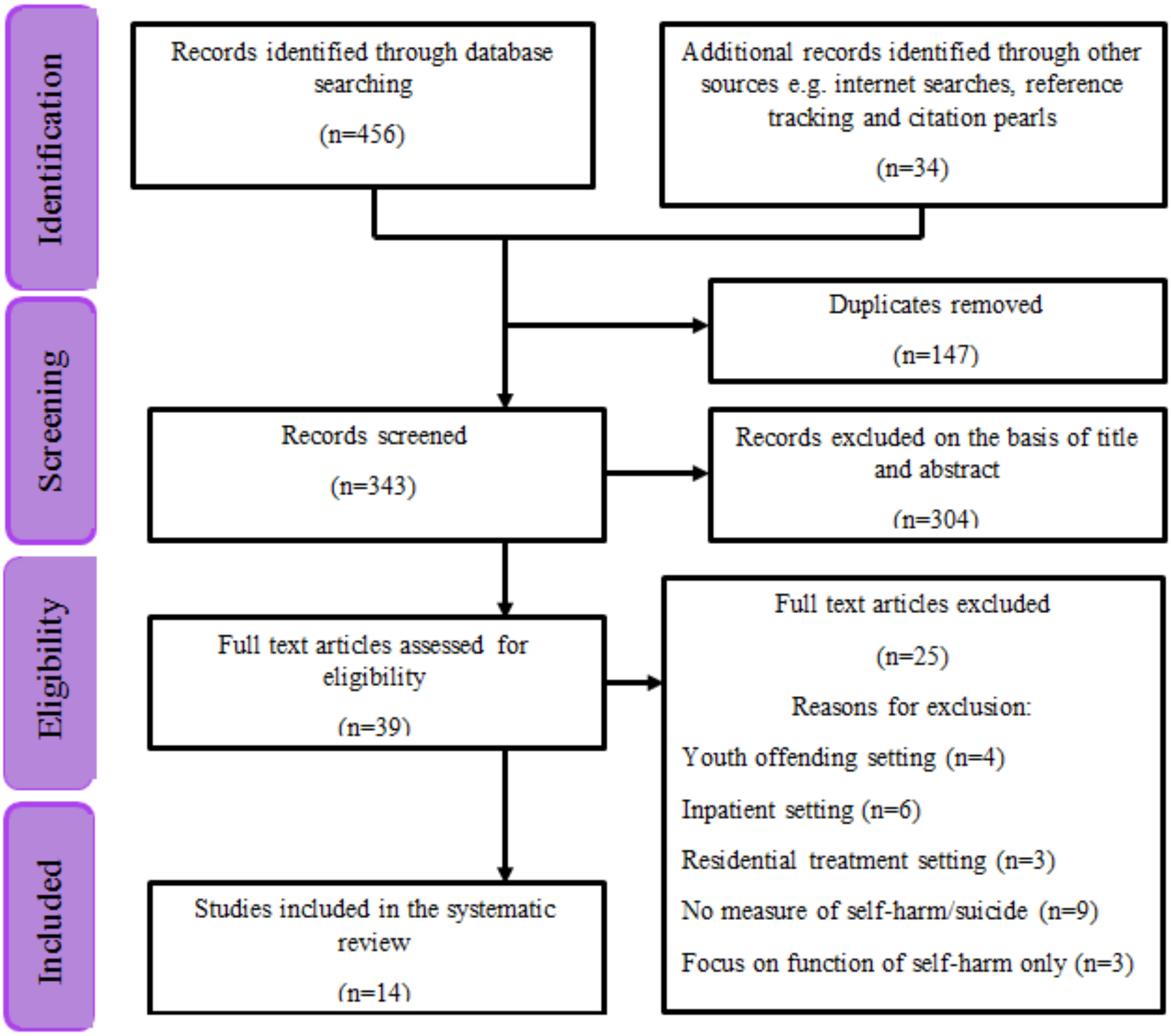

Figure 1: The flow of studies through the review

Appendix 1-B
Table 1: General characteristics and key findings of reviewed studies

Author/setting/ country/design	Participant characteristics	Main research question(s)	Primary outcome measures	Main findings
Anderson (2011) Children entering the child welfare system USA Cross-sectional design	N=2,145 1,103 Females 1,042 Males Living at home: N=1930 LAC placement: n=37 residential care n=67 non- relative foster family n=86 relative foster family n=26 other out-of-home placement	Is there an association between type of placement, depressive symptoms and suicidal behaviour in LAC?	Children's Depression Inventory (CDI)	Among LAC at baseline (n=549), those living in a group home were 7.25 times more likely to have suicide ideation compared to those in kinship care (p<0.01). Additionally, those in a group home were 4.6 times more likely to have clinically significant depressive symptoms than those in kinship care. As expected, clinically significant depressive symptoms were significantly associated with suicide ideation (OR=7.7, p<0.01). The number of LAC placements since entering the study at baseline was significantly associated with subsequent suicide ideation, adjusting for age, gender and race/ethnicity. An odds ratio of 1.68 (p<0.05) indicated that the likelihood of suicide ideation increased by 68% for each placement breakdown. A statistically significant effect of number of LAC placements on prior or current clinically significant depressive symptoms (OR=1.62, p<0.05), supporting the role of clinically significant depressive symptoms as a mediator of the relationship between number of LAC placements and subsequent suicide ideation.
Cheung & Goodman (2007) Children in child welfare settings Canada Cross-sectional design	N=72 All single self-harmers. Repeat self-harmers excluded. Minority: n=34 Non-minority: n=38	Do cultural differences in self-harming behaviours exist in children in care?	No primary outcome measures used. Case file review only.	Minority and non-minority LAC did not differ in the number of self-harming attempts or threats that are reported, suggesting no ethnic differences in the amount of self-harm. However, the results suggested that when compared to minority children in care (18%), non-minority children in care were more likely to engage in cutting behaviours when attempting to self-harm (37%). Across all types of self-harming threats, minority status was not found to be significantly related to any of the behaviours. These results suggest that despite differences in minority status, how LAC threaten self-harm did not differ.

General characteristics and key findings of reviewed studies (continued)

Author/setting/ country/design	**Participant characteristics**	**Main research question(s)**	**Primary outcome measures**	**Main findings**
Cousins et al. (2008) Young people living in looked-after care UK Cross-sectional design	N=165 79=Female 86=Male LAC placement: n=74 residential care n=74 non- relative foster family n=17 relative foster family	What is the prevalence of self-harm and suicidal behaviour in LAC? Is self-harm and suicidal behaviour associated with emotional and behavioural status of LAC on the SDQ?	Strengths and Difficulties Questionnaire (SDQ)	Over the course of their lifetime, a total of 17 of the 165 young people (10.3%) were recorded as having made an attempt at ending their own life. Of these attempts, 8 were attempted by males and 9 by females. A total of 21 young people (12.7%) were recorded as having engaged in self-harm at some point in their life. Of these events, 8 were male and the remaining 13 were female. It was found that 49.6% of the young people scored within the abnormal range of the SDQ total difficulties score. Regarding self-harm, statistically significant correlations were found on the SDQ emotional symptoms score (r=0.278, p<0.001). No significant correlations were found between self-harm and social skills, hyperactivity and peer problems.
Cousins et al (2010) Young people living in looked-after care UK Cross-sectional design	N= 165 79 Females 86 Males LAC placement: n=74 residential care n=74 non- relative foster family n=17 relative foster family	What are the characteristics of LAC? Does the type of placement impact upon mental health outcomes? How does the mental health of LAC compare to those living at home?	Strengths and Difficulties Questionnaire (SDQ)	Building upon the findings from Cousins et al.'s (2008) results, this study used the same data to explore whether type of placement had different outcomes for young people. Young people living in residential care accommodation were significantly more likely (p<0.005) than young people living in foster care to present with challenging behaviour, however no significant differences were found on self-harm and attempted suicide across the two groups. On the SDQ as rated by social workers, young people in residential care were statistically more likely than their peers in foster care to be scored higher on conduct problems (p<0.01), hyperactivity (p<0.001) and peer problems (p<0.005). However no significant differences were found for emotional problems, including self-harm and suicidal behaviour.

General characteristics and key findings of reviewed studies (continued)

Author/setting/ country/design	**Participant characteristics**	**Main research question(s)**	**Primary outcome measures**	**Main findings**
Gearing et al (2015) Residential LAC setting Jordan Cross-sectional design	N=86 41 Females 45 Males All participants in residential care setting	What is the prevalence and correlated of PTSD, depression and suicidal behaviour among LAC?	PTSD Index for DSM-IV (UPID) Centre for Epidemiological Studies Depression Scale (CES-D) Child Behaviour Checklist (CBCL) Self-Efficacy Scale Social Support Survey for Adolescents	Of the three mental health conditions, the most endorsed was depression (45%). A quarter of participants (24%) met criteria for PTSD, with suicidality identified in 27% of the sample. LAC with PTSD were found to be 2.6 times more likely to report suicidality than young people without PTSD. For LAC with depression, there was a 3.5 times greater likelihood of reporting suicidality than for those without depression. Young people with a history of abuse were 4 times more likely to present with suicidality than those who did not report abuse. General self-efficacy and the presence of close peer relationships were found to be statistically significant correlated of depression. For every unit increase in general self-efficacy, the odds of depression decreased by 65%. The odds of depression for young people who reported having close peer relationships were 88% less than the odds of depression in those without close peer relationships.
Greger et al. (2015) Child welfare institutions Norway Cross-sectional design	N=335 196 Females 139 Males All participants in residential care setting	What is the impact of childhood maltreatment on the prevalence and comorbidity of psychiatric disorders among children in residential care?	Child Behaviour Checklist (CBCL) Child and Adolescent Psychiatric Assessment (CAPA) Adverse Childhood Experiences (ACE) questionnaire	Overall, there was a high prevalence of self-reported maltreatment (71%) among children in residential settings. Among females, 40.8% had experienced sexual abuse, and 46.4% reported having been a victim of family violence. This was substantially more than for male participants, where 6.5% had experienced sexual abuse, and 27.3% were victims of family violence. Adolescents that reported exposure to one of more types of maltreatment has significantly higher odds for conduct disorder, dysthymia and anxiety disorders (including social phobia, panic, agoraphobia and general anxiety disorder). Additionally, they had significantly higher odds of having current suicidal thoughts and of having ever attempted suicide. Victims of family violence had significantly higher odds for suicidal thoughts, while victims of sexual abuse or rape had significantly higher odds for attempted suicide.

General characteristics and key findings of reviewed studies (continued)

Author/setting/ country/design	**Participant characteristics**	**Main research question(s)**	**Primary outcome measures**	**Main findings**
Grenville et al. (2011) Looked-after children Canada Cross-sectional design	N=252 112 Females 140 Males All participants in residential care setting	What are the key characteristics of LAC that self-harm? What factors are associated with repeat self-harm among LAC?	No primary outcome measures used. Case file review only.	Across all 621 incidents of self-harm, 112 females accounted for 386 (62.1%) of the incidents. Of the 252 participants, 177 (70.2%) participants had a single incident of deliberate self-harm (sDSH), where 75 (29.8%) had repeat self-harm incidents (rDSH). Regression analysis of the association between gender, type of behaviour and age with frequency of incidents found females were more likely than males to self-harm than threaten self-harm (AOR 1.34, ACI 0.79-2.27), and females with more than one DSH incident were significantly more likely to have rDSH incidents than males (AOR 2.55, ACI 1.08-6.02). Moreover, older children (≥14yrs) had an increased likelihood of having rDSH incidents (AOR 1.20, ACI 0.38-1.83) when compared to their younger peers (<14). Finally, females (AOR 1.26, ACI 0.79-2.02), older children (AOR 4.26, ACI 2.51-7.21) and rDSH (AOR 1.32, ACI 0.85-2.05) were more likely to require medical attention following an incident than males and sDSH.
Hamilton et al. (2015) Social services evaluation of young people leaving care UK Cross-sectional design	N=164 92 Females 72 Males LAC placement: n=52 living with foster family n=19 living in residential care n=96 no longer living in care placement	What is the incidence of suicidal behaviour in LAC leaving care? What are the risk factors associated with suicidal behaviour in LAC leaving care?	No primary outcome measures used. Case file review only	The number of placements since coming into care and number of suicide attempts had a significant positive correlation (r = 0.157, p<0.05), with higher number of placement moves associated with higher number of suicide attempts. Young people who were not engaged in education or employment presented with a higher incidence of self-harm (34%), suicidal thoughts (28%) and suicidal attempts (10%) than those in education or employment (18%, 13% and 6% respectively). 36% of young people in care were known to mental health services, and 13% had a diagnosable mental health difficulty, with a significant positive correlation between mental health diagnosis and number of suicidal thoughts (r = 0.263, p<0.01). History of alcohol and/or drug use also associated with a higher incidence of self-harm and suicidal behaviour.

General characteristics and key findings of reviewed studies (continued)

Author/setting/ Country/design	**Participant characteristics**	**Main research question(s)**	**Formal outcome measures**	**Main findings**
Harkess-Murphy et al. (2013) LAC children in school settings UK Cross-sectional design	N= 102 48 Females 54 Males LAC placement: n=93 living with parents n=4 living with grandparents n=3 living with foster family n=2 unknown	What are the psychological and social differences between LAC and young people who have self-harmed compared to those who have never self-harmed?	Reasons for Living Inventory for Adolescents (RFL-A) Forms of Self-Criticising and Self-Reassurance Scale (FSCRS) Functions of Self-Criticising Scale (FSCS) Bachman's School Ability Self-Concept Index Self-Reported Self-Harm	No significant gender differences in self-harm incidences (x^2 (1) = 3.104, p= 0.078). Participants in the self-harm group had significantly less reasons for living (t (46) = -5.787, p<0.001) and significantly lower academic self-esteem (t (100) = -3.838, p<0.001) than those who do not self-harm. Self-harming participants were found to be significantly more likely to have a problem with friends/boyfriends/girlfriends (x^2 (2) = 11.658, p<0.01), and perceive their problems as significantly more difficult to cope with (t (38) = 4.424, p<0.001) than non-self-harmers. Participants who reported self-harming behaviours had a significantly more self-criticism (t (46) = 8.112, p<0.001) than participants who had never self-harmed. Self-criticism had a significant effect on predicting self-harm. As levels of self-criticism increased, the odds of engaging in self-harm increased by 5.2 times (p<0.001).
Harpin et al. (2013) LAC children in school settings USA Cross-sectional design	LAC living out of home: N=5,516 Female=2,457 Male=3,059 Children living at home: N=5,500 Female=2,772 Male=2,728		No primary outcome measures used. Case file review only.	LAC reported greater degrees of suicide attempts (x^2 = 70.58, p<0.001) and sexual (x^2 = 113.3, p<0.001) and physical abuse (x^2 = 189.7, p<0.001) than students living at home. Among the risk factors, emotional distress (t= -11.02, p<0.001) and suicidality (t= -13.28, p<0.001) had higher scores among LAC. Protective factors such as parental caring (t=19.33, p<0.001), other adult caring (t=16.47, p<0.001), school connectedness (t=15.27, p<0.001), and grade point average (t=21.01, p<0.001) were reported significantly more frequent among youths at home, than for LAC. Regression analysis found parental caring, other adult caring, school connectedness, GPA, suicidality, physical maltreatment and sexual abuse were significantly correlated with emotional distress for LAC (F=230.0, p<0.001). Parental caring (β= -0.11) and school connectedness (β = -0.12) were particularly strong factors correlating with decreased mental health distress in LAC.

General characteristics and key findings of reviewed studies (continued)

Author/setting/ country/design	**Participant characteristics**	**Main research question(s)**	**Primary outcome measures**	**Main findings**
Heneghan et al. (2013) Children entering the child welfare system USA Cross-sectional design	N=815 488 Females 327 Males Home without services: n=456 Home with child welfare services: n=220 LAC placement: n=145	What are the associated correlated and prevalence of mental health difficulties among children in care compared to those living at home?	Youth Self-Report (YSR) to assess suicidality Child Behaviour Checklist (CBCL) Children's Depression Inventory (CDI) CRAFTT Screening Test to assess substance use	Overall, 42.7% of teens reported having at least one mental health problem. Nine percent of the sample reported depression, 13.9% suicidality, 23% substance use/abuse, 13.5% anxiety, and 18.6%ADHD. Females were significantly more likely to report depression and suicidality. Regression analysis results suggest that teen and placement factors are related to mental health problems. Teens in LAC placement prior to the intake interviews had odds 2.29 times higher of reporting a MH problem (95% CI 1.38-3.81) than those living at home. Black children were significantly less likely to indicate suicidality (OR=.27, 95% CI .09-.76).
Hukkanen et al (2003) LAC children settings Finland Cross-sectional design	N=98 49 Females 49 Males All participants in residential care setting	What are the participant characteristics and risk factors associated with suicidal behaviour among LAC?	Spectrum of Suicidal Behaviour Scale Spectrum of Assaultive Behaviour Scale Child Behaviour Checklist (CBCL) Children's Global Assessment Scale (CGAS) Self-reported self-mutilation and traumatic experiences	Of the 98 participants, 24% had presented suicidal thoughts or threats of suicide during the last 6 months, while 8% (n=8) had made a suicide attempt. Children with suicidal thoughts, threats and attempts were pooled together (n=32) and compared with non-suicidal children. Thirty-nine per cent of girls and 27% of boys were suicidal, however gender differences did not reach significance. Factors significantly associated with suicidality in the chi-square comparison were low CGAS level (p=0.002), self-harm (p<0.001), violent ideas, threats and behaviour (p=0.005) and clinical range functioning on the CBCL (p=0.047). Regression analysis found self-harm, low CGAS level and violence were associated with suicidality. Half of children with suicidality had self-harmed during the past 6 months. Almost 90% of children with self-harm were also having suicidal ideas or suicide attempts. Furthermore, self-harm was significantly associated with violent acts against others (p=0.001), with 63% of children who self-harm committing aggressive acts towards others.

General characteristics and key findings of reviewed studies (continued)

Author/setting/ country/design	**Participant characteristics**	**Main research question(s)**	**Primary outcome measures**	**Main findings**
Hurley et al. (2009) Children in residential group home care USA Cross-sectional design	N=1,047 388 Females 659 Males Cohort 1 (95-96) = 482 Cohort 2 (04-05) = 565 All participants in residential care setting	Has the mental health status of LAC living within residential care remained constant? or changed over time from 1995 to 2004?	No primary outcome measures used. Case file review only.	Child demographics, placement characteristics and psychiatric diagnoses at admission varied substantially between cohorts. There was a substantial difference from cohort 1 to cohort 2 in the race of children, with significantly fewer Caucasian children in cohort 2 (from 60% to 49%). For mental health variables, there was no significant change between cohorts on suicidal behaviour, with 35% of cohort 1 and 39% of cohort 2 indicating some type of suicidal thoughts or activities. However there was a significant increase in the number of children with two or more psychiatric diagnoses, from 28% to 53%. Regression analysis demonstrated that suicide behaviour was not a significant predictor of cohort membership.
Hurley et al. (2014) Residential LAC setting USA Cross-sectional design	N=509 192 Females 317 Males All participants in residential care setting	What are the demographic and mental health variables associated with suicide risk in LAC?	Child Behaviour Checklist (CBCL)	Males were significantly more likely to be in the low suicide risk group, where females were more likely to be in the high suicide risk group (x^2 = 33.61, p<0.001). Caucasian children had significantly higher representation in the high suicide risk history group (x^2 = 60.48, p<0.001). No significant differences in age were found between high and low suicide risk groups. Scores on the CBCL for the high suicide risk group were significantly higher than those in the low suicide risk history group (F=18.36, p<0.001).

Appendix 1-C

Table 2: The Application of the Quality Assessment Tool for Quantitative Studies

Name of study	Selection bias	Study design	Confounders	Data collection	Withdrawals and dropouts	Overall quality rating
Anderson (2011)	Strong	Weak*	Strong	Moderate	Moderate	Moderate
Cheung & Goodman (2007)	Moderate	Weak*	Weak	Moderate	Moderate	Weak
Cousins et al. (2008)	Moderate	Weak*	Weak	Strong	Moderate	Weak
Cousins et al. (2010)	Strong	Weak*	Weak	Strong	Moderate	Weak
Gearing et al. (2015)	Moderate	Weak*	Moderate	Moderate	Moderate	Moderate
Greger et al. (2015)	Moderate	Weak*	Strong	Strong	Moderate	Moderate
Grenville et al. (2011)	Moderate	Weak*	Moderate	Moderate	Moderate	Moderate
Hamilton et al. (2015)	Moderate	Weak*	Weak	Moderate	Moderate	Weak
Harkess-Murphy et al. (2013)	Strong	Weak*	Moderate	Strong	Moderate	Moderate
Harpin et al. (2013)	Strong	Weak*	Strong	Strong	Moderate	Moderate
Heneghan et al (2013)	Strong	Weak*	Strong	Strong	Moderate	Moderate
Hukkanen et al. (2003)	Strong	Weak*	Strong	Strong	Moderate	Moderate
Hurley et al (2009)	Moderate	Weak*	Strong	Moderate	Moderate	Moderate
Hurley et al. (2014)	Moderate	Weak*	Weak	Moderate	Moderate	Weak

*Quantitative quality tool deems cross-sectional designs to be methodologically weak

Appendix 1-D: Quality Appraisal Criteria

Quality Assessment Tool for Quantitative Studies

COMPONENT RATINGS

A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?

1 Very likely
2 Somewhat likely
3 Not likely
4 Can't tell

(Q2) What percentage of selected individuals agreed to participate?

1 80–100% agreement
2 60–79% agreement
3 less than 60% agreement
4 Not applicable
5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

B) STUDY DESIGN

Indicate the study design

1 Randomized controlled trial
2 Controlled clinical trial
3 Cohort analytic (two group pre + post)
4 Case-control
5 Cohort (one group pre + post (before and after))
6 Interrupted time series
7 Other specify ________________________________
8 Can't tell

Was the study described as randomized? If NO, go to Component C.

No Yes

If YES, was the method of randomization described? (See dictionary)

No Yes

If YES, was the method appropriate? (See dictionary)

No Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?

1 Yes
2 No
3 Can’t tell

The following are examples of confounders:

1 Race
2 Sex
3 Marital status/family
4 Age
5 SES (income or class)
6 Education
7 Health status
8 Pre-intervention score on outcome measure

(Q2) If YES, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis).

1 80–100% (most)
2 60–79% (some)
3 Less than 60% (few or none)
4 Can’t Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?

1 Yes
2 No
3 Can't tell

(Q2) Were the study participants aware of the research question?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?

1 Yes
2 No
3 Can't tell

(Q2) Were data collection tools shown to be reliable?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

F) WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?

1 Yes
2 No
3 Can't tell
4 Not Applicable (e.g., one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

1 80–100%
2 60–79%
3 less than 60%
4 Can't tell
5 Not Applicable (e.g., Retrospective case-control)

RATE THIS SECTION	**STRONG**	**MODERATE**	**WEAK**
See dictionary	1	2	3

GLOBAL RATING

Please transcribe the information from the grey boxes on pages 1–4 onto this page. See dictionary.

A	SELECTION BIAS	STRONG	MODERATE	WEAK	
		1	2	3	
B	STUDY DESIGN	STRONG	MODERATE	WEAK	
		1	2	3	
C	CONFOUNDERS	STRONG	MODERATE	WEAK	
		1	2	3	
D	BLINDING	STRONG	MODERATE	WEAK	
		1	2	3	
E	DATA COLLECTION METHOD	STRONG	MODERATE	WEAK	
		1	2	3	
F	WITHDRAWALS AND DROPOUTS	STRONG	MODERATE	WEAK	
		1	2	3	Not Applicable

GLOBAL RATING FOR THIS PAPER (circle one):

1	STRONG	(no WEAK ratings)
2	MODERATE	(one WEAK rating)
3	WEAK	(two or more WEAK ratings)

Appendix 1-E: Author Guidelines for Journal

Child and Adolescent Mental Health

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Edited by: Crispin Day, Jane Barlow, Kapil Sayal, Leslie Leve
and Paul Harnett
Impact Factor: 1.441 Online ISSN: 1475-3588
ISI Journal Citation Reports © Ranking: 2014: 64/120 (Pediatrics); 73/119 (Psychology Clinical); 75/133 (Psychiatry (Social Science)); 94/140 (Psychiatry)
Associated Title(s): Journal of Child Psychology and Psychiatry

Author Guidelines

Why submit to *Child and Adolescent Mental Health*?

- An international journal with a growing reputation for publishing work of clinical relevance to multidisciplinary practitioners in child and adolescent mental health
- Ranked in ISI: 2014: 73/119 (Psychology Clinical); 93/140 (Psychiatry (Social Science)); 63/119 (Pediatrics); 75/133 (Psychiatry)
- 4000+ institutions with access to current content, and a further 5000+ plus institutions in the developing world
- High international readership - accessed by institutions globally, including North America (36%), Europe (41%) and Asia-Pacific (15%)
- Excellent service provided by editorial and production offices
- Opportunities to communicate your research directly to practitioners
- Every manuscript is assigned to one of the Joint Editors as decision-making editor; rejection rate is around 84%.
- Acceptance to Early View publication averages 45 days
- Simple and efficient online submission – visit http://mc.manuscriptcentral.com/camh_journal
- Early View – articles appear online before the paper version is published. Click here to see the articles currently available.
- Authors receive access to their article once published as well as a 25% discount on virtually all Wiley books.
- All articles published in CAMH are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF)

The journal encourages pre-submission enquiries, which may be sent via the Managing Editor at camh@acamh.org.uk

1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications

for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Measurement Issues; Innovations in Practice.

Original Articles: These papers should consist of original research findings.
Review Articles: These papers are usually commissioned; they should survey an important area of interest within the general field.
Measurement Issues: These are commissioned review papers that aim to evaluate evidence-based measurement issues in child mental health disorders and services.
Innovations in Practice: Submission to this section should conform to the specific guidelines, given in full below.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original article, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. For detailed instructions please go to: http://mc.manuscriptcentral.com/camh_journal and c*heck for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal c*reate a new account.* Help with submitting online can be obtained from Piers Allen at ACAMH (e-mail Piers.Allen@acamh.org.uk)

4. Authors' professional and ethical responsibilities

Disclosure of interest form
All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

Ethics
Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the *Ethical principles of psychologists and code of conduct* (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (ICJME) and is also a member and subscribes to the principles of the Committee on Publication Ethics (COPE).

Informed consent and ethics approval
Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study

county. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

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The Journal requires authors to conform to CONSORT 2010 (see CONSORT Statement) in relation to the reporting of randomised controlled clinical trials; also recommended is the Extensions of the CONSORT Statement with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of the main text, and in the online manuscript submission. Trials should be registered in one of the ICJME-recognised trial registries:

Australian New Zealand Clinical Trials Registry
Clinical Trials
Nederlands Trial Register
The ISRCTN Register
UMIN Clinical Trials Registry

Manuscripts reporting systematic reviews or meta-analyses should conform to the PRISMA Statement.

The Equator Network is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields and on quasi-experimental http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research and mixed method designs http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond

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scholarly and professional plagiarism. The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscripts to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

5. Manuscripts should be double spaced and conform to the house style of *CAMH*. The first page of the manuscript should give the title, name(s) and address(es) of author(s), and an abbreviated title (running head) of up to 80 characters. Specify the author to whom correspondence should be addressed and provide their full mailing and email address.

Summary: Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

Keywords: Please provide 4-6 keywords (use MeSH Browser for suggestions).

6. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Original Articles should not exceed 5,500 words, including References and Tables. Occasionally, longer articles may be accepted after negotiation with the Editors. Authors should include a word count of their paper.

7. Authors who do not have English as a first language may choose to have their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

8. Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

9. All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

Study funding: Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

Conflicts of interest: Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

Contributorships: Please state any elements of authorship for which particular authors are responsible, where contributionships differ between the author group. (All authors must share responsibility for the final version of the work submitted and published; if the study includes original data, at least one author must confirm that he or she had full access to all the data in the study, and takes responsibility for the integrity of the data and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked.

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References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

11. Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

12. Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file. See http://authorservices.wiley.com/bauthor/illustration.asp for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.

13. Footnotes should be avoided, but end notes may be used on a limited basis.

Section 2: Thesis Empirical Paper

Running head: EXPERIENCES OF THE SELF-HARM OF OTHERS

Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs

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Abstract

Background: As adolescent self-harm is a growing public health concern, more research is needed to identify potential risk factors. Studies have highlighted that exposure to the self-harm of others may be a potential risk factor associated with engagement in self-harm. However, research investigating young people's experiences of the self-harm of others has been limited.

Method: The present qualitative study aimed to explore young people's experiences of the self-harm of others and interviewed a total of eight young people (5 females and 3 males; aged between 13 and 18 years) resident at one of two adolescent mental health inpatient units in the North of England.

Results: The interviews were analysed using interpretative phenomenological analysis and five themes were identified: 'Pre-admission exposure to self-harm', 'Exposure on the inside: An unpleasant environment', 'Helper vs helped', 'Separation from the attention seekers', and 'Competing for authenticity'.

Conclusions: Prevention efforts to reduce the social transmission and stigma surrounding self-harm amongst young people are discussed; including the implementation of peer support groups to facilitate social connectedness and reduce peer competition, and staff training to ensure young people feel more supported and confident about seeking care and support at times of distress without a fear of being derided as an 'attention seeker'.

Keywords: Self-harm; young people; qualitative; experiences; contagion; interpretative phenomenological analysis

The incidence of self-harm among young people has continued to rise in the UK over the past 20 years and is said to be among the highest in Europe (Royal College of Psychiatrists, 2010). Although there is some international variability in its prevalence, self-harm among adolescents has been shown across several studies to be as high as 10% in community-based samples (De Leo & Heller, 2004; Hawton, Rodham, Evans, & Weatherall, 2002; Madge, Hewitt, Hawton, Wilde, Corcoran, Fekete et al, 2008; Hargus, Hawton, & Rodham, 2009; Moran, Coffey, & Romanuik, 2012). Such studies also consistently show that self-harm is more common among females than males (De Leo & Heller, 2004; Madge et al., 2008), and that cutting is the most common method of self-harm in adolescents (Madge et al., 2008).

Self-harm is defined within this paper as an intentional act of self-injury or self-poisoning irrespective of the degree of suicidal intent (NICE, 2011). The high levels of suicidal intention reported by adolescents who self-harm raises the question of how much their self-harm reflects an attempt to end their life, or an attempt to temporarily alleviate intolerable distress (Boergers, Spirito, & Donaldson, 1998). This question draws attention to the need to better understand the meaning behind self-harm.

Relatively little is known about why young people start self-harming and what factors may be associated with engagement in self-harm (Hasking, Andrews, & Martin, 2013). Hospital statistics have shown that the frequency of adolescent admissions for self-harm has greatly increased over the past few decades (Hawton, Hall, Simkin, Bale, Bond, & Codd et al., 2003). Research has speculated that a greater availability of medication, increased stress facing adolescents and greater alcohol and drug use (Hawton, Saunders, & O’Connor, 2012) may have contributed to its increase. Emerging research has also suggested that peer influence may be a contributing factor (Hasking, Andrews, & Martin, 2013; Heilbron & Prinstein, 2008).

According to psychological theory, one of the most robust predictors of the behaviour of adolescents is the extent to which they perceive that their peers are engaging in similar behaviours (e.g. Social Cognitive Theory; Bandura, 1986). This association can be explained by ‘selection effects’ i.e. a tendency to associate with others similar to ourselves or by ‘socialisation effects’ whereby engagement in specific behaviours may increase the likelihood of such behaviours in others (Becker & Curry, 2014). Several studies have provided support for both selection and socialisation effects across a wide range of adolescent health risk behaviours including substance use (Becker & Curry, 2014), eating disorders (Hutchinson & Rapee, 2007), depression (Prinstein, 2007) and suicidal behaviour (Prinstein, Boergers, & Spirito, 2001).

Importantly, research has also shown self-harm to be a risk behaviour susceptible to peer influence (Hasking et al., 2013; Heilbron & Prinstein, 2008). For example, a study of 3,757 high school students by De Leo and Heller (2004) found that self-reported exposure to others’ self-harm (e.g. friends and family) more than tripled the risk of their own engagement in self-harm. Hawton et al. (2002) also reported the self-harm of others as a predictor of own self-harm, with an increased risk of over five to seven times for female and male adolescents respectively. Moreover, exposure to the self-harm of others is also likely to have a distressing emotional impact on young people (De Leo & Heller, 2004, Hawton et al., 2012). Whether young people are at an increased risk of self-harm due to the distress caused by exposure to the self-harm of another, or whether they learn self-harm as a coping strategy from parents and peers warrants further exploration.

The social transmission of self-harm has become known in the literature as the “contagion effect”. Initially within inpatient samples (Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen, & Kelenius, 1998) and more recently in community settings (Claes, Houben, Vandereycken, Bijttebier, & Muehlenkamp, 2010), research has shown that exposure to self-harm through friends and family may not only be related to the frequency of self-harm among adolescents but also the initiation of this behaviour (Deliberto & Nock, 2008; Hasking et al., 2013; Prinstein, Helibron, Guerry, Franklin, Rancourt, Simon, & Spirito, 2010). Moreover, young people reporting self-harm have been shown to be more likely to have a parent/family member who self-harms (Hawton et al., 2012), know more friends who self-harm (Claes et al., 2010) and be more likely to start self-harming for social motives, including “wanting to fit in with others” (Muehlenkamp, Brausch, Quigley, & Whitlock, 2013).

Although research has suggested that exposure to the self-harm of others may have a role in the development of self-harm among adolescents (Claes et al., 2010; Heilbron & Prinstein, 2008; Prinstein et al., 2010), an awareness of self-harm among others alone is unlikely to be sufficient to encourage self-harm in the individual. Research with adolescent inpatients focusing on the type and strength of the relationship as a moderator of peer influence found that the most salient determinant of future self-harm among adolescents is not the total number of people who self-harm the individual is exposed to, but the quality of these relationships (Hasking et al., 2013; Madge et al., 2011). Indeed, there may be other possible “third variables” exerting their influence upon the social transmission of self-harm in adolescence which require further exploration (Prinstein et al., 2010).

It is logical that much of the early research exploring young people’s exposure to self-harm was conducted within inpatient settings, since levels of exposure and distress among young people in inpatient services are generally higher than in other settings. However, contagion effects of self-harm have also been shown to be present among adolescents in the community (Claes et al., 2010). Thus, the factors influencing the contagion of self-harm in community settings, such as exposure to self-harm through home, school, media and peer influence, are also likely to influence the self-harming behaviour of adolescent inpatients (Claes et al., 2010; Nock, Prinstein, & Sterba, 2009; Prinstein et al., 2010).

There are only a few published qualitative studies looking at the experience of adolescents who self-harm. These reveal some of the conflicts and paradoxes around self-harm (Crockwell & Burford, 1995; Klineberg, Kelly, Stansfield, & Bhui, 2013; Spandler, 1996). Themes such as “wanting help vs not wanting help” and “needing to share vs need of privacy” were commonly reported. However, less attention has been paid to the social contagion of self-harm among adolescents. Although quantitative studies have provided robust evidence in support of the social transmission of self-harm in adolescence, qualitative research is needed to develop our understanding of how adolescents make sense of the self-harming behaviour of others, and how, if at all, the self-harm of others influences their own behaviour and well-being. Searches revealed no qualitative research exploring young people’s experiences of self-harm of others in community settings, however, two studies have qualitatively explored the impact of exposure to the self-harm of others within inpatient settings (Crouch & Wright, 2004; Taiminen et al., 1998).

The first of these studies utilised quantitative methods to investigate the prevalence of contagion and clinical interviews to explore the psychological mechanisms behind contagion (Taiminen et al., 1998). This study highlighted the need for further qualitative exploration in this area as the results from the clinical interviews showed that participant self-harm was “influenced by interaction with other inpatients” (p. 214). However, the qualitative findings from this paper are difficult to interpret, given the lack of methodological and analytical detail. Building upon the novel qualitative focus of Taiminen et al. (1998), Crouch and Wright (2004) investigated the personal and interpersonal processes involved in self-harm within an inpatient setting using Interpretative Phenomenological Analysis (IPA). The results from this study highlighted a struggle for individuals to be considered genuine self-harmers and not ‘attention seekers’. This was similar to the earlier findings of Taiminen et al. (1998) which suggested some young people who self-harm can be labelled as ‘fake’ or a ‘pretender’ (p.215). Moreover, Crouch and Wright (2004) also commented on a ‘behavioural tariff’; whereby young people who self-harm were only seen as ‘genuine’ if a certain amount of damage was inflicted on the self-harmer; which again has parallels to the findings from Taiminen et al. (1998) that instances of self-harm acted as “an initiation rite that strengthened group cohesion” (p.215).

Self-harm is of particular concern in inpatient settings, where its incidence is higher than elsewhere (Apter & Freudenstein, 2000). In the UK, inpatient services aim to provide comprehensive assessment and treatment to help young people aged 13-17 with significant and complex mental health needs, including self-harming behaviours, mood disorders and psychosis, and who require admission into a specialist inpatient unit or day unit. Young people are typically referred initially for a stay of up to 28 days, either voluntarily or under section 2 of the Mental Health Act (MHA, 1983). If assessment suggests that treatment is required, young people will either remain within inpatient services for their treatment or be discharged to receive treatment from community-based services. For those young people receiving treatment from inpatient services, a range of interventions are provided to support young people and their families, including pharmacological treatment, direct psycho-therapy, family therapy and parent support groups. The length of stay for adolescents receiving treatment from inpatient services can vary depending on the individual’s level of need and responsiveness to intervention, however for those who are under section 3 of the MHA (MHA, 1983), their stay is typically up to 6 months.

The present study aimed to build upon existing qualitative research by exploring adolescent inpatients’ experiences of the self-harm of others. In doing so, the research aimed to explore any impact that social contagion and exposure to self-harm of others might have upon an adolescents own psychological well-being and/or self-harm. The present study used a qualitative interview-based methodology to explore adolescents' experiences of the self-harm of others (including peers, parents and adults) both within the context of the inpatient setting but also within the wider context of their lives outside. This broader focus was felt to be important as factors influencing the contagion of self-harm in community settings are also likely to influence the self-harming behaviour of adolescent inpatients (Claes et al., 2010, Nock et al., 2009). Furthermore, although research highlights peer influence as a risk factor for self-harm among inpatient adolescents, exposure to familial self-harm has also been shown to increase the risk of adolescent self-harm. Since there is concern that adolescents exposed to the self-harm of others will be at an increased risk of harm to themselves, such information may help to increase understanding of the social transmission of self-harm, and help inform prevention and early intervention programmes for adolescents.

Method

Design

Using Interpretative Phenomenological Analysis (IPA), one to one semi−structured interviews were used to explore young people's experiences of the self-harm of others. The qualitative design of this study allowed participants to share their lived experiences whilst recognising that their interpretation and 'meaning making' can be shaped by social, cultural and political contexts. The researcher's own subjectivity and interpretation in this process was also recognised.

During the design of the proposed study, adolescent service users with experience of others' self-harm were consulted about the interview schedules and recruitment-related documentation, and feedback and comments were received from a service research group. All the suggestions from these public involvement groups were incorporated into the research design. Ethical and research governance approval was obtained through a National Health Service (NHS) research ethics committee and NHS trust R&D departments.

Participants

Participation in the study was open to any young person aged between 13 and 18 years who was currently resident at one of two adolescent mental health inpatient units in the North of England. Young people were not able to participate in an interview before they had been admitted for a period of two weeks as it was important that the clinical team were able to accurately assess whether they met the inclusion/exclusion criteria for the study. A young person did not have to have self-harmed, in the past or present, to be a participant, in keeping with the broad focus of the study on experiences of the self-harm of others.

Young people were excluded from participating if the care team's assessment indicated that the interview process was likely to have a detrimental effect on their mental health and/or that the young person was too unwell to participate. Furthermore, young people were also excluded if the clinical team's assessment indicated cognitive or communication difficulties that would make it too difficult for the young person to engage in an interview, and/or if that the young person was unable to give informed consent. Young people who were unable to speak or read English were also excluded due to resource constraints prohibiting the use of translators and interpreters.

Initially, potential participants were made aware of the project via the researcher's attendance at ward meetings and the displaying of advertising posters on the wards. Posters directed potential participants to speak to the psychologists at the service who then liaised with the clinical team to check whether they met the inclusion/exclusion criteria. If met, a participant information sheet was provided by the service psychologist who then contacted the researcher to book the interview if the young person wanted to take part. Participants over the age of 16 who were deemed fit to participate in the study were asked to complete a consent form prior to the interview. Young people under the age of 16 completed an assent form and their parent or guardian was asked to complete a parent/guardian consent form.

In total, eight participants gave their consent to be interviewed (n=8). Of the young people interviewed, five were female and 3 were male, aged 15-17 years, and all but one were recruited from the same inpatient unit. The duration of time on the inpatient ward prior to the interview varied from 3 weeks to 7 months. It is noteworthy that the majority of participants recruited (n=7) self-harmed themselves.

Data collection and analysis

Interviews were held in private rooms on the wards. Immediately prior to the interview the researcher checked with the clinical team that the participant was still fit to participate. Before commencing each interview, the interviewer introduced herself and the study and answered any questions the participant had about the process. If participants were happy to continue, written consent was obtained (see ethics appendix 4-E). Brief demographic details, including the participant's age, gender and the duration of contact with the service, were collected in order to provide a context in which each participant's individual experiences could be understood.

Interviews lasted between 23 and 46 minutes, and were digitally recorded. The interviews were subsequently transcribed and pseudonyms were assigned. All identifying information was removed to protect anonymity. The first audio recordings were reviewed by the academic supervisor to review the interview technique before continuing with data collection.

The data collected was analysed using IPA. The first step of IPA involves immersion in the data by reading and re-reading each transcript. Next, the researcher examined the semantic content of the transcript, making initial notes about how the participant talked about and made sense of the topic under discussion (Smith, Flowers, & Larkin, 2009). Using these initial notations, emergent themes were then identified within the transcript. Due to the relatively large sample of participants for an IPA study (see Smith, Flowers, & Larkin, 2009, p106-107), super-ordinate themes were then identified by looking for connections across the emergent themes of participant transcripts as opposed to finding super-ordinate themes for each individual transcript.

Since IPA is inherently interpretative, the position of the researcher is bound to exert its influence over which elements of the participants' experience are given the most attention; therefore, to reduce bias, all themes were checked with the academic supervisor for reliability, validity and consistency. Furthermore, a reflective diary was kept throughout the research process to consider the potential impact that the researchers own subjectivity may have had upon the collection, analysis and interpretation of the data.

Results

Five themes were identified from the adolescents' experiences; 'Pre-admission exposure to self-harm', 'Exposure on the inside: An unpleasant environment', 'Helper vs helped', 'Separation from the attention seekers', and 'Competing for authenticity'.

Theme 1: Pre-admission exposure to self-harm

Across participant accounts, the relationship between exposure to the self-harm of others and the development of their own self-harm was thought to be established before admission to inpatient services. Participants described different levels of pre-admission exposure to self-harm that influenced the function and meaning of their own relationship with self-harm, including self-harm exposure through family, peers and social media. First, participants shared their experiences of familial self-harm, how they made sense of these behaviours and the impact that it had upon them and their well-being. These early and intimate exposure experiences seemed to carry a greater level of power and influence over the young people's relationship with self-harm: "One member of my family used to self-harm so that kind of took an effect. It was hard to see them struggling, so, I guess it just rubbed off" (Sarah). "I've seen my mum self-harm when I was younger…she tried to slit her wrists and it was quite disturbing for me. When I first self-harmed, I hurt myself on my wrists too. I think I got that from seeing her do it" (Joey). Young people found this level of exposure particularly difficult and distressing; perhaps due to the closeness of their relationship with the self-harmer.

The second level of exposure described by young people was from peers. Exposure to peer self-harm may represent the first level of exposure for some young people: "I knew a girl who self-harmed. I used to support her, but people can learn from it and sometimes if other people self-harm you might copy it" (Mark); "I didn't really know what cutting was, but in year eight, it became a phase for a lot of people to do that…so I kind of picked that up" (Helen); yet for those already exposed to self-harm by their parents, these cumulative experiences of exposure may act to normalise and escalate their own self-harm; "There's only like so many times you can watch people self-harm around you, like your family and friends, before like you start to think its normal and do it yourself" (Joey). When talking about peer exposure, participants did not make reference to the same underlying emotional struggle they did when reflecting on the self-harm of their relatives. Thus the type and quality of the young person's relationship with the self-harmer seems to be associated with the emotional saliency of the exposure.

The third level of exposure described by participants was via social media. Anna described the internet and social blogging sites as sources of influence over her own and other people's self-harming behaviour; "I had a look on the helpline message boards, and that's how I learnt other ways to do it, which was a bit unhelpful", and Jess expressed her concern that such exposure can promote and glamorise self-harm among young people; "You get so many things on social media and, it just promotes it…in a very sick way it's sort of idolised" (Jess). Exposure to self-harm through social media seemed to serve a different function to exposure through friends and family. Where exposure via friends and family was reported as being associated with the initiation and copying of self-harm as a strategy for managing distress, social media was described here as a means of developing young people's already existing relationship with self-harm (e.g. learning new self-harm methods).

This theme highlights the different levels of exposure to self-harm experienced by young people before admission to inpatient services, and how such exposure influences a young person's understanding of self-harm and the potential development of their own.

Theme 2: Exposure on the inside: “An unpleasant environment”

When compared with their experiences in the outside world, participant’s accounts of exposure on the ward were much more intense and condensed, and the descriptions of the environment within inpatient services, both physical and social, created this intensity. Being surrounded by the distress of others was difficult for participants; “Most people here were negative about everything and I am a happy person, so that’s difficult” (Jack); “The fact that someone else is low in mood changes your mood, like you can be happy and see someone else struggling makes you struggle. It goes in a circle with everybody” (Sarah). Moreover, Nicola expressed her concern about the consequences of such intense exposure and the impact it would have on the development of her own self-harm:

> A lot of people have said hospital is making me worse…it’s like you can’t win because they bring you in to hospital to keep you safe and then you pick up all these things and come out doing more than you did when you came. (Nicola)

Participants described a ‘ripple effect’ when another young person harmed themselves. This effect was described as both physical; “When somebody self-harms it has an effect on everyone else. People’s rooms get searched, all the staff are upset…and it has a bad effect on everyone else. It makes an unpleasant environment” (Mark); and emotional; “There’s almost always a difficult ward atmosphere…when somebody does something, like self-harms publically…it can set everybody off. It’s a difficult place to be really” (Jess).

Participants described the ward environment as having a direct detrimental effect on their own well-being, including their own self-harm; “Sometimes it’s traumatising cos you just, you’re constantly surrounded by people who self-harm” (Mark); “On a basic level, it can just be upsetting to see, but when you think about it even more it can be a negative reminder of the things you want to do yourself” (Jess). In this way, the intensity of exposure to self-harm within inpatient settings socialises young people to self-harm as a means of coping with distress; thus endangering their own risk of self-harm.

In addition to the emotional intensity described, the social dimension of self-harm is also intensified by the physical proximity and undiluted contact with others with similar difficulties. In response to the increased physical restrictions placed upon young people within inpatient settings to keep them safe, such as confiscation of self-harm contraband, participants shared their experiences of exposure to new, evolved and almost ‘expert’ self-harm methods not seen in the outside world:

> People get clever with self-harm, like you learn places where you can hide things and you learn ways that you can get things you shouldn’t have, you learnt how to make everyday objects into something you could harm yourself with…and you learn without trying to. (Jess)

Moreover, participants shared their experiences of how the intense ward environment manifests a social struggle with self-harm; “Three people that hung around together self-harmed on the same night…it was like a chain…one person self-harms, then another, and another” (Joey); “I see people trying to copy it…when someone’s done it [self-harm] then the other person will automatically just go and, it just seems a bit bizarre so close to each other…it just seems so sudden for it to happen in time with each other” (Anna). Seemingly, the intense exposure to the self-harm of others not only normalised self-harm but also appeared to contribute towards the formation of self-harm ‘pacts’; where members agree to self-harm together. Such participant experiences make reference to the underlying and menacing social motives reinforcing the copying and transmission of self-harm.

Theme 3: Helper vs Helped

Young people with mental health difficulties are admitted to inpatient services for help and support. Despite being admitted to be ‘helped’, the young people’s accounts suggested that exposure to other young people in difficulty often led to them adopting a role of ‘helper’; “If you are struggling and someone else is going through pretty much similar you can talk to each other about it and that helps them…you’re giving them something positive” (Helen). Although Helen enjoyed her role as a helper, others found this role less manageable. As a consequence of being exposed to the self-harm of others on the ward, participants described feeling responsible for the safety of others; “Someone yesterday self-harmed and stuff and they showed me it…and I didn’t think that was right, that’s like putting responsibility on me to like basically keep someone safe when I can’t keep myself safe” (Joey):

> All it takes is one cut in the wrong place and it’s all over, so it’s kind of scary and worrying and like if no one else knows, it puts the pressure on you. You’re stuck. Tell and your friend will be mad at you, don’t tell and put their life at risk. (Sarah)

In addition, participants also described the negative affect they experienced as a result of not being able to help or prevent the self-harm of others; “The fact that we’re all in similar ages, you do get a bond and when you see that person get upset it just reminds you of friends struggling. Like how can I help? Why do I feel so worthless?” (Sarah). There was a general sense of feeling overwhelmed by others’ distress when they were already overwhelmed by their own:

> You come in with your own problems and then when you’re in here you pick up everyone else’s problems and you start thinking about them…it can make you worse and then you feel the need to hate yourself even more. (Nicola)

Participants' observations of young people assisting their peers on the ward to self-harm was also a concerning aspect of the role of 'helper'; "You are meant to be getting better, but to have people who are like helping you do things that you shouldn't do, it has a massive effect" (Jess); "A girl gave another girl a blade because she thought she was being helpful" (Joey); "I think people who self-harm help and promote other people who self-harm. They understand each other and they understand what they're doing" (Jack).

Contrary to the aim of admission to inpatient services which is for young people to be 'helped'; this theme describes how exposure to the self-harm of others can instead lead to young people taking on the role of 'helper', a role which was largely experienced as being detrimental to the recovery of young people who were already struggling with their own mental health.

Theme 4: Separation from the 'attention seekers'

This theme captures the complexity of interpersonal relationships amongst peers, both within and outside of the inpatient setting. Participants described their experiences of others making social comparisons; evaluating themselves with reference to their perceptions of others, and then modifying their behaviour to conform to social norms. Such comparisons enabled young people to make sense of why they needed support from inpatient services, when their self-harming peers in the community did not; "they can just stop [self-harming], but I always found that was something I couldn't do" (Helen).

By making such comparisons, young people were able to consider which behaviours were perceived by their peers as more favourable, and this led to the formation of in-groups and out-groups. Several participants made suggestions that there were two distinct groups of self-harmers on the ward; those who self-harmed for attention and those who did not: "I can tell the difference when people are struggling on the ward and when people are asking for attention" (Nicola); "Some people here they shouldn't be self-harming because they're alright…some people just do it for fun" (Mark).

The main distinction between these two groups was that 'genuine' self-harm was perceived as being more favourable than self-harm for 'attention'. Thus what emerged from the young people's accounts were reports that aligned themselves with the favourable 'genuine' group, and separated themselves from the socially derided 'attention' group. What is particularly interesting is that these social comparison processes and self-harm groups were not unique to inpatient contexts. Jess shared how she made made sense of her own self-harm in relation to her peers in the community; "People like at school who seem to start self-harming and are completely aware of it and the effects that it's gunna have…whereas some people genuinely do it cos they need to cope" (Jess). Jess reflected on these group differences and suggested that the increase in self-harming behaviour seen among young people represented a 'trend' whereby young people self-harm for popularity and attention:

> I think like self-harming like is becoming like an increasing issue…. for a lot of people, it's like learnt and its glamorised…I feel like it's sort of become a trend for some people, and you can always tell. I think you can convince yourself that you have a mental illness…and that's what a lot of people do these days. (Jess)

Joey also elaborated on the idea of self-harm becoming more 'trendy' among young people in the community and shared an anecdote about how young people in the outside world actively attempt to be admitted to inpatient services as validation and a 'statement' of their belonging to the 'genuine' self-harm group:

> A person who's been admitted here recently text other people on the ward before to ask how they could get admitted here…most people in here like actually need it and some people get admitted for the whole kind of statement. (Joey)

Joey's quote suggests that young people admitted to inpatient services are perceived as favourable and 'genuine' by their peers in the community; thus it is important to consider how admission to inpatient services and a stay on the ward play a part in this social process. Another marker which distinguishes between these two groups is the degree to which a young person's self-harm was concealed. In this way, participants highlighted secrecy as a key characteristic of a genuine self-harmer:

> People come up to me and say oh look at me, look what I've done and when you're in a state like that you tend to hide things away from other people and not let them see that you are struggling. (Nicola)

Purposeful displays of self-harm wounds were seen by the young people as a central attribute of the 'attention seeker'; "People would self-harm and walk around wearing short sleeved t-shirts to like show it off" (Jess); "She'd exaggerate on it and basically sat showing clearly the marks on her arms…if people want the attention they show it off as much as they can" (Joey). Moreover, it appears that group membership was also determined by the amount of damage inflicted whilst self-harming. Helen identified less severe self-harm as a mark of an attention seeker:

> It became more of a fashion statement. It wouldn't be cutting so much as scratching like, they were very very superficial…. they don't really struggle, they get a bit sad and they think that self-harm makes them more interesting… they're the kind of people that don't do it to cause much damage. (Helen).

Such distinctions between these groups of self-harmers seemed to be easier to make amongst those who self-harm. As a consequence, young people shared their concerns that they would be grouped with other young people who self-harm for attention by those who do not self-harm themselves; “I was always worried at school that people would think I was part of that so called trend and that people don’t take you seriously” (Jess). Being categorised as a self-harmer made young people worry that their self-harm would be devalued by the self-harm of those who did it for attention:

> I remember going to hospital to get stitches and I remember thinking they’re just gunna think ‘oh another teenager self-harming’, cos there are so many, I thought it devalued me in a way and made me just one of them. (Helen)

This theme captures how social comparison processes divided young people’s perceptions of their peer’s self-harm across both community and inpatient settings. Although the formation of these divisive social groups did not originate within inpatient settings, such settings appear to amplify the need for young people to be recognised by their peers as a member of the socially desirable ‘genuine’ group and separate from the less favourable ‘attention-seeking’ group. However, the fact that all the participants interviewed thought of themselves as authentic calls into question how objectively meaningful this distinction is within the inpatient context.

Theme 5: Competing for authenticity

Building upon the previous theme, in an attempt to establish distance between the derided ‘attention seeker’ group, what emerged from the participants’ accounts was a need to convince others of their authenticity. In doing so, the young people described a sense of competition amongst their self-harming peers to use their self-harming behaviour as a display of ‘genuine’ distress and ill health; “It’s almost an internal competition really. It’s to do with who’s the ill-est, who’s the worst?” (Helen).

As a result, when one young person self-harmed, it appeared to initiate a social reaction among other peers, similar to that described in the first theme; “I see people trying to copy it…sounds really stupid but it’s kind of like a competition” (Anna); “Sometimes people think she’s getting more attention than me and I’m struggling more so they do it to get attention off other people” (Nicola); “People are desperate to self-harm and like if you see someone else who has done it, well they’ve managed to do it so I can…they’ve done it so why can’t I brave it?” (Jess). Moreover, this competition to be seen as ‘genuinely ill’ seemed to be linked not just to the maintenance and escalation of self-harm, but also the initiation of self-harming behaviour as a display of group membership:

> When you come into hospital, everyone talks about what’s the matter with them…erm and if you haven’t got cuts, you think you need to because people are thinking there’s nothing the matter with me…it’s like you are trying to fit in with everyone. (Nicola)

In an attempt to make sense of their personal circumstances, levels of distress and self-harm, young people benchmarked their reasons for self-harm against the reasons of others; “I’ve met people in a much worse situation than me and it made me feel bad cos the reasons why I self-harm is nowhere near as bad as some people” (Mark); “I sometimes feel a bit pathetic cos mine’s not as severe as theirs” (Anna). Furthermore, it seemed such comparisons were not just specific to those who self-harmed. Jack also benchmarked his own ill-health against his peers’ and felt that he had a greater justification to self-harm than most but chose not to; “It still surprises me that people want to self-harm…I know I thought about it, but that’s only because I was seriously unwell whereas most people here are fit and healthy” (Jack).

This theme also captures the struggle described by participants to be accepted by others as authentic:

> If someone is out of control…and staff members go running, it's almost like everyone else on the ward kind of rolls their eyes and bitches about them. I thought here you could escape the reputation of being an attention seeker, but it follows you everywhere. (Helen)

This struggle also captured the conflict amongst young people between not wanting to be classed as an 'attention seeker' yet needing to elicit care from others at times of distress. Social comparison processes exacerbated this conflict and made it difficult for young people to prioritise their own recovery over their need to conform to social norms.

Discussion

What emerged from the participants' accounts was a profound social dimension to both the initiation and maintenance of self-harm in adolescence. Most explanations for self-harm have considered emotional factors such as the alleviation of distress and/or infliction of pain as a display of self-hatred (Nock, 2008), however, the present data highlighted several social motivations for self-harm too. The social contagion literature suggests that self-harm is a behaviour susceptible to familial and peer influence (Taiminen et al., 1998), and the participant accounts support this. Participants described different levels of pre-admission exposure that influenced the function and meaning of their own relationship with self-harm. Consistent with previous research (Hasking et al., 2013; Madge et al., 2011), the type and quality of the young person's relationship with the self-harmer seemed to moderate the emotional saliency of the exposure; with intimate relationships being the most influential determinant of their own self-harm.

The exposure environment also appeared to moderate the saliency and influence of the self-harm of others. When compared with their experiences in the outside world, participant’s accounts of exposure on the ward were much more intense and condensed. All of the young people interviewed found exposure to the distress of others on the ward, and the ‘ripple effect’ of change that occurred following a young person’s self-harm, extremely challenging. Similar experiences were also shared by participants in Taiminen et al.’s (1998) study, who suggested that the clustering together of young people of similar age, gender and mental health difficulties exacerbated their vulnerability to contagion and the promotion of self-harming. Moreover, the young people talked about self-harm being copied and learnt as a result of their close proximity to exposure on the ward; with similar experiences documented elsewhere (Crouch & Wright, 2004). Troublingly, the anecdotes of copying among young people on the ward also gave the impression of insidious, collective and planned ‘pacts’ to self-harm.

Research investigating ‘pacts’ amongst young people has primarily focused upon suicide pacts (Bell, 2014; Gould, Jamieson & Romer, 2003), however such research may help towards understanding how self-harm pacts are formed. Developmental researchers have hypothesised that peer behaviour may be adopted as a basis for identity formation within particular social groups (Hergovich, Sirsch, & Felinger, 2002), and this might help to explain why the self-harm of others is a strong predictor of own engagement in such behaviours.

Similarly, Social Identity Theory (Helibron & Prinstein, 2008; Tajfel, 2010) would suggest that at times of profound distress, young people would be more likely to engage in behaviours that help them to establish or maintain a positive sense of self-concept. If young people learn to associate self-harm with peer rewards and favourable group membership, then young people are likely to view self-harm as a desirable aspect of their identity and increase their engagement in this behaviour. In Taiminen et al.’s (1998) study, participants explicitly claimed to have harmed themselves so not to feel like 'ousiders' (p. 214). Similar group dynamics were also found by Crouch and Wright (2004) and amongst participant accounts in the present research, highlighting the powerful role that peer group membership and 'pacts' might play in the initiation and maintenance of this behaviour.

Feeling responsible for the safety of young people who self-harm was another social phenomenon to emerge from the participants' accounts. Exposure to other young people in difficulty led to feelings of helplessness and inadequacy when they were not able to help. Since self-harm is thought of as a strategy to cope with intense emotion (e.g., Klonsky 2009), an increased number of environmental stressors, may well prove a tipping point between exposure to the self-harm of others and engagement in their own self-harm (Hankin & Abela, 2011; Zetterqvist et al., 2012). Therefore, it is crucial that both the physical setting and the peer relationships developed within inpatient services are given careful consideration to ensure that they are helpful and not damaging.

Two distinct groups of self-harmers emerged from the young people's accounts; those who were perceived to self-harm for attention and those perceived as genuine, highlighting further complexity in the interpersonal relationships between young people. A similar divide between groups of self-harmers was also described by participants in Crouch and Wright's (2004) study. Participants across both the present study and Crouch and Wright's study were explicit in their concerns that their self-harm would be devalued by the self-harm of those who did it for attention. Furthermore, members of the 'attention seeking' groups across both studies were regarded by their peers as being less justified in their reasons to self-harm.

Secrecy and severity of self-harm were highlighted as key characteristics of the 'genuine' self-harmer, which was particularly concerning given the motivation to be recognised as authentic by their peers. The implication being that young people were not only more likely to engage in more severe behaviour to pledge their allegiance to the "genuine self-harmer group", but also do so more privately; significantly inflating their level of risk. Similar findings have been reported by Taiminen et al. (1998) and by Nock (2008), who suggested that the act of self-harm functions as a 'rite of togetherness' or a 'sense of belonging' for young people engaging in these behaviours. Such social dynamics, and the organised nature of self-harm among young people on the ward are troubling given inpatient services' aim to reduce levels of risk.

The results also captured the conflict described by participants in needing to be accepted by their peers as authentic and not an 'attention seeker' whilst desperately trying to elicit care from others. What was particularly interesting was that no participant within the present study identified as a member of the 'attention-seeking' group. Of course it was possible that no-one from the attention group was interviewed, however it seemed more likely that no young person would purposefully identify themselves as someone who self-harms for attention. Consequently, and in line with Social Identity Theory (Tajfel, 2010), it appeared that group membership was socially determined, and that other young people made a decision about whether their self-harm was 'authentic enough' to be a part of the 'in-group' (Helibron & Prinstein, 2008).

Young people therefore felt compelled to convince others of their authenticity and described feeling competitive with their peers; using their self-harm as a way to convince others of their 'authenticity'. As a result, when one young person self-harmed, it initiated a wider social reaction. This competition and striving to be recognised as authentic and to feel accepted by a desirable peer group may contribute towards the wider understanding of the impact of social contagion on the self-harm of young people (Jarvi et al., 2013; Rosen & Walsh, 1989; Taiminen et al., 1998).

Clinical Implications

Young people's accounts strongly supported the need for service development to manage the social impact of self-harm within inpatient services, and consider how prevention efforts might help to reduce the social contagion of self-harm within the community. Across accounts, participants noted the benefits of peer support for their self-harm. Participants described a sense of belonging and felt understood by other young people with similar struggles and histories, and found the opportunity to share their problems with their peers helpful. However, consideration needs to be given to how this can be managed safely and without the adverse implications of feeling responsible and burdened by the distress of others.

Research has shown that social support can be protective against self-harm (Hasking et al., 2013; Rotolone & Martin 2012). However, the fear of contagion around this behaviour has led to avoidance of open discussion on this topic (Hasking et al., 2013; McAllister et al. 2010). Self-harm and social contagion still have a high prevalence, particularly within inpatient settings, thus it seems avoidance of the topic has not worked. Moreover, participants in the present study described sharing their stories with their peers despite there being strict service rules enforced to discourage this, and that such sharing and feeling understood by others was actually helpful.

Conceivably then, the introduction of a clinically facilitated self-harm support group within services to encourage a therapeutic milieu (Jones, 2013; Kennard, 2004; Manning, 2013) may represent a helpful alternative to avoidance of the topic. It would also allow for the sharing of stories to be better controlled and monitored by clinical staff and done in a way which was less detrimental to young people's well-being. Moreover, such groups may provide alternative and more adaptive sources of social and emotional support for those young people identifying with destructive and isolating self-harm pacts. Although speculative, fostering a circle of support around the young people (Ward, 2003), which extends beyond professionals, may help to reduce the stigma of being an ‘attention seeker’ and help towards reducing contagion behaviour. Indeed, it has been suggested by others that when self-harm is discussed in a neutral way, the frequency of self-harm decreased (Ross & Mckay, 1979; Taiminen et al., 1998).

Postvention, a term coined by Shneidman (1981), describes appropriate and supportive action taken after trauma. Exposure to the self-harm of others is in itself a traumatic experience for young people. In addition to a peer support group, it is crucial that the inpatient staff recognise the impact that such exposure has upon the well-being of other young people on the ward and the increased risk of further self-harm incidents. This may represent a possible need for staff training on how to manage young people’s reactions to the self-harm of others after exposure, and how to work towards creating a more therapeutic environment within inpatient services where young people do not need to engage in competition for care. Moreover, if the maintenance and spread of self-harm within inpatient units can be explained, at least in part, by the apparent motivation amongst young people to be recognised as ‘authentic’ and not an ‘attention seeker’, it would be helpful for staff to challenge the popular discourse that ‘young people harm themselves for attention’, which only contributes to the maintenance of such sub-groups (Crouch & Wright, 2004). Clinical psychologists working within inpatient services would be appropriately skilled to deliver staff training and facilitate support groups as recommended.

The present findings also have clinical implications for prevention work within the community. Many have feared direct discussion about the self-harming behaviour of young people over concern that it will increase awareness and contagion of the behaviour. However, Muehlenkamp et al. (2010) evaluated a school based prevention programme for self-harm and found it had no additional contagion effects after the prevention programme had been implemented. Moreover, it was found to be well received, easy to implement and effective at increasing knowledge about self-harm. Thus, carefully developed primary prevention efforts, delivered by skilled clinical psychologists working within community mental health teams, can help to increase awareness and knowledge about these behaviours without glorifying self-harm.

Study Limitations

Participation in this study was limited to those proficient in English and the findings of this study may not apply to young people who self-harm but who have not yet come to the attention of services. The voices of these young people may be much harder to capture. Given the qualitative nature of this study, it is important to acknowledge that the small participant sample size recruited was not intended to be generalisable or representative of all young people’s experiences. Moreover, recruitment of participants across the two inpatient sites for the present study was also unbalanced, thus the interview conducted at the second service may not have been representative of other young people’s experiences of that ward. Nonetheless, and in line with the phenomenological aims of the present study, these findings do contribute to our understanding of the experiences and challenges faced by young people in inpatient services.

Future Research

Building upon the current research findings, it is important for future research to further explore these social motivations for young people to self-harm, including the antecedents to self-harm, impact of the self-harm of others on their own self-harm, the formation of ‘pacts’ and how self-harm is being socially reinforced. The dramatic increase in the exposure to self-harm via social media also warrants further attention (Jarvi et al., 2013). Additional qualitative research exploring young people’s experiences of exposure to the self-harm of others via the internet and social media such as online blogging and social networking sites would be particularly helpful to comprehend the emerging popular culture considered to be ‘pro self-harm’ (Whitlock, Powers, & Eckenrode, 2006). An understanding of how young people use and make sense of these sites, and the reciprocal impact that exposure to such sites has upon the well-being of young people accessing the sites may help to highlight how parents, families, school and services can best address the use of these sites and support the young people who access them.

It would also be beneficial for researchers to reproduce the current study with participants from non-English speaking backgrounds, and with young people exposed to the self-harm of others in the community. Further qualitative exploration of young people’s experiences of the self-harm of others, prior to being admitted to inpatient services, would determine whether their experiences and ‘sense making’ is qualitatively different from young people admitted to inpatient services.

Conclusion

Despite an abundance of quantitative evidence investigating self-harm in adolescence, there is limited published qualitative research concerning young people’s experiences of exposure to the self-harm of others. This study provides pertinent information on the experiences of young people residing within inpatient settings, how young people make sense of the self-harming behaviour of others and the impact of such exposure upon their own well-being. Moreover, this research builds upon existing qualitative studies (Crouch & Wright, 2004; Taiminen et al., 1998) by providing a more up-to-date account of young people’s experiences of the self-harm of others, a broader focus on young people’s experiences of self-harm exposure pre-and post-admission, and an understanding of the how contagion effects and social comparison processes exist amongst young people both inside and outside inpatient settings. The emotional reactions of the young people towards those who they deem as being an ‘attention seeker’ may have implications for service delivery, and how services can best support young people to elicit care without being derided for being an ‘attention seeker’.

References

Apter, A., & Freudenstein, O. (2000). Adolescent suicidal behaviour: Psychiatric populations. In K. Hawton & van Heeringen (Eds.). The international handbook of suicide and attempted suicide (pp.261-273). John Wiley & Sons: Chichester.

Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Prentice-Hall: NJ.

Becker, S., & Curry, J. (2014). Testing the effects of peer socialization versus selection on alcohol and marijuana use among treated adolescents. *Substance use & misuse*, *49*(3), 234-242. http://dx.doi.org/10.3109/10826084.2013.824479

Bell, J. (2014). Harmful or helpful? The role of the internet in self-harming and suicidal behaviour in young people. *Mental Health Review Journal*, *19*(1), 61-71. http://dx.doi.org/10.1108/mhrj-05-2013-0019

Boergers, J., Spirito, A., Donaldson, D. (1998). Reasons for adolescent suicide attempts: associations with psychological functioning. *Journal of American Academic Child and Adolescent Psychiatry,* 37: 1287–93. http://dx.doi.org/10.1097/00004583-199812000-00012

Claes, L., Houben, A., Vandereycken, W., Bijttebier, P., & Mueh- lenkamp, J. (2010). Brief report: The association between non-suicidal self-injury, self-concept and acquaintance with self-injurious peers in a sample of adolescents. *Journal of Adolescence*, 33, 775–778. http://dx.doi.org/10.1016/j.adolescence.2009.10.012

Crockwell, L. & Burford, G. (1995). What makes the difference? Adolescent females' stories about their suicide attempts. *Journal of Child and Youth Care*, 10(1), 1-14.

Crouch, W., & Wright, J. (2004). Deliberate self-harm at an adolescent unit: A qualitative investigation. *Clinical Child Psychology and Psychiatry*, 9, 185–204. doi:10.1177/13591045 04041918.

De Leo, D., & Heller, T. (2004). Who are the kids who self-harm? An Australian self-report school survey. *Medical Journal of Australia*, **181:** 140–44.

Deliberto, T., & Nock, M. (2008). Exploratory study of the correlates, onset, and offset of non-suicidal self-injury. *Archives of Suicide Research*, 12, 219–231. http://dx.doi.org/10.1080/13811110802101096

Di-Cicci-Bloom, B., & Crabtree, B. (2006). The Qualitative Research Interview. *Medical Education,* 40: 314-321. http://dx.doi.org/10.1111/j.1365-2929.2006.02418.x

Gould, M., Jamieson, P., & Romer, D. (2003). Media contagion and suicide among the young. *American Behavioral Scientist*, *46*(9), 1269-1284. http://dx.doi.org/10.1177/0002764202250670

Hankin, B., & Abela, J. (2011). Nonsuicidal self-injury in adolescence: Prospective rates and risk factors in a 2 1/2 year longitudinal study. Psychiatry Research, 186, 65–70. http://dx.doi.org/10.1016/j.psychres.2010.07.056

Hargus, E., Hawton, K., & Rodham, K. (2009). Distinguishing between subgroups of adolescents who self-harm. *Suicide and Life Threatening Behaviour*; **39:** 518–37. http://dx.doi.org/10.1521/suli.2009.39.5.518

Hasking, P., Andrews, T., Graham, M. (2013). The role of exposure to self-injury among peers in predicting later self-injury. *Journal of Youth and Adolescence*, 42:1543-1556. http://dx.doi.org/10.1007/s10964-013-9931-7

Hawton, K., Hall, S., Simkin, S., Bale, L., Bond, A., Codd, S., & Stewart, A. (2003). Deliberate self-harm in adolescents: a study of characteristics and trends in Oxford, 1990–2000. *Journal of Child Psychology and Psychiatry*, *44*(8), 1191-1198. http://dx.doi.org/10.1111/1469-7610.00200

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:** 1207–11. http://dx.doi.org/10.1136/bmj.325.7374.1207

Hawton, K., Saunders, K. E., & O'Connor, R. C. (2012). Self-harm and suicide in adolescents. *The Lancet*, *379*(9834), 2373-2382. http://dx.doi.org/10.1016/s0140-6736(12)60322-5

Heilbron, N., & Prinstein, M. (2008). Peer influence and adolescent nonsuicidal self-injury: A theoretical review of mechanisms and moderators. *Applied and Preventative Psychology*, 12, 169–177. http://dx.doi.org/10.1016/j.appsy.2008.05.004

Hergovich, A., Sirsch, U., & Felinger, M. (2002). Self-appraisals, actual appraisals and reflected appraisals of preadolescent children. Social Behavior and Personality, 30, 603–612. http://dx.doi.org/10.2224/sbp.2002.30.6.603

Hutchinson, D. M., & Rapee, R. M. (2007). Do friends share similar body image and eating problems? The role of social networks and peer influences in early adolescence. *Behaviour Research and Therapy*, *45*, 1557–1577. http://dx.doi.org/10.1016/j.brat.2006.11.007

Jarvi, S., Jackson, B., Swenson, L., & Crawford, H. (2013). The impact of social contagion on non-suicidal self-injury: A review of the literature. *Archives of Suicide Research*, 17, 1-19. http://dx.doi.org/10.1080/13811118.2013.748404

.Joiner, T. (1999). The clustering and contagion of suicide. *Current Directions in Psychological Science*, 8, 89–92. http://dx.doi.org/10.1111/1467-8721.00021

Jones, M. (2013). *Social psychiatry: A study of therapeutic communities*. Routledge: Oxon.

Kennard, D. (2004). The therapeutic community as an adaptable treatment modality across different settings. *Psychiatric Quarterly*, *75*(3), 295-307. http://dx.doi.org/10.1023/b:psaq.0000031798.95075.26

Klineberg, E., Kelly, M. J., Stansfeld, S. A., & Bhui, K. S. (2013). How do adolescents talk about self-harm: a qualitative study of disclosure in an ethnically diverse urban population in England. *BMC public health*, *13*(1), 572. http://dx.doi.org/10.1186/1471-2458-13-572

Klonsky, E. D. (2009). The functions of non-suicidal self-injury in young adults who cut themselves: Clarifying the evidence for affect regulation. Psychiatry Research, 166, 260–268. http://dx.doi.org/10.1016/j.psychres.2008.02.008

Madge, N., Hawton, K., McMahon, E., Corcoran, P., De Leo., D., De Wilde, E., & Arensman, E. (2011). Psychological characteristics, stressful life events and deliberate self-harm: findings from the Child and Adolescent Self-harm in Europe (CASE) Study. *European Child & Adolescent Psychiatry*, 20 (10): 499-508. http://dx.doi.org/10.1007/s00787-011-0210-4

Madge, N., Hewitt, A., Hawton, K., Wilde, E., Corcoran, P., Fekete, S., ... & Ystgaard, M. (2008). Deliberate self-harm within an international community sample of young people: comparative findings from the Child and Adolescent Self-harm in Europe (CASE) Study. *Journal of Child Psychology and Psychiatry*; **49:** 667–77. http://dx.doi.org/10.1111/j.1469-7610.2008.01879.x

Manning, N. (2013). *The therapeutic community movement: Charisma and routinisation*. Routledge: Oxon.

McAllister, M., Hasking, P., Estefan, A., McClenaghan, K., & Lowe, J. (2010). A strengths-based group program on self-harm: A feasibility study. *Journal of School Nursing*, 26, 289–300. http://dx.doi.org/10.1177/1059840510368801

Moran, P., Coffey, C., Romaniuk, H., et al. (2012). The natural history of self-harm from adolescence to young adulthood: a population-based cohort study. *Lancet,* **379:** 236–43. http://dx.doi.org/10.1016/s0140-6736(11)61141-0

Muehlenkamp, J., Brausch, A., Quigley, K., & Whitlock, J. (2013). Interpersonal features and functions of non-suicidal self-injury. *Suicide and Life-Threatening Behavior,* 43, 67–80. http://dx.doi.org/10.1111/j.1943-278x.2012.00128.x

Muehlenkamp, J., Walsh, B., & McDade, M. (2010). Preventing non- suicidal self-injury in adolescents: The signs of self-injury program. *Journal of Youth and Adolescence*, 39, 306–314. http://dx.doi.org/10.1007/s10964-009-9450-8

National Institute for Clinical Excellence (2011). Self-harm: longer term management. NICE clinical guideline 133. National Collaborating Centre for Mental Health: London.

Nock, M. (2008). Actions speak louder than words: An elaborated theoretical model of the social functions of self-injury and other harmful behaviors. *Applied and Preventative Psychology,* 12, 159–168. http://dx.doi.org/10.1016/j.appsy.2008.05.002

Nock, M. K., & Prinstein, M. J. (2005). Contextual features and behavioral functions of self-mutilation among adolescents. *Journal of Abnormal Psychology*, *114*, 140–146. http://dx.doi.org/10.1037/0021-843x.114.1.140

Nock, M. K., Prinstein, M. J., & Sterba, S. K. (2009). Revealing the form and function of self-injurious thoughts and behaviors: Real- time ecological assessment study among adolescents and young adults. Journal of Abnormal Psychology, 118, 816–827. http://dx.doi.org/10.1037/a0016948

Prinstein, M. J. (2007). Moderators of peer contagion: A longitudinal examination of depression socialisation between adolescents and their best friends. Journal of Clinical Child and Adolescent Psychology, 36, 159–170. http://dx.doi.org/10.1080/15374410701274934

Prinstein, M. J., Boergers, J., & Spirito, A. (2001). Adolescents' and their friends' health-risk behaviors: Factors that alter or add to peer influence. Journal of Paediatric Psychology, 26, 287–298. http://dx.doi.org/10.1093/jpepsy/26.5.287

Prinstein, M. J., Heilbron, N., Guerry, J. D., Franklin, J. C., Rancourt, D., Simon, V., & Spirito, A. (2010). Peer Influence and Nonsuicidal Self Injury: Longitudinal Results in Community and Clinically-Referred Adolescent Samples. Journal of Abnormal Child Psychology, 38(5), 669–682. http://doi.org/10.1007/s10802-010-9423-0

Rosen, P., & Walsh, B. (1989). Patterns of contagion in self-mutilation epidemics. *Americian journal of Psychiatry, 146,* 656-658. http://dx.doi.org/10.1176/ajp.146.5.656

Ross, R., & McKay, H. (1979). *Self-Mutilation.* Toronto: Lexington Books.

Rotolone, C., & Martin, G. (2012). Giving up self-injury: A comparison of everyday social and personal resources in past versus current self-injurers. Archives of Suicide Research, 16, 147–158. http://dx.doi.org/10.1080/13811118.2012.667333

Royal College of Psychiatrists (2010). *Self-harm, suicide and risk: Helping people who self-harm.* Final Report of a working group: College report CR158. Royal College of Psychiatrists: London. Retrieved from http://www.rcpsych.ac.uk/files/pdfversion/ cr158.pdf

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. Sage publications: London.

Shneidman, E. S. (1981). Postvention: The care of the bereaved. *Suicide and Life-Threatening Behaviour*, *11*, 349-359.doi: 10.1177/1066480706291128

Spandler, H. (1996). Who's hurting who? Young people, self-harm and suicide. Manchester: 42nd street.

Taiminen, T., Kallio-Soukainen, K., Nokso-Koivisto, H., Kaljonen, A., & Kelenius, H. (1998). Contagion of deliberate self-harm among adolescent inpatients. Journal of the American Academy of Child and Adolescent Psychiatry, 37, 211–217. http://dx.doi.org/10.1097/00004583-199802000-00014

Tajfel, H. (2010). *Social identity and intergroup relations*. University Press: Cambridge.

Ward, A. (2003). *Therapeutic communities for children and young people* (Vol. 10). Jessica Kingsley Publishers: London.

Whitlock, J. L., Powers, J. L., & Eckenrode, J. (2006). The virtual cutting edge: the internet and adolescent self-injury. *Developmental Psychology*, *42(3*), 407.doi.org/10.1037/0012-1649.42.3.407

Zetterqvist, M., Lundh, L., & Svedin, C. G. (2012). A comparison of adolescents engaging in self-injurious behaviors with and without suicidal intent: Self-reported experiences of adverse life events and trauma symptoms. *Journal of Youth and Adolescence.* doi:10.1007/s10964-012-9872-6.

Appendix 2-A: Example transcript analysis

JESS

Interviewer – Ok thanks ever so much for coming today, the first thing I'd like to, as you know, as we spoke about, this kind of interview is about understanding the experiences of the self-harm of others and to see how that's maybe had an impact on you or hasn't had an impact on you, okay? So, just to start off then, could you start by telling me a little bit about yourself and how you've come to be in this service?

Participant – Erm, well I had a diagnosis of depression since as long as I was 13 and I'm now 17 so that's quite a while, and I was I've been depressed and had like negative emotions as long as I can remember, but then, when I was 13 I started self-harming because it was a way to cope. Then I got to the age of about 15, self-harm didn't really help me cope anymore and then it became an act of trying to attempt suicide, than an attempt at trying to cope. And then two weeks after my 17th birthday, between my 17th birthday and my admission, two weeks later, I was extremely suicidal and was self-harming and taking overdoses pretty much daily, without telling anybody. And then in the end I got rushed to hospital and after I was treated there I was brought straight here and I've been here ever since.

Interviewer – What has been your experience since being on the ward?

Participant – Erm, in complete fairness I still feel the exact same as admission but they're still trying to find the right combination of medication to help me so, I'm just stuck here for a bit.

Interviewer- And what's it been like being here with the other young people?

Annotations

- Diagnosis-what does that mean for her?
- Time-struggle over time
- Medicalised language
- New equilibrium
- SH as a coping strategy
- SH becoming ineffective
- Escalating behaviours
- SH/SB continuum
- Changing methods? Cutting vs overdose
- Private vs public SH
- Her journey into services

Emerging Themes

- Coping as a process
- Looking for new ways to cope
- Progression of SH from coping to intent
- Internalised medical explanation for difficulties e.g ill, medication etc

- Tension/difficult atmosphere
- Exposure
- Un-containing
- Shared experiences
- Unmet needs from staff
- Contagious/ infectious
- Staffing-feeling unsupported?
- Influencing/ triggering
- Medicalised language “ill”, “triggering”
- What does it mean to be ill?
- Who is they?
- Desperation-unmet need
- Removal of coping strategy
- Witnessing others SH
- Intentional vs unintentional
- Diverts attention
- No escape
- Forcing-does it feel punitive?
- Exposure/ surrounded
- Only “pretty” difficult? language
- Continuous/cyclic

Participant – Erm, it could, it was quite difficult, a lot of, there’s almost always a difficult ward atmosphere. A lot of people who struggle, cos everybody’s gunna struggle, can set other people off, it tends to be where there’s days on the ward where everybody is really low in mood and requires more support than is available cos of the patient to staff ratio and when somebody does something, like self-harm or ligatures publically, like in front of the other patients, it can set everybody off, it’s quite triggering for everyone, so it’s a difficult atmosphere to be, like, be in, it’s a difficult place to be really.

Interviewer- Yeah, so there’s something about triggering there, I was wondering if you could just tell me a little bit more about what you mean about that?

Participant – Yeah, more, a lot, a lot of the time, cos, obviously a lot of people are really ill, they will get pretty desperate to be able to do things such as self-harm cos that’s a lot of people’s coping mechanisms. Then they will, they’ll self-harm and then they’ll walk around with like bloody arms and things and for a lot of people, I know for me, it’s quite triggering, even just a normal injury and it can make people like think of self-harming a lot. And I think being on a ward in this kind of atmosphere it makes you like focus a lot on your illness rather than anything else because it’s pretty difficult because that’s all you can think about because that’s what you’re surrounded by 24/7.

Interviewer- So there’s something about it triggering and kind of bringing up your own upset and your own distress when you see other people do that?

Participant – Yeah

Interviewer – Yeah, and has that something experienced throughout your stay here?

Participant – Err yeah, pretty much, when I first came I was on a smaller ward…I think that was a lot easier than on the bigger ward, I

- Exposure as triggering
- Exposure to SH on the ward
- Are inpatient settings helpful?
- The language of SH e.g. triggering, contraband, intrusive thoughts, coping strategy-how meaning is constructed thorough language-but whose language?
- Exposure as problematic-drawing attention to own difficulties-narrowing focus

- Smaller wards
- Less exposure
- More manageable
- Easier to cope?
- Down there?
- Alternative diagnoses are easier to be exposed to
- References to “being depressed” and “being schizophrenic”- as part of them not separate from them
- Control? Suggests other people aren’t in control when she is?
- Bigger ward=harder
- Overwhelming?
- Evidence of SH- hiding the evidence
- “Incidents”- sharing “contraband”, techniques etc- language
- Desperate to SH
- Guilt- responsibility for triggering others by talking about contraband
- Guilt leading to SH
- Ripple effect

was on **** ward before it became single gender wards and that was a lot easier because there was only 5 patients and there was only me and one other patient that were down there because of depression and self-harm and the others were down there for things such as psychosis and being schizophrenic so I found that a bit easier because it I think for me it was personally less triggering, even though it was still upsetting and quite distressing to see people like have episodes not in control of themselves but I think that was a lot easier because on the bigger ward especially 15 people, like its more people than you think it is, and you find things that you don’t want to find, like I know often like there’s been times like when you find like bloody tissues about on the ward because people have got rid of them and don’t want them in their room because if some like a staff member was to find a bloody tissue in their room they’d get questioned. And, yeah and then there’s incidents as well, where people will like, if a patient overhears that you’ve maybe got something in your room that you shouldn’t have there’s quite often incidents going into each other’s rooms to find contraband cos they’re that desperate and that puts like a lot of like guilt on you, and then you feel worse and then you want to do something negative and it’s just, I think it’s quite a knock on effect on people in the ward.

Interviewer- Yeah. Yeah, that sounds like, you know obviously, if people, you’re seeing that on a daily basis, it does sound like that’s having an impact and you said about almost feeling guilty and that knock on effect as well. Erm, I mean is that, would you think that is a shared experience? Do you think other people have had similar experiences to that?

Participant- Yeah I think a lot of people do, like a lot of the people feel pretty guilty from things that have happened. I know there was an incident where a patient brought, erm was admitted as an emergency and she was hiding razor blades in her bra and she lost one of them on the ward and a patient found it and they had to go to

- The physical vs emotional environment
- The grouping together of people similar difficulties creates a toxic, self-perpetuating environment.
- Attempt to find own identity among others with similar difficulties
- Exposure leads to copying and learning
- SH as a display of group membership?
- Desperation to self-harm when others have
- Ripple effect of others self-harm

- Fighting to keep their coping strategies
- Hiding contraband
- Contraband poses a risk to others
- Feelings of responsibility and guilt if their contraband is used
- Is SH used to communicate their guilt to others on the ward??
- Facilitating self and other SH
- Sharing ideas for objects to harm themselves with
- SH because they are ill
- Coping linked to being able to SH
- Ward is meant to stop SH, but other patients help you to-against the advice of professionals.
- Peer pressure/support
- SH support group
- Promoting awareness
- Sharing experiences

hospital and then they were continuously attempting to do, like to self-harm or to do things because they felt so bad about it.

Interviewer- So it sounds like there's a real connection between the experiences around everybody's self-harm there. Do you have anything more to say about that in terms of the impact everybody's self-harm has on each other.

Participant- I think sometimes as well it can have quite a bad impact, there was a time when people were helping each other like hide razor blades or contraband in each other's rooms when they were doing room searches and they would, there was a time when people were providing each other with sharp things that they shouldn't have because they were ill and they thought it was better to self-harm that to not self-harm and not cope very well because it was their coping mechanism and that's why that why they need somewhere like this where you're meant to be getting better, to have people who are like helping you do things that you shouldn't do, it's gunna have a massive effect.

Interviewer- Yeah, so it sounds like although there's been some, maybe negative experiences and other people's self-harm is triggering, it sounds like actually there is something about kind of shared experiences of self-harming, almost kind of other that people being in the same boat, erm almost like a helpful side of the fact that there's other people going through a similar experience. Is that how, am I understanding that right?

Participant- Yeah

Interviewer- Yeah, okay. You managed to explain all that from one question! ha ha. Okay. So, before you came to the service did you have any experience of other people's self-harm?

Participant – Erm, partially, I was part of a err a group at like the counselling that I was part of and they had like, it was like an awareness group that they did like once a month and like I met with

- Intentionally vs. unintentionally playing a part in others SH e.g. exposure, sharing, contraband etc
- Intent to self-harm present before admission
- Exposure on the outside?
- Guilt when others SH
- Helper vs helped
- Facilitating the SH of others
- Coping as a process
- Others facilitating SH with good intentions

- SH becoming more common/popular as a coping strategy
- “Revert to it”- as if it’s the only option?
- SH is idolised/ glamorised
- “very sick”- socially unacceptable? Concerning? Difficult to understand?
- SH is wrong/part of mental illness
- SH as ineffective
- SH shouldn’t be encouraged- reflective/advice to others
- SH as a trend
- “some people”- separate from her e.g. Us vs them
- Stops herself distinguishing herself from others
- Lying about having a mental illness vs convincing yourself
- SH as evidence of group membership
- “learnt behaviour”
- “Struggler” leading followers

other people there that had gone through similar things, and had self-harmed but I didn’t really know all that much about them really, but, I don’t know, I think like self-harming like is becoming like an increasing issue. Like, I think like a lot more people revert to it now than they used to.

Interviewer- Hmm, and what are your thoughts about why that is?

Participant- I think a lot of the time it’s because its, in like a very sick way it’s sort of idolised, for a lot of people, it’s like learnt and its glamorised and it shouldn’t be because it’s just wrong, it’s like connected to mental illness and it doesn’t solve anything in the long run and it’s just very negative and it’s not something you want to get started with, but I feel like it’s sort of become a trend for some people, and you can always tell, because there’s other, but I think the most part about it is you can like if you, lie, well not so much lie as like convince yourself that you have a mental illness you can develop mental illness and I feel like that’s what a lot of people do these days. I know there’s been incidents on the ward where there were times when there was a friendship group who lived in XXXXX and when they got admitted to this unit for being really depressed and being suicidal, and then all, cos I watched this happen, over the like 4 weeks or so every person from that friendship group was admitted here because one person genuinely struggled and then it’s like a learnt behaviour, everybody else, like, reverted to that in the end. And they all got admitted here and then discharged within like a week or two. Because they weren’t mentally ill they’d just convinced themselves that they were and I don’t really know how the people here manage to tell the difference, discharge the people and keep the people who genuinely need help to be here but that’s what happens and yeah.

Interviewer – And that’s something only you’ve noticed since being here, did you notice that before you came here as well?

- Shared exposure experiences
- SH growing in popularity
- Both as a way to cope and a way to express group membership?
- Trend? Pact?
- Social comparisons e.g. them, other people etc
- SH is viewed as favourable
- Different types of self-harmers e.g. The “genuinely ill” vs “the trendies”
- Separating out different types of people who SH e.g SH to cope vs SH to elicit care?
- Being separate/ different and distinguishable from others who SH
- Self-harm pacts

- Genuine vs convincers?
- Art of detecting the fakes?
- Filtering through patients to find genuinely poorly patients
- “Bullied out of high school”
- SH happening in groups
- Physical exposure of SH
- “showing off their SH”
- Group membership?
- Hating term “attention seeking”-personal experience of the –ve connotations of this term??
- SH without understanding why-to fit in/trend
- Other forms of SH
- Not recognising some methods as SH?
- Coping in the absence of cutting
- Hair pulling more acceptable as a form of SH
- Patches vs scars?

Participant- Yeah, was like, like I was bullied out of my high school but before I was you could there was always groups of people and you could see it. And it was, it was one of, you could tell it was becoming a trend and it always was, there were people who were like self-harm and walk around wearing like short sleeved t-shirts even though like you meant to wear long sleeved as part of the uniform, they were purposely wearing short sleeved shorts to like show it off I guess. And like I completely despise the word attention seeking because I feel that’s not the right word at all to describe it but it was made, it is like a trend but people don’t realise what they’re doing when they’re doing it I think.

Interviewer- And is that, you’ve spoken a lot about, you know the cutting and things like that. I’m wondering if you’ve experienced any of these things with different kinds of self-harm?

Participant – Err yeah, I used to know someone who used to erm burn themselves quite a lot and I know I’ve had some past experience where erm, but it became, it was classed as self-harm but it was a way of coping without cutting I guess and I used to pull my hair like out, like just sit and do it for hours like I’ve got really bad patches like where my fringe were, the hair just won’t grow back anymore. Slightly there you can partially see it but and then I had to get my hair cut really short cos there was patches of it all over the head.

Interviewer- And do you tend to see, what we’ve been talking before about that kind of trend emerging, does that tend to be more with the cutting side of self-harm?

Participant – Yeah, definitely you don’t really see people doing the other things, but I think it’s like scars and stuff are glamorised. They really are and like you get so many things on social media and, it just promotes it because like at first people think oh look at this we’re not alone, but you become obsessed with in and in a very sick way it’s sort of idolised erm, I only know cos I’ve seen people like go

- Self-harmers all grouped together-can’t separate genuine from trendy
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- The “genuinely ill” vs “the trendies”
- Displaying SH as a sign of trendiness
- Hating the word because of its negative associations and closeness to her own self-harm?
- Public vs private self-harm
- Conflict with people’s perception, understanding and language around SH e.g. accepting of some (medical explanations, coping strategy), but rejecting of others (-ve associations such as attention seeking)
- Evolving SH: Understanding of SH, coping, methods all changing overtime.

- Hiding evidence of past SH
- Only cutting that's seen on the ward
- Cutting and evidence of cutting (scars) is more acceptable? Glamourous?
- Influence of social media
- Promotion of SH
- "we're not alone"-group membership
- SH as an obsession
- SH among friends and family
- MH and SH are hereditary for her-justification-not like everyone else
- Medical explanation-whose language?
- Choice vs no choice
- Inherited vs learnt
- Understandable vs copied
- SH & SB promotion-blogs, pictures, quotes
- "angels trying to get back home"

through it and like my family, like, every person in my family has got some form of mental illness, my dad's been in an inpatient unit before and like I obviously am right now, it's quite, in my family it's quite hereditary, like, there's just a chemical imbalance in the brain and that's why there trying to sort out medication but a lot of people, it's like learnt and its glamorised and there's a whole like world of social media where, it's just all over social media and like it can be upsetting for people. See I don't want to say people who genuinely struggle because you will struggle with it if you've learnt the behaviour but for people who say are born with a chemical imbalance or born into bad sort of situations where it will make you become depressed as opposed to people who sort of learn it I guess and it's like all over social media. I think tumbler is a particularly bad one where people start blogs and it's all dedicated around self-harm and suicide and depression and it's just people who like create blogs and then like post pictures of self-harm or quotes that glamorise suicide. There's always one, and it's like I think suicidal people are just angels trying to go back home and it's like why would you glamorise it? Because that's what it is and people don't realise it, it just frustrates me.

Interviewer- So it sounds like not only was there a huge impact of social media before you came, came to be here but there was that impact of like almost seeing it in most friendship circles and things like that. Is there any, do you have any other experiences of self-harm of others before coming on to the ward?

Participant- Erm, no not massively but I've always like been very isolated in the sense so I don't, most of my experience of other people is like online because I was bullied out of high school and then I was home schooled, then I attempted to go to a college and had to drop out because I have really bad anxiety issues, erm and then I ended up here so.

- Something powerful about familial exposure-early and intense experiences
- Constructing personal meaning for her SH-belonging? e.g. hereditary, medical explanations
- Us & them. Understanding her identity as a self-harmer
- The "genuinely ill" vs "the trendies"
- Attempt to find own identity among others with similar difficulties
- Indirect exposure via social media
- First time vs cumulative exposure

- Such behaviours are glamorised which feels to insult those who use it for “genuine“ reasons
- Frustrated and undermined
- Loss of power in her actions/behaviour
- Limited experience of other ‘groups’ SH- mainly virtual via social media
- How does she come to make these decisions about true vs learnt SH
- Cutting becoming “normalised” through exposure
- Increasingly popular and heard about
- Understanding the “concept”- some people are making an informed choice
- SH as a choice for others but not for her.
- How can they still SH when they understand the impact it will have on others/family?- implies others are selfish/careless

Interviewer- And, being around, you know, being exposed to other people’s self-harm in that way, whether it be over the internet or it be those groups of people, how has that, what kind of effect has that had on you?

Participant- Being around people that self-harm? I don’t know really, I think, just being exposed in a sense, like it’s always on your mind, when, like if something becomes seen as normal, which I know self-harm isn’t but particularly people like cutting like it’s becoming more of a, like everybody seems to know about it now. Whereas, I’d say when I was like just turned a teenager, it was like nobody knew anything about it really it was like an unheard of thing. Like when I first started self-harming I didn’t even know the concept self-harm, I just, I don’t know how I ended up starting doing it but I didn’t know what it was, I didn’t know what depression was I just somehow came to that conclusion whereas people like at school who seem to start self-harming are completely aware of it are completely aware of the effects that its gunna have on other people, on their family, on themselves and still choose to do it, whereas some people genuinely do it cos they need to cope, it’s their coping mechanism but a lot of people learn it as a coping mechanism rather than it being a last resort of coping. Yeah, people want to self-harm and they want to have a mental illness, it’s like personality trait for some people, which it shouldn’t be and that effects other people because then, I know I was always worried at school, I mean I was bullied out anyway but that people would find out that I self-harmed and thought that I was part of that like so called trend and that people don’t take you seriously because they like, think that you’re just, that there’s like, I don’t know, it’s just not seen as much as a big issue as it used to be because people have desensitised each other by everything that’s on social media.

Interviewer- Hmm, so there’s something about, almost not wanting to, you know, or being very very private with some of your own behaviour just because you didn’t want to fall into that kind of

- Loss of power/control in how SH is perceived by others? Feels stereotyped by others who SH for different reason
- understanding of others SH borne out of stereotypes?
- Reframing her experiences- taking a position of things being out of her control e.g. things happen that have happened to me, “bullied out”, “chemical imbalance”, and taking control of these using SH
- Evolving SH: Understanding of SH, coping, methods all changing overtime.
- Exposure normalises SH
- Us & them. Understanding her identity as a self-harmer
- The “genuinely ill” vs “the trendies”
- Attempt to find own identity among others with similar difficulties

stereotype of being part of a trend. Erm, yeah, okay. So I think we've tapped into quite a bit of it already, I suppose the next question was more specifically about, you know what have been your experiences of people, other people's self-harm since being on this ward?

Participant – Yeah, well erm, I've witnessed a lot of people self-harm since being on the ward, which isn't the most pleasant thing to see. Erm, yeah, a lot, a lot of people on here struggle with self-harm and I've known people who have been admitted at this hospital for things such as eating disorders and then when they leave self-harm is a major issue in their life, like it gets from being in this sort of environment it can be learnt as a coping strategy, like subconsciously without you realising, like if you're exposed to something long enough it, it's in your head really and yeah a lot of people, either learn it or become worse in here without realising it. Just because you're exposed to it so often, erm, even something as simple as people walking around and they have like scars on show, but they can't help, it'll probably be there for the rest of most people's lives but just something like that without you realising can become stuck in your head, not that I'm saying like, oh if you've self-harmed like you can't show off your arms when you've got scars that are like a few years old and stuff like that but it does, I think it does affect people more than people probably realise but I think it can't be helped at the same time so.

Interviewer- Yeah, so it does sound like it's almost because you're all you know here together, there's something about being exposed to other people's self-harm that kind of triggers something in yourself and in your own, even reflecting on some of those experiences of people who perhaps didn't use self-harm before coming on to the ward and actually learning some of those behaviours. I suppose I wondered about the types of self-harm that you've seen and whether the type, certain types of self-harm of other people, do they have any different effect on you or?

- ➢ Choice vs no choice-it's the only way to cope
- ➢ A learnt coping mechanism implies choice vs doing it because you are desperate
- ➢ Something about others having the capacity to consider other options? When she had exhausted all hers.
- ➢ Others WANT an illness/SH- "personality trait"
- ➢ Strive to show herself as being separate from this "type" of SH
- ➢ "bullied out"
- ➢ Anxious/offended to be associated with the "trend"- Invalidating
- ➢ SH has less of an impact now- desensitised- does this explain why it doesn't work for her anymore?
- ➢ Exposed to more SH since being admitted
- ➢ A struggle with SH
- ➢ Acquiring SH from being admitted
- ➢ Exposed to and learnt
- ➢ Habituated to SH- subconscious v conscious learning

- ➢ The "genuinely ill" vs "the trendies"
- ➢ Choice vs. no choice
- ➢ Attempt to find own identity among others with similar difficulties
- ➢ Feeling invalidated by other peoples SH
- ➢ SH as a process- effective to ineffective overtime
- ➢ Normalising and desensitising
- ➢ Exposure within inpatient settings
- ➢ SH as contagious. Conscious/ unconscious exposure and learning
- ➢ Initiation of SH
- ➢ Culture of inpatient services- keeping YP safe or placing them at risk?

- Inpatient services makes your SH worse
- Passive exposure/learning
- Feeling helpless- can't stop being exposed
- Places the responsibility of exposure onto others, as opposed to acknowledging that she might actively look for evidence of SH?
- Types of SH on the ward
- Immediate pain e.g. burning/cutting and delayed pain e.g. seeking infection- prolonged pain?
- Differences between types of SH seen outside and inside inpatient services
- Seeking ways to SH that the staff can't stop-sense of personal control?
- Use of language around SH "contraband"
- Sneaking in contraband
- Getting clever/wise to the system/thinking outside the box

Participant – The majority just self-harm by cutting themselves, there's people on here who scratch themselves like or like, there was a time when people used to use coins to give themselves really bad friction burns and then like leave it so it would like purposely get infected. I remember when people used to do that erm, there's a lot of people who, I don't think you get many people who burn themselves in here cos it's pretty much impossible but there was times when people used to like put like hot coffee on themselves and stuff like that, erm, I know I used to pull my hair out quite a lot. I did that before I came in here but I did that in here as well, because, like they can take things like contraband off you, they can take like razors away from you but they can't stop you from pulling your hair out. And I know that became a massive deal for me when I was first admitted cos like the majority of people who are admitted as an emergency, I was admitted as an emergency, will have something on them that they shouldn't have, but I think, something about being in here is like, people get clever and you think a lot more about it, like, when I first came I had no concept of what a ligature was, and the only concept I had of it was like people who would like hang themselves from like ceiling fans and stuff, I had no concept of like a non-suspended ligature of anything and you see that and like almost daily in here and people get clever with self-harm like you learn places where you can hide things and you learn ways that you can get things that you shouldn't have, you learn ways to make everyday objects into something that you could self-harm with and that's not the best thing to learn. And you don't do it intentionally either it's like, I've been here for like almost half a year and that's, it's something you learn without trying to. And I think that's pretty bad.

Interviewer- And is there any learning from each other with regards to that kind of thing?

Participant – Yeah, there's quite a lot. Erm, there's, there was a time when there was a patient who snapped a pen and sharpened it and had a really sharp piece of plastic that we used to self-harm with and

- Evolved and expert SH methods
- SH as a coping strategy to control emotional pain
- SH is controlled by staff, thus yp revolt/fight for control by sharing/learning etc
- Us vs them
- Outsmarting the system
- Control
- Desperation to SH
- Plan to SH prior to entering services

- Learning new techniques from others/new hiding places/becoming more resourceful with acquiring/making objects to harm themselves
- Sense of achievement/ beating the system
- Passive-without intention
- Inpatient services as an unhelpful learning environment
- Sharing instruments?
- Ease of access to resources
- Needing to be one step ahead of the staff
- Finding new and accessible methods to inflict harm on themselves
- Desperation among YP on the ward-working together/shared goals
- Seeking out objects to harm vs objects to kill
- Staff promote confidentiality-but there are no secrets
- If sharing is unhelpful, why do people share??

then pens almost became contraband on the ward because everybody started doing it, but it was easy enough because, they'd come in and they'd take away the pens, it's easy enough to get another one, you can get pens everywhere. People like, it just takes one person to do something, there was a person who split a battery open from a clock that was hung on the wall and drunk the acid inside of it and had to go to hospital and then all of the batteries from the ward suddenly went missing and there was a few people trying to do it. If, but it's one of those things people are so desperate, if people find out that there's something that can harm you or for a lot of people like potentially kill you, they will try and do it. It's just the finding out really, but everybody finds out everything in this place, things aren't as secret as they probably should be, but people like, the staff are very like, promote like confidentiality and that you shouldn't take about your issues with people but people still do and that's quite bad for a lot of people on here.

Interviewer- So there's something about sharing each other's stories, do you think that's maybe a negative thing cos of the impact it has on other people?

Participant- Yeah, people like will see self-harm marks in other people and be like how did you do that? And then like, they'll be like oh it was just plastic, then people will be like right plastic, you can sharpen it enough for it to do that and then people will go and do it. People used to snap cutlery in here as well and use that and there was a time when there was only allowed to be two people eating at once so they could monitor the cutlery because people were snapping it and using it and there was a patient who was, who would use it not just to harm herself but to try and harm any staff that came to take it away from her. And she got moved to a more secure, cos this is a non-secure so that's a step higher up than here. So that's pretty bad.

Interviewer- So you've spoken quite a lot about how there was this kind of learning from other people, I am wondering how other

- Outsmarting the system
- Exposure encourages learning
- Unhelpful environment
- Being resourceful
- Us vs them, "we uses"- sharing SH tools?
- SH as an addiction
- SH as a process-ie. From injury to attempt at own life
- Self-harm pacts?
- Exposed-no secrets/no confidentiality
- exposed in two ways: personal SH exposed to others and others SH exposed to you
- An expectation to SH? Part of their identity on the ward?

- SH as addictive?
- Seeking objects for different purposes e.g. to harm themselves vs harming others
- She seems to believe that this sharing is an unhelpful thing, both for her safety and the safety of others inc staff
- Blood as a trigger
- Knowing what to look out f
- SH of others impacts her own well being
- “on edge”
- “bothers me”
- “not nice to see”
- “If they can, I can”
- Transition from SH as a coping strategy to SH with intent
- Sense making- this is how SH escalated to SB for me?
- She is able to reflect on her own journey by looking at others who are further behind than her
- Maturity- I know that I don’t find that helpful anymore

people, if the self-harm for other people has ever had an impact on you and in those ways?

Participant- Erm, seeing blood impacts me a lot. I know when people walk around with like bloody arms or just even like, when people like who self-harm wear long sleeves and then it goes through the long sleeves and you can see it, that impacts me, but.

Interviewer – In what way does that impact you?

Participant – Oh, it’s difficult to explain, it just really bothers me and it makes me like really on edge really, it’s just not good. It’s pretty, like, not nice to see. And I think it’s like a reminder as well because, obviously people are desperate to self-harm and like if you see if someone else has done it, well they’ve managed to do it why can’t I brave it. Cos I know that erm self-harm doesn’t help me as a coping mechanism, I’ve not, I have self-harmed but with the intention of killing myself rather than coping whereas I’d say the majority of people who self-harm do it because it helps them cope. But, I used to be like that but it doesn’t help me anymore, but, like, there’s a lot of patients will do things, they’ll use plastic or they’ll use cutlery to self-harm but whereas I’m a bit different from that because I’m not gunna self-harm with a piece of plastic because I know that won’t kill me and that won’t like do much and I think that’s the difference between me and a lot of other people in here really because a lot of people will self-harm as much as they can because it helps them whereas nothing helps me really so that’s why I ended up here really but blood impacts me. Other people self-harming, not so much I don’t think, just because, I know that if I was in the mind-set that I was a few years ago when self-harm used to help me I think it would impact more just because it’s like they’ve done it, so why can’t I brave it.

Interviewer – Have you seen how, perhaps the self-harm of others affects other people on the ward, you know if there’s other young people here and they see somebody else who’s self-harming in a

- An expectation to SH if you can?
- If others do it- so should I
- Pact?
- SH as a process
- SH with and without intent
- Us vs them
- SH as a process
- Developing understanding/ maturity as a self-harmer
- Identity-I’m different
- Social comparisons
- SH no longer effective-past help now- linked to SB?
- “Brave it” Peer pressure? Expectation? Display of being ill?

- "I'm different"- my situation is different
- Nothing helps me now
- Blood impacts me now
- SH impacted her differently before
- Compelled to do it to be "brave"
- Peer pressure
- Different reactions
- Unresponsive, absorbed in own thoughts, distant.
- Considers how the impact of seeing other people SH might be similar to the impact her SH had upon her family
- Witnessing SH can trigger lots of negative memories
- What memories does it trigger for her?
- Addictive
- The only option
- It's the only thing that helps

similar way, does it affect them any differently to how its perhaps affecting you?

Participant – I've seen people like, become really, like unresponsive, when they've seen someone self-harm or has seen somebody who just has self-harmed and they become very like absorbed in their own thoughts and very distant. God knows what's running through their heads but like obviously had an impact on people, like, I know like, my self-harm and stuff has really impacted my family massively. And I always feel bad about that, but, it impacts a lot of people, like, like on a basic level it can just be upsetting to see, but then like when you think about it more it can be like a really bad thing for some people, it can be like a negative reminder of the things you want to do to yourself. It can be upsetting for people to see, it's just unpleasant and it really affects people in a lot of ways. Yeah.

Interviewer- Yeah. I suppose what I'm really interested in is what you mentioned maybe people coming on to the ward for different reasons who perhaps haven't used self-harm before and the impact that you've maybe noticed or you've seen the self-harm of others have on them.

Participant – Yeah. There was, like I said there was a girl who came here with an eating disorder and by the time she'd left she had started self-harming. I just think it's being in an environment with so many people use it to cope and there's not always staff available to help you if you're going through like a particularly bad morning or feeling really negative and low that day. Sometimes like people like see other people doing it and like know that's how they cope and, people are just desperate to be able to cope because things feel too difficult to manage and I think that's how it becomes learnt because so many people like say that like the self-harm helps them cope, that like people think I can't cope this is the only option that's left really and it is addictive. And like, I think like once you first start self-harming, like you realise nothing really helps as much as that. Cos it's just, I

- Holding up a mirror
- Witnessing the SH of others helps her to understand the impact of her SH on her family e.g. guilt, shame, regret?
- Ripple effect. Seeing distress is distressing.
- What is understood as SH? Certain behaviours not recognised as SH e.g. eating disorder
- How do YP define SH? Personal experiences? Exposure to media? Medical opinion? etc

think for me anyway, I used to have a lot of intrusive thoughts and feelings that were all very negative and like I used to say like that my head almost felt like a really busy place cos there was so much going on and I couldn't keep track of any of it. And, to self-harm was to like focus on that pain which would be like a relief because that, like, hurt less, in a sense than trying to figure out everything that was going on in my head, and it's like you have toothache or something and people say oh I'd like punch a wall or something so that I can have a break from the pain of my toothache and feel the pain somewhere else and I think that's what it's like. And because it is, it does feel like a relief, because you like, everything that's going on you totally forget about it for a bit and you just sort of focus on that one thing and then like, I don't know, I just, like, the whole sensation of it and the feel of it and obviously like if you feel pain everything just sort of stops and your whole body focuses on the pain and like, yeah, so I think people realise that and I think that's probably how people sort of come to self-harming cos everyone, everyone like, it's become a very popular, fact, that everyone knows that most people who self-harm don't do it because they want to die but because it's the only way they know of coping so I think people become desperate and nothing else is helping them, they revert to that in hope that it'll be something that can help them.

Interviewer- From what you're describing it sounds like perhaps the use of self-harm becomes different to when it's for people who've been admitted to the ward. That perhaps although this is a trend for people outside of the ward, do you notice that same trend here or is this, is it used differently on the ward.

Participant- No, you can notice it here with some people, there's always, I think everywhere you go there's always gunna be them people who have learnt it really and I know there's a certain patient here obviously I'm not going to mention any names, but there was a time when there was a girl on the ward who had, like, been on home leave and self-harmed quite badly on the neck and then there was this

- "Intrusive thoughts"-whose language-how has she come to understand this?
- SH as a way to focus/control overwhelming thoughts/feelings
- SH as a distraction from emotional pain
- Inflicting physical pain to slow/stop/control / distract from emotional pain
- Reverting to SH as a last resort to help her cope
- What happens when it no longer helps you to cope? Does it then become an attempt at your life?
- Everyone knows? Whose everyone?

- Language-whose terminology?
- Control?
- SH is the only option to cope
- Focus of attention/ distraction
- SB when SH becomes ineffective
- Continuum?
- Her understanding of how others experience SH
- SH as emotional regulation
- SH as social though too?

- Trend of SH among some people on the ward
- Some peoples SH is more valid than others-hierarchy?
- Seeing some SH as copying? not genuine?
- Examples of copying
- Something about people copying visible SH only?
- Copying elicits care?
- Copied behaviour
- Two types of copying: because they're desperate vs. they want attention
- Hating the word attention-why? Personal experience?
- SH to elicit care/attention from staff over others
- SH commands the attention/care of staff
- Competition for care from staff?

girl and she got a piece of black plastic and started self-harming on her neck so people could see it in that sense because its encouraged on the ward to wear long sleeve because people don't know how scars or cuts or anything affect other people. But she did that so people could see it and yeah there was a time when somebody else was like scratching on their hands, like, and like friction burn on the back of her hands and the same girl who cut her neck with the plastic started to do that. And it is, it's like a copied behaviour and I think no matter where you go you'll always see it.

Interviewer-So it's almost as if some people perhaps copy the behaviour but other people are perhaps learning different types of behaviour. Do you feel like there's a difference between those people that copy and those people that learn?

Participant- I think there probably is, I mean the people who, yeah the people who learn it, well I don't know really because there's people who copy because they find out a way of doing something and they're desperate but at the same time you get people who copy people because, I hate the word attention but like if the same person, I'm not naming names but, if anybody's struggling and requires staff support they had to be suffering more and they had to be seen in as struggling more than the other person because the staff members attention at that time wasn't completely devoted to them. Like I hate the word attention but that's.

Interviewer- I suppose it's like care eliciting isn't it.

Participant- Yeah, really, like there's people who like to be staff members favourites and if that isn't the case they'll do something that will require staff support or even like increased like observation so staff are there for them more frequently.

Interviewer- And you see in those people who you see the copying, the copying of the types of self-harm?

Participant- Yeah.

- The "genuinely ill" vs "the trendies"
- Choice vs. no choice
- Some SH more valid than others
- Public vs private
- Not unique to inpatient settings
- Care eliciting/attention seeking associated with "trendy" SH not genuine SH
- Genuine = serious, no choice, private
- Trendy = copying, choice, more superficial and public

Interviewer- Okay. That's really interesting. Okay. So I think I've asked all the main questions, I'm just going to see if there's any additional ones that I, that we haven't covered but to honest you've done a really good job of covering them before I've even asked them. Okay, so we've covered things like what are your thoughts about other people's self-harm, you've already spoke about that and how their self-harm makes you feel, you've talked about how blood is a big trigger for you. I suppose what's interesting in those circumstances where you do notice other people's self-harm, what do you do to manage that?

Participant- Erm, I don't know. I lot of the time I isolate myself. Before I was admitted here I hadn't left my house in around seven months because of my anxiety. I'm very open to isolating myself, generally I don't, I don't massively get involved in things that happen on the ward I just sort of see them as like, <u>I'm pretty invisible on the ward</u> but, sometimes things can affect me and <u>I just end up shutting myself away really, like, just get away from it for a bit</u>. I think a lot of the time you just have to remind yourself of where you are and that those things are going to happen and there's nothing you can do about it. Like, people are struggling, there's probably been days where like I've probably affected people without realising, like you can't, I think in this sort of environment you can't really hold people personally responsible because that's why they're here.

Interviewer- Yeah, okay, so we've spoken again about how the self-harm of others has impacted upon you and how it's impacted others. We've spoken, we've touched on how it's affected your own wellbeing being around people who have self-harmed and actually been able to reflect just then that you know perhaps they've got their own things going on and how that impacts upon you and how you developed new strategies to cope with that. I suppose, what I would probably be interested to know, what kind of support you've had, you know when you've witnessed other people self-harm and things

- Other coping strategies- isolating myself
- "I'm invisible"-the all seeing eye! An outside observer of what happens on the ward
- Shutting myself away
- Acceptance that SH is going to happen
- Finding new ways to cope
- Reciprocal-they affect me but I probably affect them
- Not their fault-diffusion of responsibility

- Private SH- "invisible"
- SH as a process-now sees it from a mature perspective
- Exploring new ways to cope- SH running its course i.e. end of the process
- As progress through process-can reflect on the impact it has on others

- Support only available to those in crisis
- Negative reinforcement i.e. attention/care removed when seen to be coping?
- Peer support in the absence of staff support
- Diversion away from triggering events
- Remove self from situation
- Not enough staff to provide an ideal amount of support
- Support is prioritised

like that. What support have you had from the staff team or from the other people on the ward? If any?

Participant- Like, a lot of the time the staff are like focused on the person who has self-harmed or hurt themselves so there's not really a lot available other than just sort of like people asking if you're okay really. I know a lot of the time, like, young people on the ward will like comfort each other or remove each other from the area that stuffs happening in. I know a lot of the time people used to all like go into somebody's bedroom and like lock the door til everything was sorted. Like, outside of the ward, just because it was quite negative stuff going on and it impacts people but I think a lot of the time people just sort of attempt to help themselves and just remove themselves from the situation, I think that's about all you can do because the staff to patient ratio is just, isn't really enough to provide an ideal amount of support to every patient at the exact time they need it so they have to prioritise and obviously someone who's gone to the effort to do something like self-harm at that moment in time its gonna require more support than someone who's upset from witnessing it. I think you just need soft a distraction more than anything so that you just don't think about it. Over thinking is like one of the worst things you can do, especially here.

Interviewer- Okay. So I suppose I think we've covered pretty much everything in there. I think you've done a really, really great job of being able to reflect on all those experiences for me. I suppose, is there anything else you feel like I haven't asked you that you feel you would like to have. Right well I think we'll finish there then.

END OF INTERVIEW

- Peer support- positive and negative experiences
- A need for those who are coping to be cared for- negative reinforcement i.e. to get care I need to hurt myself
- Whoever cries the loudest-but people who don't cry might be most a risk? i.e. escalated to SB
- Competing for care?

Section 3: Critical Appraisal

Running head: CRITICAL APPRAISAL

Critical Appraisal

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Self-harm is a growing public health concern, particularly among young people. In response to the paucity of research pertaining to self-harm among looked-after children (LAC), the thesis literature review aimed to facilitate a broader understanding of the psychosocial risk factors associated with self-harm and suicide risk among children in care. Such a review was felt especially important given the existing vulnerabilities associated with being looked-after. Systematic appraisal of fourteen cross-sectional studies highlighted several demographic, socio-environmental and psychological factors thought to place LAC at an increased risk of self-harm and suicidal behaviour. The findings from this review therefore have substantial implications for intake assessment, treatment planning, service delivery and staff training to address the complex emotional and behavioural needs of LAC.

To date, relatively little is known about why young people start self-harming, however more recent research has highlighted that exposure to the self-harm of others may be a potential risk factor associated with engagement in self-harm over time. Following on from the literature review, the thesis research paper aimed to explore young people's experiences of the self-harm of others using Interpretative Phenomenological Analysis (IPA). A total of eight young people, resident at one of two adolescent mental health inpatient units in the North West of England, were interviewed. Five themes emerged from the interview data: 'Pre-admission exposure to self-harm', 'Exposure on the inside: An unpleasant environment', 'Helper vs helped', 'Separation from the attention seekers', and 'Competing for authenticity'. Self-harm prevention efforts, such as the implementation of peer support groups and staff training packages, were discussed in relation to the possibility of reducing the social transmission and stigma surrounding self-harm amongst young people.

The final thesis paper is a critical and reflective essay that considers all aspects of completing the thesis, including the initial decision-making processes regarding the thesis topic, the practical and procedural challenges encountered during the course of the research, my reflections on the clinical implications of the findings, and my personal journal through doctoral training and developing understanding of my position within clinical psychology.

Developing a research idea

The genesis of my interest in self-harm began long before commencing my clinical psychology training. Over a decade ago, whilst working first as a carer and later as an assistant psychologist within residential children's services, the levels of self-harm among looked-after children I was exposed to was alarming. The young people, mainly teenage girls, would cut, bite and burn their skin, pull their hair and ingest substances which they felt would do themselves harm. I remember to this day how distressing it was to see children so desperate to harm themselves and feeling hopeless when you were unable to help. I also became aware of the reactions of the other young people, care staff and parents to self-harm. Shock, distress and anger were common, and I wondered how the reactions of others may be impacting upon the young people's future engagement in self-harm.

As part of the clinical psychology training, there have been several opportunities to conduct research. Building upon my interest in self-harm, I investigated parental experiences of their child's self-harm and explored their experiences of support from inpatient services for my service-related project. The results from this research highlighted the profound distress, guilt and shame experienced by parents of self-harming adolescents, and how self-harm complicated their parenting experience. The emotional reactions of parents in response to their children's self-harm had implications for service delivery, and suggestions were made as to how services could best provide support and information to parents and families.

Upon hearing parents' stories of distress at their child's self-harm, I started to wonder about young people's experiences of the self-harm of others. Although studies had proposed that exposure to the self-harm of others was a potential risk factor for engagement in self-harm over time (Hasking, Andrews, & Martin, 2013), the research literature investigating young people's reasons for self-harm was extremely limited. I was also particularly interested in the social transmission of self-harm. Whilst working as an assistant I observed several patterns emerging in the self-harming behaviours of young people in residential care, and started to question whether such behaviours were solely driven by emotional factors (e.g. to alleviate distress) or whether there might also be social motivations to self-harm (e.g. to fit in with peers). I decided to make this the focus of my thesis empirical paper, and designed a qualitative study to explore young people's experiences of the self-harm of others, with a view to developing a greater understanding of how young people make sense of self-harm.

Throughout my research exploring self-harm among young people, I also held in mind how my early work experiences shaped and influenced my decision making and indeed my interpretations of the research findings. I was particularly concerned that I might prioritise findings that fit with my experiences and hypotheses, and neglect alternative interpretations. Therefore, I believe that it was especially important that I sought the second opinion of my academic supervisor to validate my interpretations of the young people's experiences for the analysis of my empirical paper.

Finally, it is my overall commitment to work with looked-after children (LAC) which drove the interest behind my literature review. Research focusing on the outcomes for looked-after children is extremely limited, perhaps because of the ethical obstacles to conducting research with vulnerable groups (see below for discussion). Based on my personal experiences of working with LAC, I was unsurprised that research highlighted concerning levels of self-harm and suicidal behaviour among children in care (Baker, Kurland, Curtis, Alexander, & Papa-Lentini, 2007; Department of Health [DoH], 2012; Hurley, Trout, Chmelka, Burns, Epstein, & Thompson et al., 2009). In response to the paucity of research pertaining to self-harm among LAC, I hoped that a literature review would facilitate a broader understanding of the psychosocial risk factors associated with self-harm and suicide risk among LAC. Although it would have been my personal preference to review qualitative research with LAC, unfortunately, such research is so limited that there is not enough to assimilate into a meaningful review. Thus the pragmatic appraisal of cross-sectional studies instead became the focus of my thesis literature review.

Obstacles in the research process

Throughout the research process I encountered several practical and procedural challenges. One of the earliest challenges was the National Health Service (NHS) ethical approval process for my empirical research paper. With the experience of applying to NHS Research Ethics Committee (REC) and NHS Research and Development (R&D) committees for approval for an earlier project, I was aware of the need to have a thorough and well thought out plan for my present research proposal in order to best safeguard the young people whom I hoped to be able to interview. I decided that it was important to set aside ample time to consider all of the ethical obstacles to conducting this potentially sensitive, distressing and risky research with a particularly vulnerable group of people.

My application to the REC was comprehensive, and included a thorough justification for why my research was needed, a detailed recruitment strategy and meticulous consideration of ethical issues with the application. Although the process of applying for NHS ethics and R&D approval felt lengthy, my progress through the process was relatively smooth. I received positive feedback from the committees about my application and with minimal changes my project was approved. I feel very strongly that without the level of planning and time I committed to the ethics application process, my project could easily have been dismissed due to the potential risks to an already vulnerable participant group. I was delighted that I was given permission to proceed with the research, and hope that future trainees and researchers are not discouraged from choosing topics which will likely involve several ethical obstacles.

REC procedures serve to protect the safety and wellbeing of patients involved in research (Health Research Authority, 2014). However, the pragmatic complexities in obtaining ethical approval for academic research, particularly research with vulnerable groups, could create barriers in contributing to the evidence-base of clinical psychology and wider psychological practice (British Psychological Society [BPS], 2014). Furthermore, as doctoral projects are already under significant time constraints, inadequate time spent on ethics applications is likely to delay ethical approval; jeopardising the opportunity for doctoral students to conduct their research within the NHS, and thus hindering the involvement and representation of patient views within research (Davies, 2015).

The second challenge faced during the thesis was recruitment to the study. To protect the confidentiality of patients, local collaborators at each of the inpatient sites were the main drivers behind recruitment for the study. Although recruitment from one of the sites was particularly fruitful, recruitment from the other site was far more challenging, hence the uneven distribution of participants across the two sites (7 of 8 participants recruited from one site). A further obstacle to recruitment was the need to obtain assent and parental consent for any participants under the age of 16 who expressed an interest in participating in the research. For example, an interview was arranged for me to see a young person, however when I arrived at the service to conduct the interview, the parental consent form had been misplaced for the young person expecting to be interviewed. Fortunately, the anonymity of the participant was preserved as I asked for the forms before being taken onto the ward, however

I was disappointed that the interview with that particular young person needed to be cancelled through no fault of their own. Moreover, the interview was unable to be rescheduled due to the young person being discharged shortly afterwards so the voice of this young person was not heard. These circumstances highlighted to me the importance of having engaged, invested and enthusiastic local collaborators in order to successfully recruit for NHS research, especially when ethical issues result in the recruitment responsibility for a study being largely outside the researcher's control.

A further practical challenge was the conducting of the interviews themselves. Although the interviews took place in private rooms on the ward, the rooms were designed so that young people can be visible to the staff at all times. Therefore, some participants became distracted by staff and other young people walking past the room, and by the level of noise on the ward. This led me to reflect on how young people's participation in research can be kept confidential from other young people on the ward, and how likely it was, given the culture of the ward, that participants would have talked to each other about the research anyway. Whilst conducting the interviews, I also became aware of the challenge of remaining in the role of researcher. The development of a rapport when engaged in direct therapeutic work with a client is a familiar process being a Trainee Clinical Psychologist, however building a rapport within the context of a research interview raised an interesting ethical issue.

When working clinically, rapport is used to facilitate open communication and trust, however for research purposes rapport is used to facilitate participant engagement which felt more strategic and coercive. It has been suggested that the development of a rapport in this type of study is critical given the emotive nature of self-harm (DiCicco-Bloom & Crabtree, 2006). However, this led me to consider why it is critical; Is it critical for the safety and well-being of the participant? Or critical for the collection of rich research data? With this in mind, I considered how I used rapport in the interviews. As discussed by Haverkamp (2005), maintaining the role of a researcher is difficult when our clinical training provides us with skills and experience that elicit a level of disclosure and make it easy to respond in a therapeutic manner. Indeed, the ethical dilemma is that participants have not consented to this level of interaction. I reflected that since I identify more with being a clinician than I do a researcher, I feel confident that I used rapport ethically, and for the purpose of supporting the well-being of the young people I interviewed, however it led me to consider the need for the psychologist researcher to negotiate this shift in roles with participants (Haverkamp, 2005).

During the interviews and whilst analysing the data, I also reflected upon the impact that the distressing stories shared by the young people had upon my own well-being. By the nature of interviewing young people admitted to inpatient services, it is unsurprising that their accounts included upsetting stories of significant harm to self, suicidal ideation and attempts, historical trauma and severe psychological distress. Although I have been exposed to similar stories when working clinically, the cumulative effect of completing the interviews, transcribing the data and meticulously analysing and interpreting their stories was overwhelming and distressing; akin to the feelings I experienced over a decade ago when I first started to work with vulnerable children. Where a clinician would provide containment and advice to people in distress, a researcher remains a passive observer and listener. These differences in role between a researcher and a clinician led me to reflect on how difficult I found it to withhold my support, and indeed whether it is ethical to do so (Haverkamp, 2005). Fortunately, as a trainee, we are afforded the luxury of an abundance of supervision, which I found critical in unpicking these feelings. Considerations from the psychotherapy literature led me to consider whether my feelings were caused by personal distress at hearing the difficult stories of the young people, transference, countertransference or indeed a complex interaction of them all (Hughes & Kerr, 2000).

Clinical reflections on the application of this research

Several clinical implications for staff and services for vulnerable children and young people emerged from this research. From my clinical work with looked-after children in residential services and my research with young people in inpatient services, I was struck by young people's unpleasant experiences of living within these settings. Young people's anecdotes of feeling that such services have done more harm to their well-being than good are concerning. As such, it led me to consider and reflect upon the effectiveness of such services for supporting vulnerable young people. Treating young people with complex mental health needs is challenging, particularly when a large proportion of adolescents treated through outpatient services attend very few sessions or drop out (Harpaz-Rotem & Rosenheck, 2004). As a result, inpatient services and residential care are being increasingly relied upon to support the complex needs of vulnerable young people (Connor, Miller, Cunningham, & Melloni, 2002); thus it is important to evaluate the effectiveness of these services for treating young people.

Bettmann and Jasperson (2009) reviewed the outcomes literature investigating the effectiveness of residential and inpatient treatment settings for young people, suggesting that residential settings for LAC and inpatient services are two comparable milieus. Similar to inpatient units, LAC residential settings are out-of-home, 24hr care-facilities, and the main purpose of both settings is to help young people to achieve internal stability and psychological health (Connor et al., 2002; Hair, 2005). Although residential homes for LAC are typically less restrictive than inpatient units (Connor et al., 2002; Larzelere, Dinges, Schmidt, Spellman, Criste, & Connell, 2001), the stay in residential settings is generally longer than that of an inpatient admission (Hair, 2005; Larzelere et al., 2001). Both inpatients and LAC in residential settings experience extreme behavioural and psychological difficulties which have usually been unsuccessfully treated in outpatient services (Blanz & Schmidt, 2000; Connor et al., 2002).

For decades, residential settings have been criticised regarding the necessity of removing children from their home environments for their safety (Bettmann & Jasperson, 2009). Many researchers and clinicians have questioned how inpatient and residential settings persist when there is a substantial risk of harm associated with grouping young people with similar difficulties together (Barth, 2005). Although some researchers acknowledge the benefits of being able to remove and protect young people from potentially harmful or abusive environments (Burns, Hoagwood, & Mrazek, 1999), others argue that services that attempt to impose an authoritative structure onto young people that have typically experienced chaotic, abusive and neglectful environments will feel confusing, unpleasant and uncomfortable (Ward, 2004). Moreover, Underwood and colleagues (Underwood, Barrett, Storms, & Safonte-Strumolo, 2004) suggest that such settings may even be traumatic for young people, given that many are forcibly placed in such services.

Although critics have challenged the effectiveness of inpatient and residential settings for young people with mental health difficulties, the outcome literature does suggest that these services offer successful interventions for young people (Bettmann & Jasperson, 2009); demonstrated by positive behaviour change (Lyons, Terry, Martinovich, Peterson, & Bouska., 2001) and improvements in social and familial functioning (Hooper, Murphy, Devaney, & Hultman, 2000; Larzelere et al., 2001). However, several methodological concerns, such as no comparison group and a reliance on retrospective self-report measures, threaten the validity and reliability of this research (Swales & Kiehn, 1995; Blanz & Schmidt, 2000). Moreover, the voices of the young people in the present research who described these services as “making them worse” and an “unpleasant environment” cannot be ignored. This led me to consider my interest in therapeutic communities and whether the philosophy of a therapeutic environment could be applied to inpatient and residential settings. Although therapeutic communities were initially developed for adults experiencing significant emotional and interpersonal difficulties (e.g. personality disorders) and/or severe mental health conditions such as psychosis, I wonder whether the same principles could be helpful for young people with mental health difficulties.

Therapeutic communities first started to emerge in the 1960’s (Manning, 2013). They aimed to create a more democratic and user-led therapeutic environment which avoided the authoritarian practices of traditional psychiatric and medical establishments (Jones, 2013). The core value of such communities is that clients are active participants in their own and each other’s treatment and recovery, and that the groups are self-sufficient with clients and staff sharing the responsibility for the running of the community. Since their introduction, therapeutic communities have gained a sound reputation for cost-effective success in rehabilitation, therapeutic effectiveness and patient satisfaction (Jones, 2013).

What emerged from the present research findings was a need for social connectedness among young people, and this fits with the principles of the therapeutic community (Kennard, 2004; Ward, 2003). Perhaps inpatient and residential settings could instill elements of the therapeutic community philosophy within their establishments to encourage a more service-user led and social model of care. As suggested within the research paper, the development of a peer support group, co-facilitated by patients and staff, may help to encourage young people to become active participants in their own treatment and to feel more responsible for their recovery. I also wonder whether the creation of a therapeutic milieu such as this would help to reduce the stigma and the sense of competition among adolescents who self-harm within inpatient and residential settings. Although service standards for therapeutic communities for children and young people have been developed (O'Sullivan, Shah & Paget, 2007), there is a dearth of research investigating the implementation of such service standards within inpatient settings and the effectiveness of therapeutic communities for children and young people.

My personal journey through training

My clinical psychology training journey has coincided with a very challenging three years in my non-professional life. Shortly after starting a doctorate in clinical psychology, my father was diagnosed with terminal cancer and given a devastating prognosis of 6 months without treatment and up to 18 months with treatment. My world was turned upside down. Not only was I faced with accepting my father's mortality, I was also faced with the huge challenge of managing the academic, clinical and personal demands associated with completing a doctorate. As I progressed through training, so did my father's cancer, and completing a thesis felt like an increasingly impossible task.

In February 2016, I learnt a valuable yet difficult lesson about the impact of stress and profound distress on our physiology when I was rushed to hospital with a suspected stroke. I was diagnosed with Bell's Palsy and referred to several specialists for further investigations. I was signed off work resulting in me having to reluctantly surrender my academic and clinical responsibilities, including my thesis. Contrary to what I advocate to all the patients I have worked with over the years, I found it extremely difficult to prioritise my own needs over the needs of others.

Sadly, in April 2016 my father lost his battle to cancer and shortly afterwards I was diagnosed with a benign brain tumor. At this time, I was confronted with the familiar dilemma that I have seen my clients face over the years; fight or flight. Fortunately for me, I was surrounded by a wonderful network of support, including family, friends, colleagues, doctorate peers, university tutors, and research and clinical supervisors; who each contributed to my decision to work through my distress and personal hardship and return to the programme to complete my thesis. However, my circumstances also led me to reflect upon the huge numbers of people facing similar, if not worse, challenges without the same systems of support.

Increasingly through training I have come to value to importance of context and systems of support when formulating psychological distress and the impact that our interpersonal and systemic environment can have on our well-being. Moreover, I have become increasingly interested in how macro-level systems, such as a political climate of increasing austerity in the UK, can exert their influence on the mental health of the society as a whole. I feel that my personal and professional journey since commencing training has broadened my understanding of the challenges facing the profession of clinical psychology, and has helped me to develop a more nuanced understanding of how psychologists can best promote the psychological well-being of the population by working politically and systemically as well as individually.

Sadly, I believe that our society is becoming increasingly individualistic and that this is reflected in the NHS’s changing approach to the treatment of mental health. I can’t help but draw parallels between the increases in societal levels of mental health difficulties and a move away from a collectivist culture of social connectedness. I feel strongly that psychologists are well positioned to promote therapeutic care at a community level that will challenge stigma around mental health and reduce social isolation. As I near the end of my professional training, I look forward to the challenge of advocating for social change, and the opportunity to work pragmatically and in the best interests of individuals, groups and society as a whole.

References

Baker, A., Kurland, K., Curtis, P., Alexander, G., & Papa-Lentini, C. (2007). Mental health and behavioral problems of youth in the child welfare system: Residential treatment centers compared to therapeutic foster care in the Odyssey Project population. *Child Welfare*, *86*(3), 97–123.

Barth, R. P. (2005). Residential care: From here to eternity. International Journal of Social Welfare, 14(3), 158–162. doi:10.1111/j.1468-2397.2005.00355.x.

Bettmann & Jasperson (2009). Adolescents in Residential and Inpatient Treatment: A Review of the Outcome Literature. *Child Youth Care Forum*, 38:161–183 DOI 10.1007/s10566-009-9073-y

Blanz, B., & Schmidt, M. H. (2000). Preconditions and outcome of inpatient treatment in child and ado- lescent psychiatry. Journal of Child Psychology and Psychiatry, and Allied Disciplines, 41(6), 703– 712. doi:10.1111/1469-7610.00658.

British Psychological Society. (2014). *Standards for Doctoral programmes in Clinical Psychology*. Leicester: British Psychological Society. Retrieved from: http://www.bps.org.uk/system/files/Public%20files/PaCT/dclinpsy_standards_approved_may_2014.pdf

Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. Clinical Child and Family Psychology Review, 2(4), 199–254. doi:10.1023/A: 1021826216025.

Connor, D. F., Miller, K. P., Cunningham, J. A., & Melloni, R. H., Jr. (2002). What does getting better mean? Child improvement and measure of outcome in residential treatment. The American Journal of Orthopsychiatry, 72(1), 110–117. doi:10.1037/0002-9432.72.1.110.

Davies, M. (2015). *NHS Research Ethics Approval: Open to Interpretation?* Retrieved from: http://www.nuffieldtrust.org.uk/node/4010

Department of Health. (2012). *Preventing suicide in England: A cross-government outcomes strategy to save lives.* HMSO: London.

Di-Cicci-Bloom, B., & Crabtree, B. (2006). The Qualitative Research Interview. *Medical Education,* 40: 314-321. http://dx.doi.org/10.1111/j.1365-2929.2006.02418.x

Hair, H. J. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993 to 2003. Journal of Child and Family Studies, 14(4), 551–575. doi:10.1007/s10826- 005-7188-9.

Harpaz-Rotem, I., Leslie, D., & Rosenheck, R. A. (2004). Treatment retention among children entering a new episode of mental health care. Psychiatric Services (Washington, DC), 55(9), 1022–1028. doi: 10.1176/appi.ps.55.9.1022.

Hasking, P., Andrews, T., Graham, M. (2013). The role of exposure to self-injury among peers in predicting later self-injury. *Journal of Youth and Adolescence*, 42:1543-1556. http://dx.doi.org/10.1007/s10964-013-9931-7

Haverkamp, B. E. (2005). Ethical perspectives on qualitative research in applied psychology. *Journal of Counselling Psychology*, *52*(2), 146-155. http://dx.doi.org/10.1037/0022-0167.52.2.146

Health Research Authority. (2014). *Health Research Authority: Annual Report and Accounts*. UK: NHS Health Research Authority. Retrieved from: http://www.hra.nhs.uk/documents/2015/07/hra-annual-report-9-months-31december-2014-v-2-0.pdf

Hooper, S. R., Murphy, J., Devaney, A., & Hultman, T. (2000). Ecological outcomes of adolescents in a psychoeducational residential treatment facility. The American Journal of Orthopsychiatry, 70(4), 491–500. doi:10.1037/h0087807.

Hughes, P., & Kerr, I. (2000). Transference and countertransference in communication between doctor and patient. *Advances in Psychiatric Treatment,* **6**:57–64. http://dx.doi.org/10.1192/apt.6.1.57

Hurley, K., Trout, A., Chmelka, M., Burns, B., Epstein, M., Thompson, R., & Daly, D. (2009). The changing mental health needs of youth admitted to residential group home care comparing mental health status at admission in 1995 and 2004. *Journal of Emotional and Behavioral Disorders*, *17*(3), 164-176. http://dx.doi.org/10.1177/1063426608330791

Jones, M. (2013). *Social psychiatry: A study of therapeutic communities*. Routledge: Oxon.

Kennard, D. (2004). The therapeutic community as an adaptable treatment modality across different settings. *Psychiatric Quarterly*, *75*(3), 295-307. http://dx.doi.org/10.1023/b:psaq.0000031798.95075.26

Larzelere, R. E., Dinges, K., Schmidt, M. D., Spellman, D. F., Criste, T. R., & Connell, P. (2001). Outcomes of residential treatment: A study of the adolescent clients of girls and boys town. Child & Youth Care Forum, 30(3), 175–185. doi:10.1023/A:1012236824230.

Lyons, J. S., Terry, P., Martinovich, Z., Peterson, J., & Bouska, B. (2001). Outcome trajectories for adolescents in residential treatment: A statewide evaluation. Journal of Child and Family Studies, 10(3), 333–345. doi:10.1023/A:1012576826136.

Manning, N. (2013). *The therapeutic community movement: Charisma and routinisation*. Routledge: Oxon.

Swales, M. A., & Kiehn, B. (1995). Evaluating adolescent units: Some considerations for research and clinical practice [electronic version]. Journal of Mental Health, 4, 227–242 from 10.1080/096 38239550037505

Underwood, L. A., Barretti, L., Storms, T. L., & Safonte-Strumolo, N. (2004). A review of clinical characteristics and residential treatments for adolescent delinquents with mental health disorders: A promising residential program. Trauma, Violence and Abuse, 5(3), 199–242. doi:10.1177/152483 8004264344.

Ward, A. (2003). *Therapeutic communities for children and young people* (Vol. 10). Jessica Kingsley Publishers: London.

Ward, A. (2004). Towards a theory of the everyday: The ordinary and the special in daily living in residential care. Child & Youth Care Forum, 33(3), 209–225. doi:10.1023/B:CCAR.0000029686. 10310.49.

Section 4: Ethics

Running head: ETHICS

Ethics Section

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Doctorate in Clinical Psychology

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Final NHS research ethics form

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select ‘Save’ and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Understanding the self-harm of others

1. Is your project research?

● Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product

○ Clinical investigation or other study of a medical device

○ Combined trial of an investigational medicinal product and an investigational medical device

○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice

○ Basic science study involving procedures with human participants

○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology

● Study involving qualitative methods only

○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)

○ Study limited to working with data (specific project only)

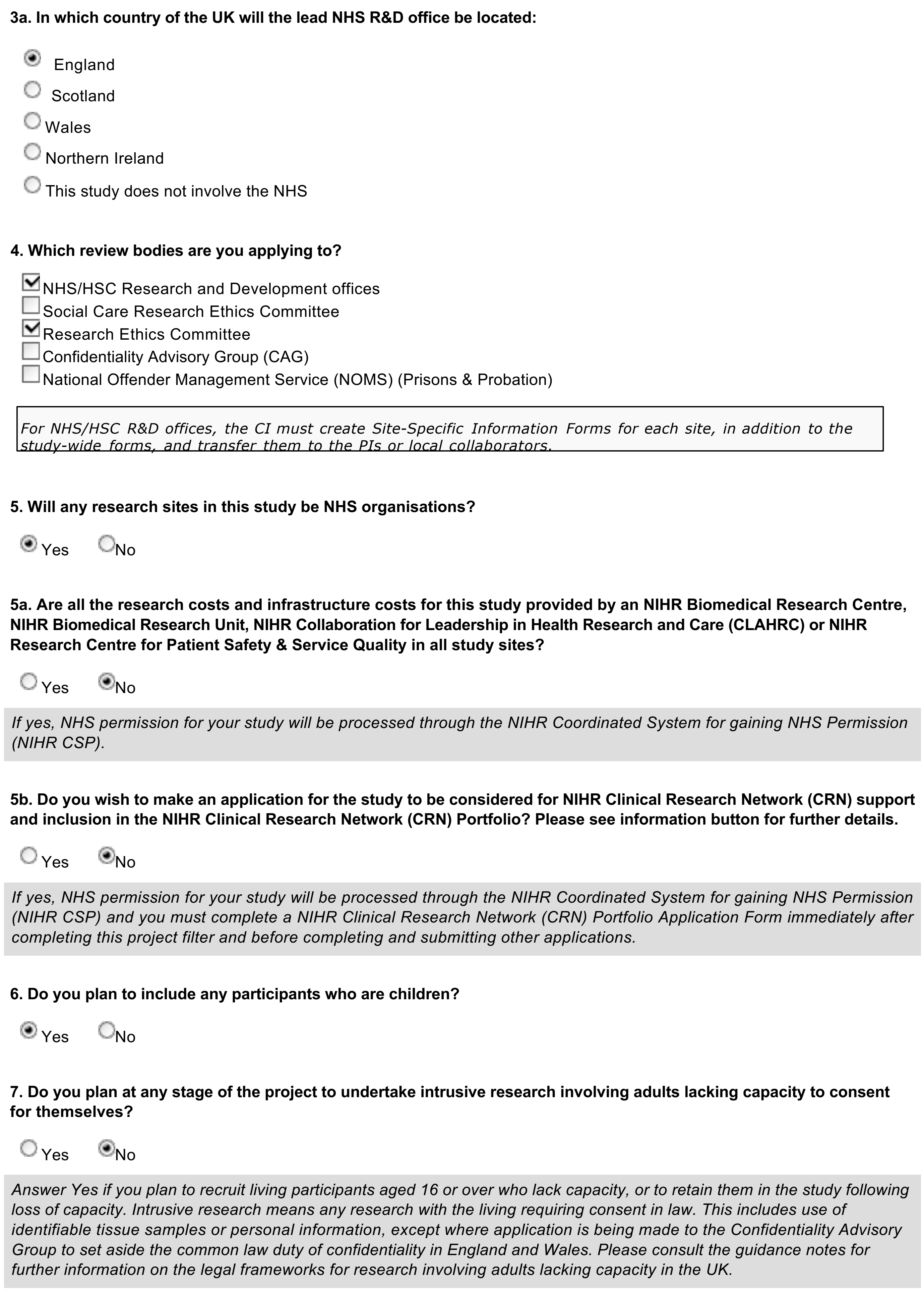
○ Research tissue bank

○ Research database

If your work does not fit any of these categories, select the option below:

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation? ○ Yes ●
No b) Will you be taking new human tissue samples (or other human biological samples)? ○ Yes
● No c) Will you be using existing human tissue samples (or other human biological samples)? ○ Yes
● No



3a. In which country of the UK will the lead NHS R&D office be located:

● England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which review bodies are you applying to?

☑ NHS/HSC Research and Development offices
☐ Social Care Research Ethics Committee
☑ Research Ethics Committee
☐ Confidentiality Advisory Group (CAG)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

● Yes ○ No

5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?

○ Yes ● No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.

○ Yes ● No

If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.

6. Do you plan to include any participants who are children?

● Yes ○ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ● No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ● No

9. Is the study or any part of it being undertaken as an educational project?

● Yes ○ No

Please describe briefly the involvement of the student(s):
Chief Investigator

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

● Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ● No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ● No

Integrated Research Application System
Application Form for Research involving qualitative methods only

Health Research Authority

Application to NHS/HSC Research Ethics Committee

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familiar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Understanding the self-harm of others

Please complete these details after you have booked the REC application for review.

REC Name:
XXXXXXXXXXXXXXXX

REC Reference Number:	**Submission date:**
XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Miss	Claire	Smith

Address 5 Catlow Court
Southfield Lane, Southfield, Burnley
Lancashire
Post Code BB10 3RN
E-mail c.smith9@lancaster.ac.uk
Telephone XXXXXXXXXXXX
Fax

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Doctorate in Clinical Psychology

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

Title	Forename/Initials	Surname
XX	XXXXX	XXXXXXX

Address	XXXXXXXXXXXXXXXXXXXXX
Post Code	XXXXXXXXX
E-mail	XXXXXXXXXXXXXXXXX
Telephone	XXXXXXXXXXXX

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	**Academic supervisor(s)**
Student 1 Miss Claire Smith	☐ XXXXXXXXXXXXXXX

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

● Student
○ Academic supervisor
○ Other

A3-1. Chief Investigator:

Title	Forename/Initials	Surname
Miss	Claire	Smith

Post	Trainee Clinical Psychologist
Qualifications	MSc Clinical and Health Psychology
Employer	Lancashire Care NHS Foundation Trust
Work Address	5 Catlow Court, Southfield Lane, Southfield, Burnley, Lancashire
Post Code	BB10 3RN

Work E-mail	c.smith9@lancaster.ac.uk
* Personal E-mail	
Work Telephone	XXXXXXXXXXXX
* Personal Telephone/Mobile	
Fax	

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and R&D reviewers that is sent to the CI.

Title	Forename/Initials	Surname
XX	XXXXXXXX	XXXXXX

Address	Research Support Office B58 Bowland Main Lancaster University, Lancaster
Post Code	LA1 4YT
E-mail	ethics@lancaster.ac.uk
Telephone	XXXXXXXXXXXXX
Fax	

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	
Sponsor's/protocol number:	
Protocol Version:	
Protocol Date:	
Funder's reference number:	
Project website:	

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ● No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, this summary will be published on the website of the National Research Ethics Service following the ethical review.*

Self-harm by young people is an area that requires more research in order to effectively direct treatment and resources. Relatively little is known about why young people start self-harming and what factors may be associated with engagement in self-harm over time (Hasking, Andrews & Martin, 2013). Emerging research, however, has suggested that peer influence may aid understanding around these issues.

Numerous studies have shown that young people reporting self-harm know more friends who self-injure relative to those not reporting this behaviour (Claes, Houben, Vandereycken, Bijttebier & Muehlenkamp, 2010). There is also concern that adolescents exposed to others self-harm will then be at risk of self-harming themselves (Robins & Conroy, 1983; Gould, Wallenstein & Kleinman, 1990; Taiminen et al., 1998).

Self-harm is of particular concern in residential settings, where its incidence is higher than elsewhere (Apter & Freudenstein, 2000). Within tier 4 inpatient settings, the present research aims to explore using a qualitative interview-based methodology, adolescents' experiences of others' self-harm (including peers, parents and adults) and the impact that exposure to self-harm can have upon young people. Such information may help to increase understanding of the potential impact that experiencing the self-harm of others may have on adolescents and help inform prevention and early intervention programmes for self-harm.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Practical issues
This research has a number of practical issues to be considered:

Interview location - Interviews will be arranged to take place at the inpatient unit in which the young person is residing. The Field Supervisor or a member of the Doctorate in Clinical Psychology administration team will aware of the date, time and location of interviews and measures will be taken to ensure that the Chief Investigator is able to communicate with the base.

Costs - Any printing, postage or photocopying costs associated with the study will be covered by Clinical Psychology Department at Lancaster University. Digital audio recording and transcription equipment, including foot pedals and headphones are available from the same department.

Ethical Issues
Ethical approval will be sought via submission to the Integrated Related Application System (IRAS). There are a number of ethical issues which will be considered throughout the design and implementation of this research:

Informed consent – Young people over the age of 16 will not be able to take part in this research if they are unable to give consent to participate. Capacity to consent will be assessed by the care team. Young people under the age of 16 will need the consent of their parent or guardian in order to participate.

Confidentiality and Anonymity – It is acknowledged that, due to the setting in which this research is taking place and the necessary liaison with the clinical team, the ward staff will be aware of who is participating in the research. However, attempts have been made to ensure that confidentiality is safeguarded as far as possible as the researcher will not have access to information about any young person unless they have expressed an interest to participate in the study. The researcher will ensure that any identifying information is removed from quotations featuring in the final piece of work in order to protect participants' identity as far as possible. Young people will be provided with information regarding anonymity and confidentiality via the participant information sheet and consent form.

Storage of data/information – All digital data will be transferred from the digital recorder to password protected file space on the University server immediately after interview and deleted from the recording device. All data will then be accessible from the University server. No data will be stored on any computer. Only the Chief Investigator (Claire Smith) and her academic supervisor (XXXXXXXXXXXXXX) will have access to the audio recordings and transcripts. Any hard copies of data which contains personal details (e.g. demographic information sheets and consent to contact sheets) will be stored in a lockable filing cabinet and destroyed as soon as possible. In accordance with the University and DClinPsy programme policy, data will be electronically stored for ten years after the thesis has been examined and then destroyed.

Negative or distressing impact of interviews – Members of the care team will be asked to inform the researcher of any young people for whom participation in the research may be detrimental (e.g. due to current presentation or risk issues). Should a participant become distressed during the interview process they will be given the opportunity to end the interview or to take a break. If the researcher has concerns regarding the impact of the interview upon a participant, this information will be shared with the shift leader on the ward and discussed with a research supervisor. Members of the care team will be available to support participants following completion of the research interview. Information regarding support agencies for young people will be provided on the Participant information sheet.

Potential disclosure(s) made in interview which lead to concern with regard to safety of the participant or others– It is recognised that it may be necessary for the researcher to breach confidentiality if it is suggested that the safety of the participants or others may be compromised. Should this issue arise the researcher will contact the field supervisor / university supervisor in order to discuss the best course of action. If appropriate, young people who have disclosed any concerning information would be notified that it is necessary to breach confidentiality. Participants will be reminded of these limits of confidentiality prior to the start of the interview.

Risks and Benefits to Participants - It may be distressing for young people to discuss the self−harm of others. However, it is anticipated that their accounts may help to increase understanding of the potential impact that experiencing the self-harm of others may have on adolescents and will help inform prevention and early intervention programmes for self-harm and contribute to service development in the future. Research by Biddle, Cooper, Owen-Smith, Klineberg, Bennewith, Hawton et al. (2012) has shown that participating in interviews about self-harm can have a cathartic effect and the findings suggest individuals are more likely to derive benefit from participation than experience harm.

A6-3. Proportionate review of REC application *The initial project filter has identified that your study may be suitable for proportionate review by a REC sub-committee. Please consult the current guidance notes from NRES and indicate whether you wish to apply through the proportionate review service or, taking into account your answer to A6-2, you consider there are ethical issues that require consideration at a full REC meeting.*

○ Yes - proportionate review ● No - review by full REC meeting

Further comments (optional):

Note: This question only applies to the REC application.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply*:

☐ Case series/ case note review
☐ Case control
☐ Cohort observation
☐ Controlled trial without randomisation
☐ Cross-sectional study
☐ Database analysis
☐ Epidemiology
☐ Feasibility/ pilot study
☐ Laboratory study
☐ Metanalysis
☑ Qualitative research
☐ Questionnaire, interview or observation study
☐ Randomised controlled trial

☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

Self-harm by young people is an area that requires more research in order to effectively direct treatment and resources. Self-harm is of particular concern in residential settings, where its incidence is higher than elsewhere. Within inpatient settings, the present research aims to explore using a qualitative interviews, adolescents' experiences of others people's self-harm (including peers, parents and adults) and the impact that exposure to self-harm can have upon them. Such information may help to increase understanding of the potential impact that experiencing the self-harm of others may have on adolescents and help inform prevention and early intervention programmes for self-harm.

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

The research also aims to promote and contribute to evidence−based practice within inpatient services.

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

Self−harm is recognised as a common yet serious problem in the UK (Hawton, Rodham, Evans, & Weatherall, 2002). It is estimated that self−harm accounts for approximately 25,000 presentations from children and adolescents at general hospitals in the UK each year, however, due to the private nature of self−harm, actual prevalence rates of self-harm may be much higher than this (Hawton et al., 2002). Despite its prevalence, there is no established universal definition for self-harm. The current research views self-harm, like Hawton and colleagues, as intentional self-injury or self-poisoning, irrespective of motivation or degree of suicidal intent (Hawton, Harriss, Simkin, Bale, & Bond, 2003).

Self-harm by young people is an area that requires more research in order to effectively direct treatment and resources. Relatively little is known about why young people start self-harming and what factors may be associated with engagement in self-harm over time (Hasking, Andrews & Martin, 2013). Emerging research, however, has suggested that peer influence may aid understanding around these issues.

Numerous studies have shown that young people reporting self-harm know more friends who self-injure relative to those not reporting this behaviour (Claes, Houben, Vandereycken, Bijttebier & Muehlenkamp, 2010). There is also concern that adolescents exposed to others self-harm will then be at risk of self-harming themselves (Robins & Conroy, 1983; Gould, Wallenstein & Kleinman, 1990; Taiminen et al., 1998).

Further, research by Prinstein, Helibron, Guerry, Franklin, Rancourt, Simon et al. (2010) and Hasking et al. (2013) suggests exposure to self-harm through friends may not only be related to the frequency of self-harm among adolescents but also the initiation of this behaviour (Heath, Ross, Toste, Charlebois & Nedecheva, 2009; Deliberto & Nock, 2008). Based on this research, it is difficult to untangle whether these individuals are emulating their friend's behaviour or whether apparent contagion effects may reflect associative relationships, whereby individuals with similar risk factors are more likely to become friends (Joiner, 1999).

Self-harm is of particular concern in residential settings, where its incidence is higher than elsewhere (Apter & Freudenstein, 2000). Within tier 4 inpatient settings, the present research aims to explore using a qualitative interview-based methodology, adolescents' experiences of others' self-harm (including peers, parents and adults) and the impact that exposure to self-harm can have upon young people. Such information may help to increase understanding of the potential impact that experiencing the self-harm of others may have on adolescents and help inform prevention and early intervention programmes for self-harm.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

Young people will recruited to take part in this study from one of two North XXXXX adolescent inpatient units.

Information regarding the research will be provided via advertisement posters displayed on the ward, the lead researchers attendance at community meetings and 1:1 psychology and nursing sessions. Smaller versions of the posters will also be used as fliers. Posters and fliers will direct potential participants to speak to the psychologists at the service. Psychologists will then liaise with the clinical team to check inclusion/exclusion criteria, and if they are met, a participant information sheet will be provided.

It is possible that not all young people who express an interest in participating will be selected to participate. A sample of young people will be selected in order to ensure that both wards are represented.

If a young person is over the age of 16 they will be asked to provide consent via the completion of a consent form. Young people under the age of 16 will be asked to complete an assent form and their parents / guardian will be asked to complete a parent / guardian consent form.

If a young person is selected to participate, arrangements will be made to carry out a 1:1 interview lasting approximately one hour. Some demographic information will also be collected at the beginning of the interview in order to provide a context in which each participant's individual experiences can be understood.

Interviews will be recorded and typed up into an anonymised transcript for analysis. Immediately prior to the interview the researcher will approach the nurse in charge of the ward in order to check that the information previously provided regarding exclusion criteria remains accurate.

Participants will be given the option to have someone else present with them during the interview (i.e. staff member/parent). Participants will also be given the option of taking a break during the interview, or the interview can be split into two interviews if this is preferable for the participant.

Interviews will take place in an appropriate room, either on or off the ward but at the unit. The location of the interview will depend on the assessment carried out by the care team in relation to risk.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

☑ Design of the research
☐ Management of the research
☐ Undertaking the research
☐ Analysis of results
☐ Dissemination of findings
☐ None of the above

Give details of involvement, or if none please justify the absence of involvement.
During the design of the proposed study, the research protocol was shared with service users at the inpatient service to encourage patient involvement and get feedback on the proposed research design.

In addition, XXXXXXXXXXXX (field supervisor) also presented the research to the Adolescent Research Forum for their feedback and comments.

All the suggestions from these public involvement groups have been incorporated into the present protocol.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Any young person who has been a resident on the ward for more than two weeks will be eligible to take part in an interview.

A young person does not have to have self-harmed themselves to be a participant.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

A young person will be excluded from participating if they meet any of the following criteria:

The clinical team states that the young person is too unwell to participate at present, e.g. experiencing significant delusional ideation which would impact upon their ability to engage.

The clinical team's assessment indicates that the interview process is likely to have a detrimental effect on their mental health.

The clinical team's assessment indicates that the young person may have cognitive or communication difficulties that would make it too difficult to engage in a one to one interview at that time.

The clinical team's assessment indicates that the young person is unable to give informed consent.

They would require an interpreter in order to participate.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Seeking consent/assent	1	N/A	15	Chief Investigator will seek consent (from young people over 16 years old) and assent (from young people under 16 years). This process will take place in a private place on the unit or, if deemed appropriate by the care team, in an alternative private room on the hospital site.
Face to face interview	1	N/A	60	All interviews will be conducted by the chief investigator (CI). This process will take place in a private place on the unit or, if deemed appropriate by the care team, in an alternative private room on the hospital site.

A21. How long do you expect each participant to be in the study in total?

The duration of time that each participant will be involved in the study will be approximately 6 weeks between expressing interest and gaining informed consent and end of interview. This will largely depend on how quickly a convenient time for the interview can be agreed.

The study is expected to involve approximately two hours' participation for each participant. This includes time taken to speak to the psychologist about the research, read information sheets, complete consent/assent and demographic information forms and the interview itself.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

Members of the care team will be asked to inform the researcher of any young people for whom participation in the research may be detrimental (e.g. due to current presentation or risk issues). If a young person is likely to be adversely effected by participating in the research they will be excluded from the research. Should a participant become distressed during the interview process they will be given the opportunity to end the interview or to take a break.

If the researcher has concerns regarding the impact of the interview upon a participant, this information will be shared with the shift leader on the ward and discussed with a research supervisor. It is hoped that members of the care team will be available to support participants following completion of the research interview. Information regarding support agencies for young people will be provided on the Participant information sheet.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

● Yes ○ No

If Yes, please give details of procedures in place to deal with these issues:

As this research will include questions regarding a young person’s experience of other's self-harm and the impact it has had upon them, there is potential for participants to experience difficult emotions during the interview process. Should a participant become distressed during the interview process they will be given the opportunity to end the interview or to take a break.

If the researcher has concerns regarding the impact of the interview upon a participant, this information will be shared with the shift leader on the ward and discussed with a research supervisor. It is hoped that members of the care team
will be available to support participants following completion of the research interview. Information regarding support agencies for young people will be provided on the Participant information sheet.

A24. What is the potential for benefit to research participants?

Although there will be no direct measurable benefits for participants, for many the chance to talk about their experiences can have a cathartic effect and be beneficial. It is anticipated that their accounts will contribute to service development, inform future work with young people who self-harm and to feedback to staff with the view to improve professionals' understanding of their issues and concerns.

A26. What are the potential risks for the researchers themselves? *(if any)*

The researcher will be conducting research in an inpatient setting. Therefore, it is necessary for the researcher to be aware of any potential risk issues associated with this setting and any specific concerns regarding the young people participating. As such, the researcher will ensure that regular contact is made with care staff in each recruitment locations and that risk assessments are up to date in order to ensure safe practice is maintained.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Up to 10 participants, male or female, aged between 13 and 18 years who have been admitted to one of two XXXXXXXXXXX adolescent mental health inpatient units will be recruited for this study.

Initially, potential participants will be made aware of the project via the researcher’s attendance at ward community meetings and the displaying of advertising posters on the wards. Smaller versions of the posters will also be used as fliers. Posters and fliers will direct potential participants to speak to the psychologists at the service for more information about the study. The local collaborator (XXXXXXXXXXX) will then liaise with the clinical team to check inclusion/exclusion criteria, and if they are met, a participant information sheet will be provided. If after reading the participant information sheet they still wish to take part, consent will be sought directly from young people over the age

Parent / guardian consent forms must be completed prior to any interview arrangements being made with the young person.

Once consent/assent is confirmed, the local collaborator will contact the researcher to book the interview. Immediately prior to the interview the researcher will approach the nurse in charge of the ward in order to check that the information previously provided regarding exclusion criteria remains accurate, and all consent forms will be collected.

In order to ensure that the sample is as representative of the two recruitment sites as possible, attempts will be made to ensure that a range of participants take part in the interviews. As such, not every young person who volunteers to participate will be selected for interview.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ● No

Please give details below:

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

● Yes ○ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

Posters will be displayed in communal areas on each participating unit. The chief investigator will also attend community meetings in order to provide information regarding the research project and to provide young people with participant information sheets.

A29. How and by whom will potential participants first be approached?

The principal researcher will attend community meetings in order to provide information regarding the project. The research will also be publicised utilising posters displayed in communal areas. Young people will also be provided with information regarding the project via the care team.

A30-1. Will you obtain informed consent from or on behalf of research participants?

● Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Participants over the aged of 16 will be asked to confirm that they consent to taking part via the completion of a consent form. Young people under the age of 16 will complete an assent form and their parent or guardian will be provided with a parent / guardian information sheet and asked to complete a parent / guardian consent form.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

● Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

Participants will not be allowed to volunteer to participate until they have been in receipt of the relevant information, via provision of a participant information sheet, for more than 24 hours.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

Due to the financial and practical constraints associated with this study, provision will not be made for young people who do not speak English or who have significant communication difficulties to participate in the study. This exclusion criterion has been used as it assumed that young people who do not speak English or have communication difficulties may have considerably different experiences.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

● Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☐ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☑ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☑ Use of audio/visual recording devices
- ☐ Storage of personal data on any of the following:
  - ☐ Manual files including X−rays
  - ☐ NHS computers
  - ☐ Home or other personal computers
  - ☑ University computers

☐ Private company computers
☐ Laptop computers

Further details:
The interview will be audio recorded onto a digital recorder. Any identifiable data will be transferred to an encrypted, password protected computer as soon as is practicably possible and the original recording will be deleted. Audio recordings will be deleted following completion of the study.

Data will then be transcribed and anonymised by the chief investigator. Anonymised transcripts will also be saved on a encrypted,password protected file on a secure computer. Anonymised transcripts and completed consent forms will be scanned electronically and stored on a password protected, encrypted file space on the University server, the contents of which will be deleted 10 years after the project
has been completed. Storage and deletion of this material will be the responsibility of the Research Coordinator (Doctorate in Clinical Psychology, Lancaster University).

Anonymised quotations will be utilised in the final research and any subsequent publications. Participants will be made aware that direct quotations will be used and that these will be anonymised in order to ensure that they will not be identifiable from these quotes.

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

In order to maintain confidentiality of personal data pseudonyms will be assigned for each participants and all identifying information, including that relating to the identification of the service, will be removed from transcripts and the resulting final research. Where verbatim quotes are used, identifiers will be omitted or changed to preserve participant anonymity.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Nobody outside the direct care team will have access to participants personal data during the study. The identity of participants actually taking part in the study will be known only to myself and the direct care team. I will keep all participant information and research data confidential. As part of supervision, XXXXXXXXX (Academic Supervisor) will have access to the research data (including transcripts and listening to audio recordings).

Storage and use of data after the end of the study

A43. How long will personal data be stored or accessed after the study has ended?

● Less than 3 months
○ 3 – 6 months
○ 6 – 12 months
○ 12 months – 3 years
○ Over 3 years

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

○ Yes ● No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ● No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ● No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ● No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

○ Yes ● No

Please give details, or justify if not registering the research.
No public database available.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study?*Tick as appropriate:*

☑ Peer reviewed scientific journals

☑ Internal report

☐ Conference presentation

☐ Publication on website ☑
Other publication

☐ Submission to regulatory authorities
☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators

☐ No plans to report or disseminate the results

☐ Other (please specify)
There is potential for the results of this investigation to be disseminated via a range of avenues:
- Publication in a peer reviewed journal
- Presentation of research at Lancaster University
- Sharing of results with participants
- Sharing of results with recruitment sites
- Sharing of results with service user groups

A53. Will you inform participants of the results?

○ Yes ● No

Please give details of how you will inform participants or justify if not doing so.
The young people who participate in this research will not be contacted directly by the researcher with the results of the project as they will not be asked to provide their contact details and will no longer have contact with the service by the time the results are published. However, the results of this research will be disseminated via a range of alternative avenues as described above.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed?*Tick as appropriate:*

☐ Independent external review
☐ Review within a company
☐ Review within a multi−centre research group
☑ Review within the Chief Investigator's institution or host organisation
☑ Review within the research team
☑ Review by educational supervisor
☑ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The research protocol has been reviewed by the academic supervisor (XXXXXXXXXXXXXXX) and field supervisor (XXXXXXXXXXX), to ensure the research question is valid and the project is suitably designed. During the design of the proposed study, I also consulted with service users at the inpatient service to encourage patient involvement and get feedback on the proposed research design. In addition, XXXXXXXXXXX (field supervisor) also presented the research to the Adolescent Research Forum for their feedback and comments. All the suggestions from these public involvement groups have been incorporated into the present protocol.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size:	10
Total international sample size (including UK):	10
Total in European Economic Area:	

Further details:
Up to 10 participants will be recruited for this investigation.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

Interpretative Phenomenological Analysis (IPA) studies are conducted with relatively small sample sizes in order to allow for a detailed exploration of participants experiences, perceptions and understanding. Up to 10 participants will be recruited for this investigation. The number of participants recruited will partially rely upon the richness of the data collected. It is anticipated that by recruiting up to 10 participants, analysis will allow for an in depth exploration as well as the examination of similarities and differences.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The data collected will be analysed using Interpretative Phenomenological Analysis (IPA). This approach aims to explore how people make sense of their experiences via the analysis of detailed first person accounts (Larkin & Thompson, 2012). The researcher aims to understand the meanings that are made by participants by gathering information about the ways in which they relate to the world. In order to do this effectively, it is essential that the researcher considered their own experiences and assumptions and reflects upon their role in the development of interpretations. A reflective research journal will be used alongside supervision in order to facilitate the process of analysis. Thematic validity will be checked via supervision with research supervisors.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co‑applicants, protocol co‑authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	XX	XXXXXXXX	XXXX
Post	XXXXXXXXXXXXX		
Qualifications	PhD		
Employer	Lancaster University		
Work Address	Doctorate in Clinical Psychology, Faculty of Health Research Furness College, Lancaster University Lancaster		
Post Code	LA1 4YG		
Telephone	XXXXXXXXX		
Fax			
Mobile			
Work Email	XXXXXXXXXXXXXX		

	Title	Forename/Initials	Surname
	Dr	XXXX	XXXXXX
Post	Clinical Psychologist		
Qualifications	Doctorate in Clinical Psychology		
Employer	XXXXXXXXXXXXXXXXXXXXXXXX		
Work Address	XXXXXXXX XXXXXXXXXX XXXXXXX		
Post Code	XXXXXX		
Telephone	XXXXXXXXX		
Fax			
Mobile			
Work Email	XXXXXXXXXXXXXXXXX		

	Title	Forename/Initials	Surname
	XX	XXXXXXXX	XXXXX
Post	Clinical Psychologist		
Qualifications	Doctorate in Clinical Psychology		

Employer	XXXXXXXXXXXXXXXXXXX
Work Address	XXXXXXXXXXXX XXXXXXXXXX XXXXXXXXX
Post Code	XXXXXXX
Telephone	XXXXXXXXXX
Fax	
Mobile	
Work Email	XXXXXXXXXXXXXXXXX

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:	○ NHS or HSC care organisation ● Academic ○ Pharmaceutical industry ○ Medical device industry ○ Local Authority ○ Other social care provider (including voluntary sector or private organisation) ○ Other	Commercial status:	Non-Commercial

If Other, please specify:

Contact person

Name of organisation	Lancaster University
Given name	XXXXX
Family name	XXXXXXX
Address	Research Support Office, B58 Bowland Main
Town/city	Lancaster University, Lancaster
Post code	LA1 4YT
Country	UNITED KINGDOM
Telephone	XXXXXXXXXXXXX
Fax	
E-mail	ethics@lancaster.ac.uk

Is the sponsor based outside the UK?

○ Yes ● No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

☐ Funding secured from one or more funders

☐ External funding application to one or more funders in progress

☑ No application for external funding will be made

What type of research project is this?

● Standalone project

○ Project that is part of a programme grant

○ Project that is part of a Centre grant

○ Project that is part of a fellowship/ personal award/ research training award

○ Other

Other – please state:

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ● No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

	Title Forename/Initials Surname XXXXXXXXXXXXXX
Organisation	XXXXXXXXXXXXXX
Address	XXXXXXXXXXXXXXXX XXXXXXXXXXXX XXXXXXXXX
Post Code	XXXXXXX
Work Email	XXXXXXXXXXXXXXXX
Telephone	XXXXXXXXXXXXX
Fax	
Mobile	

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/06/2015

Planned end date: 31/05/2016

Total duration:

Years: 0 Months: 11 Days: 31

A71-2. Where will the research take place? *(Tick as appropriate)*

☑ England

☐ Scotland

☐ Wales

☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study 2

Does this trial involve countries outside the EU?
○ Yes ● No

A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? *Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:*

☐ NHS organisations in England 2
☐ NHS organisations in Wales
☐ NHS organisations in Scotland
☐ HSC organisations in Northern Ireland
☐ GP practices in England
☐ GP practices in Wales
☐ GP practices in Scotland
☐ GP practices in Northern Ireland
☐ Social care organisations
☐ Phase 1 trial units
☐ Prison establishments
☐ Probation areas
☐ Independent hospitals
☐ Educational establishments
☐ Independent research units
☐ Other (give details)

Total UK sites in study: 2

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only) ☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

PART B: Section 7 - Children

1. Please specify the potential age range of children under 16 who will be included and give reasons for carrying out the research in this age group.

Young people aged between 13 and 18 years will be eligible to take part in this research as this is the age range of young people who can access adolescent inpatient services.

2. Indicate whether any children under 16 will be recruited as controls and give further details.

No children under the age of 16 will be recruited as controls.

3-2. Please describe the arrangements for seeking informed consent from a person with parental responsibility and/or from children able to give consent for themselves.

Potential participants over the age of 16 who are deemed fit to participate in the study will be approached to arrange a suitable time for the interview to take place. Any potential participants under the age of 16 who are deemed fit to participate in the study will be informed that their parent or guardian will be approached in order to seek consent to participate. If this is acceptable and the young person wishes to proceed, parental consent will be sought prior to any further arrangements being made.

Participants over the aged of 16 will be asked to confirm that they consent to taking part via the completion of a consent form. Consent forms will be completed just prior to the interview. Young people under the age of 16 will complete an assent form and their parent or guardian will be provided with a parent / guardian information sheet and asked to complete a parent / guardian consent form.

4. If you intend to provide children under 16 with information about the research and seek their consent or agreement, please outline how this process will vary according to their age and level of understanding.

All young people will be provided with a participant information sheet which has been adapted in order to make it accessible for young people. The chief investigator will ensure that young people participating in the research understand the information provided on the participant information sheet and the consent form. Young people will be provided the opportunity to ask questions regarding the information provided.

Copies of written information sheet(s) for parents and children, consent/assent form(s) and any other explanatory material should be enclosed with the application

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.*

Research site		Investigator/ Collaborator/ Contact	
Institution name	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	Title	Dr
Department name	XXXXXXXXXXXXXXXXXXXXX	First name	XXXXXX
Street address	XXXXXXXXXXXXXXXXXXXXXX		
Town/city	XXXXXXXXXXX	Surname	XXXXXXX
Post Code	XXXXXXX		
Institution name	XXXXXXXXXXXXXXXXXXXXXXXX	Title	Dr
Department name	XXXXXXXXXXXXXXXXXXXXX	First name	XXXXXXX
Street address	XXXXXXXXXX		
Town/city	XXXXXXXXXX	Surname	XXXXXXXX
Post Code	XXXXXXX		

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.

3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.

4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.

5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.

6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.

7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.

8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.

9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:

    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.

10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.

11. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee’s final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

Chief Investigator

Sponsor

Study co-ordinator

Student

Other – please give details

None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by Miss Claire Smith on 27/05/2015 11:10.

Job Title/Post:	Trainee Clinical Psychologist
Organisation:	Lancaster University
Email:	c.smith9@lancaster.ac.uk

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co‒sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.

2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.

3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.

4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.

   Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

This section was signed electronically by An authorised approver at ethics@lancaster.ac.uk on 02/06/2015 15:53.

Job Title/Post:	Research Support Officer
Organisation:	Lancaster University
Email:	XXXXXXXXXXXX

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Dr XXXXXXXXXXXXXX on 27/05/2015 11:24.

Job Title/Post: Lecturer in Health Research

Organisation: Lancaster University

Email: XXXXXXXXXXXXXXXXX

Appendix 4-A: Thesis research protocol

THESIS RESEARCH PROTOCOL

Title:	Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs
Applicant:	Claire Smith, Trainee Clinical Psychologist
Research Supervisors:	Dr XXXXX XXXXXXX (Academic Supervisor) Dr XXXX XXXXXXXXXX (Field Supervisor)

Introduction

Self–harm is recognised as a common yet serious problem in the UK (Hawton, Rodham, Evans, & Weatherall, 2002). It is estimated that self–harm accounts for approximately 25,000 presentations from children and adolescents at general hospitals in the UK each year, however, due to the private nature of self–harm, actual prevalence rates of self-harm may be much higher than this (Hawton et al., 2002). Despite its prevalence, there is no established universal definition for self-harm. The current research views self-harm, like Hawton and colleagues, as intentional self-injury or self-poisoning, irrespective of motivation or degree of suicidal intent (Hawton, Harriss, Simkin, Bale, & Bond, 2003).

Self-harm by young people is an area that requires more research in order to effectively direct treatment and resources. Relatively little is known about why young people start self-harming and what factors may be associated with engagement in self-harm over time (Hasking, Andrews & Martin, 2013). Emerging research, however, has suggested that peer influence may aid understanding around these issues.

Numerous studies have shown that young people reporting self-harm know more friends who self-injure relative to those not reporting this behaviour (Claes, Houben, Vandereycken, Bijttebier & Muehlenkamp, 2010). There is also concern that adolescents exposed to others self-harm will then be at risk of self-harming themselves (Robins & Conroy, 1983; Gould, Wallenstein & Kleinman, 1990; Taiminen et al., 1998).

Further, research by Prinstein, Helibron, Guerry, Franklin, Rancourt, Simon et al. (2010) and Hasking et al. (2013) suggests exposure to self-harm through friends may not only be related to the frequency of self-harm among adolescents but also the initiation of this behaviour (Heath, Ross, Toste, Charlebois & Nedecheva, 2009; Deliberto & Nock, 2008). Based on this research, it is difficult to untangle whether these individuals are emulating their friend's behaviour or whether apparent contagion effects may reflect associative relationships, whereby individuals with similar risk factors are more likely to become friends (Joiner, 1999).

Self-harm is of particular concern in residential settings, where its incidence is higher than elsewhere (Apter & Freudenstein, 2000). Within tier 4 inpatient settings, the present research aims to explore using a qualitative interview-based methodology, adolescents' experiences of others' self-harm (including peers, parents and adults) and the impact that exposure to self-harm can have upon young people. Such information may help to increase understanding of the potential impact that experiencing the self-harm of others may have on adolescents and help inform prevention and early intervention programmes for self-harm.

Method: Participants

Up to 10 participants, male or female, aged between 13 and 18 years who have been admitted to one of two XXXXXXXXXX adolescent mental health inpatient units will be recruited for this study (see procedure for further information about participant recruitment).

Inclusion criteria: Any young person who has been a resident on the ward for more than two weeks will be eligible to take part in an interview. Young people will not be able to participate in an interview before they have been admitted for a period of two weeks as it is thought that they will be less able to reflect on their experiences and the development of important relationships prior to this point. A young person may convey interest in the study prior to this point but will not be interviewed until they have been on the ward for two weeks or more. A young person does not have to have self-harmed themselves to be a participant.

Exclusion criteria: A young person will be excluded from participating if they meet any of the following criteria:

- The care team states that the young person is too unwell to participate at present, e.g. experiencing significant delusional ideation which would impact upon their ability to engage.
- The clinical team's assessment indicates that the interview process is likely to have a detrimental effect on their mental health

- The clinical team's assessment indicates that the young person may have cognitive or communication difficulties that would make it too difficult to engage in a one to one interview at that time
- The clinical team's assessment indicates that the young person is unable to give informed consent
- They would require an interpreter in order to participate.

Method: Design

The study will use a qualitative design employing Interpretative Phenomenological Analysis (IPA) and one to one semi−structured interviews to explore young people's experiences of the self-harm of others. The aim of these interviews is to facilitate an exploratory conversation utilising open ended questions which focus on participants' lived experiences. An interview guide (Appendix 2) will be used in order to facilitate a consistent approach. However, since the participant is considered to be the experiential expert other issues may be introduced by the participant that were not predetermined by the researcher. This approach allows for the development of a rapport between the participant and the researcher, which is critical given the emotive nature of the subject under discussion.

During the design of the proposed study, young people who have experience of others' self-harm were consulted during the development of the interview schedules and related documentation. In addition, XXXXXXXXXX (field supervisor) also presented the research to an Adolescent Research Forum for their feedback and comments. All the suggestions from these public involvement groups have been incorporated into the present protocol.

Method: Procedure

Participants will be recruited from two adolescent inpatient units in the North West of England. Initially, potential participants will be made aware of the project via the researcher's attendance at ward community meetings and the displaying of advertising posters on the wards (see Appendix 1). Smaller versions of the posters will also be used as fliers. Posters and fliers will be direct potential participants to speak to the psychologists at the service. Psychologists will then liaise with the clinical team to check inclusion/exclusion criteria, and if they are met, a participant information sheet will be provided (Appendix 3). If they still wish to take part, then the psychologists will contact the researcher to book the interview.

Potential participants over the age of 16 who are deemed fit to participate in the study will be approached to arrange a suitable time for the interview to take place. Any potential participants under the age of 16 who are deemed fit to participate in the study will be informed that their parent or guardian will be approached in order to seek consent to participate. If this is acceptable and the young person wishes to proceed, parental consent will be sought prior to any further arrangements being made.

Participants over the aged of 16 will be asked to confirm that they consent to taking part via the completion of a consent form (Appendix 4). Consent forms will be completed just prior to the interview. Young people under the age of 16 will complete an assent form (Appendix 5) and their parent or guardian will be provided with a parent / guardian information sheet (Appendix 6) and asked to complete a parent / guardian consent form (Appendix 7). This process is in line with the British Psychological Society's Code of Human Research Ethics (British Psychological Society, 2010).

Parent / guardian consent forms will be completed following discussion with the care team regarding exclusion criteria and prior to any interview arrangements being made with the young person. Young people will be approached to inform them that, due to their age, consent to participate will be sought from their parent / guardian. If this is acceptable parent / guardian consent forms (Appendix 7) and information sheets (Appendix 6) will be handed out by the ward staff or a member of the clinical team as they are likely to have regular contact with a young person's family during visiting times or meetings. These forms will be returned in a sealed envelope addressed to the main researcher. Once the researcher is in receipt of completed parent / guardian consent forms arrangements will be made with the young person for the interview to take place. Young people under the age of 16 will be asked to complete an assent form (Appendix 5) just prior to the interview taking place.

Potential participants will not be able to volunteer to participate during the community meetings, instead they will be asked to consider the information provided for at least 24 hours in order to ensure that they have time to consider the information fully and do not feel pressurised to volunteer. In order to ensure that the sample is as representative of the two recruitment sites as possible, attempts will be made to ensure that a range of participants take part in the interviews. As such, not every young person who volunteers to participate will be selected for interview.

Immediately prior to the interview the researcher will approach the nurse in charge of the ward in order to check that the information previously provided regarding exclusion criteria remains accurate. Interviews will take place in an appropriate room, either on or off the ward but at the unit. It is anticipated that the interview will take approximately 1 hour for each participant. Participants will be given the option to have someone else present with them during the interview (i.e. staff member/parent). Participants will also be given the option of taking a break during the interview, or the interview can be split into two interviews if this is preferable for the participant. Some demographic information will also be collected in order to provide a context in which each participant's individual experiences can be understood (Appendix 8).

The interview will be audio recorded using a digital recorder and transferred to an encrypted file on a password protected computer as soon as is practicably possible and the original recording will then be deleted. Audio recordings will be deleted after the thesis has been examined. The data will then be transcribed and anonymised by the chief investigator. Anonymised transcripts will be saved in an encrypted file on a password protected computer.

Anonymised transcripts and completed consent forms will be scanned electronically and stored on a password protected, encrypted file space on the University server, the contents of which will be deleted 10 years after the thesis has been examined. Storage and deletion of this material will be the responsibility of the Research Coordinator (Doctorate in Clinical Psychology, Lancaster University).

Proposed analysis

The data collected will be analysed by the Chief Investigator using Interpretative Phenomenological Analysis (IPA). This approach aims to explore how people make sense of their experiences via the analysis of detailed first person accounts (Larkin & Thompson, 2012). The researcher aims to understand the meanings that are made by participants by gathering information about the ways in which they relate to the world. In order to do this effectively, it is essential that the researcher considers their own experiences and assumptions and reflects upon their role in the development of interpretations. A reflective research journal will be used alongside supervision in order to facilitate the process of analysis. Thematic validity will be checked via supervision with research supervisors.

Practical issues

This research has a number of practical issues to be considered:

- *Interview location* - Interviews will be arranged to take place at the inpatient unit in which the young person is residing. The Field Supervisor or a member of the Doctorate in Clinical Psychology administration team will aware of the date, time and location of interviews and measures will be taken to ensure that the Chief Investigator is able to communicate with the base.
- *Costs* - Any printing, postage or photocopying costs associated with the study will be covered by Clinical Psychology Department at Lancaster University. Digital audio recording and transcription equipment, including foot pedals and headphones are available from the same department.

Ethical Issues

Ethical approval will be sought via submission to the Integrated Related Application System (IRAS). There are a number of ethical issues which will be considered throughout the design and implementation of this research:

- *Informed consent* – Young people over the age of 16 will not be able to take part in this research if they are unable to give consent to participate. Capacity to consent will be assessed by the care team. Young people under the age of 16 will need the consent of their parent or guardian in order to participate.
- *Confidentiality and Anonymity* – It is acknowledged that, due to the setting in which this research is taking place and the necessary liaison with the clinical team, the ward staff will be aware of who is participating in the research. However, attempts have been made to ensure that confidentiality is safeguarded as far as possible as the researcher will not have access to information about any young person unless they have expressed an interest to participate in the study. The researcher will ensure that any identifying information is removed from quotations featuring in the final piece of work in order to protect participants' identity as far as possible. Young people will be provided with information regarding anonymity and confidentiality via the participant information sheet and consent form.
- *Storage of data/information* – All digital data will be transferred from the digital recorder to password protected file space on the University server immediately after interview and deleted from the recording device. All data will then be accessible from the University server. No data will be stored on any computer. Only the Chief Investiagtor (Claire Smith) and her academic supervisor (XXXXXXXXX) will have access to the audio recordings and transcripts. Any hard copies of data which contains personal details (e.g.

demographic information sheets and consent to contact sheets) will be stored in a lockable filing cabinet and destroyed as soon as possible. In accordance with the University and DClinPsy programme policy, data will be electronically stored for ten years after the thesis has been examined and then destroyed.

- *Negative or distressing impact of interviews* – Members of the care team will be asked to inform the researcher of any young people for whom participation in the research may be detrimental (e.g. due to current presentation or risk issues). Should a participant become distressed during the interview process they will be given the opportunity to end the interview or to take a break. If the researcher has concerns regarding the impact of the interview upon a participant, this information will be shared with the shift leader on the ward and discussed with a research supervisor. Members of the care team will be available to support participants following completion of the research interview. Information regarding support agencies for young people will be provided on the Participant information sheet.
- *Potential disclosure(s) made in interview which lead to concern with regard to safety of the participant or others*– It is recognised that it may be necessary for the researcher to breach confidentiality if it is suggested that the safety of the participants or others may be compromised. Should this issue arise the researcher will contact the field supervisor / university supervisor in order to discuss the best course of action. If appropriate, young people who have disclosed any concerning information would be notified that it is necessary to breach confidentiality. Participants will be reminded of these limits of confidentiality prior to the start of the interview.
- *Risks and Benefits to Participants* - It may be distressing for young people to discuss the self–harm of others. However, it is anticipated that their accounts may help to increase understanding of the potential impact that experiencing the self-harm of others may have on adolescents and will help inform prevention and early intervention programmes for self-harm and contribute to service development in the future.

Timescale

Submit draft research protocol and ethics materials: April 2015
Submit application to NHS REC and R&D: May 2015
Write introduction and method: May-November 2015
Recruitment of Participants: August 2015

Begin data collection:	September-November 2015
Transcription and analysis:	October-December 2015
Write up results and discussion:	December-January 2015/6
Submission of draft report:	January 2016
Deadline for submission of thesis:	May 2016
Submit for Publication:	September 2016

Appendices

Appendix 1: Advertising Poster
Appendix 2: Interview Topic Guide
Appendix 3: Participant Information Sheet
Appendix 4: Consent Form (for young people over 16)
Appendix 5: Assent Form (for young people under 16)
Appendix 6: Parent/Carer Information Sheet
Appendix 7: Parent/Guardian Consent Form (For young people under 16)
Appendix 8: Demographic Information Form

References

Apter, A., & Freudenstein, O. (2000). Adolescent suicidal behavior: Psychiatric populations. In Hawton, K. E., & van Heeringen, K. E. (Eds), *The international handbook of suicide and attempted suicide* (pp.261-273). Chichester: Wiley.

British Psychological Society. (2010). *Code of Human Research Ethics* (pp. 1–44). Leicester: British Psychological Society. Retrieved from http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf

Claes, L., Houben, A., Vandereycken, W., Bijttebier, P., & Muehlenkamp, J. (2010). Brief report: The association between non-suicidal self-injury, self-concept and acquaintance with self-injurious peers in a sample of adolescents. *Journal of Adolescence*, *33*(5), 775-778.

Deliberto, T. L., & Nock, M. K. (2008). An exploratory study of correlates, onset, and offset of non-suicidal self-injury. *Archives of Suicide Research*, *12*(3), 219-231.

Gould, M. S., Wallenstein, S., & Kleinman, M. (1990). Time-space clustering of teenage suicide. *American Journal of Epidemiology*, *131*(1), 71-78.

Hasking, P., Andrews, T., & Martin, G. (2013). The role of exposure to self-injury among peers in predicting later self-injury. *Journal of youth and adolescence*, *42*(10), 1543-1556.

Hawton, K., Rodham, K., Evans, E., & Weatherall, R. (2002). Deliberate self-harm in adolescents: self-report survey in schools in England. *BMJ*, ***325***(7374), 1207-1211.

Hawton, K., Harriss, L., Hall, S., Simkin, S., Bale, E., & Bond, A. (2003). Deliberate self-harm in Oxford, 1990-2000: a time of change in patient characteristics. *Psychological medicine*, ***33***(6), 987-995.

Heath, N. L., Ross, S., Toste, J. R., Charlebois, A., & Nedecheva, T. (2009). Retrospective analysis of social factors and nonsuicidal self-injury among young adults. *Canadian Journal of Behavioural Science*, *41*(3), 180.

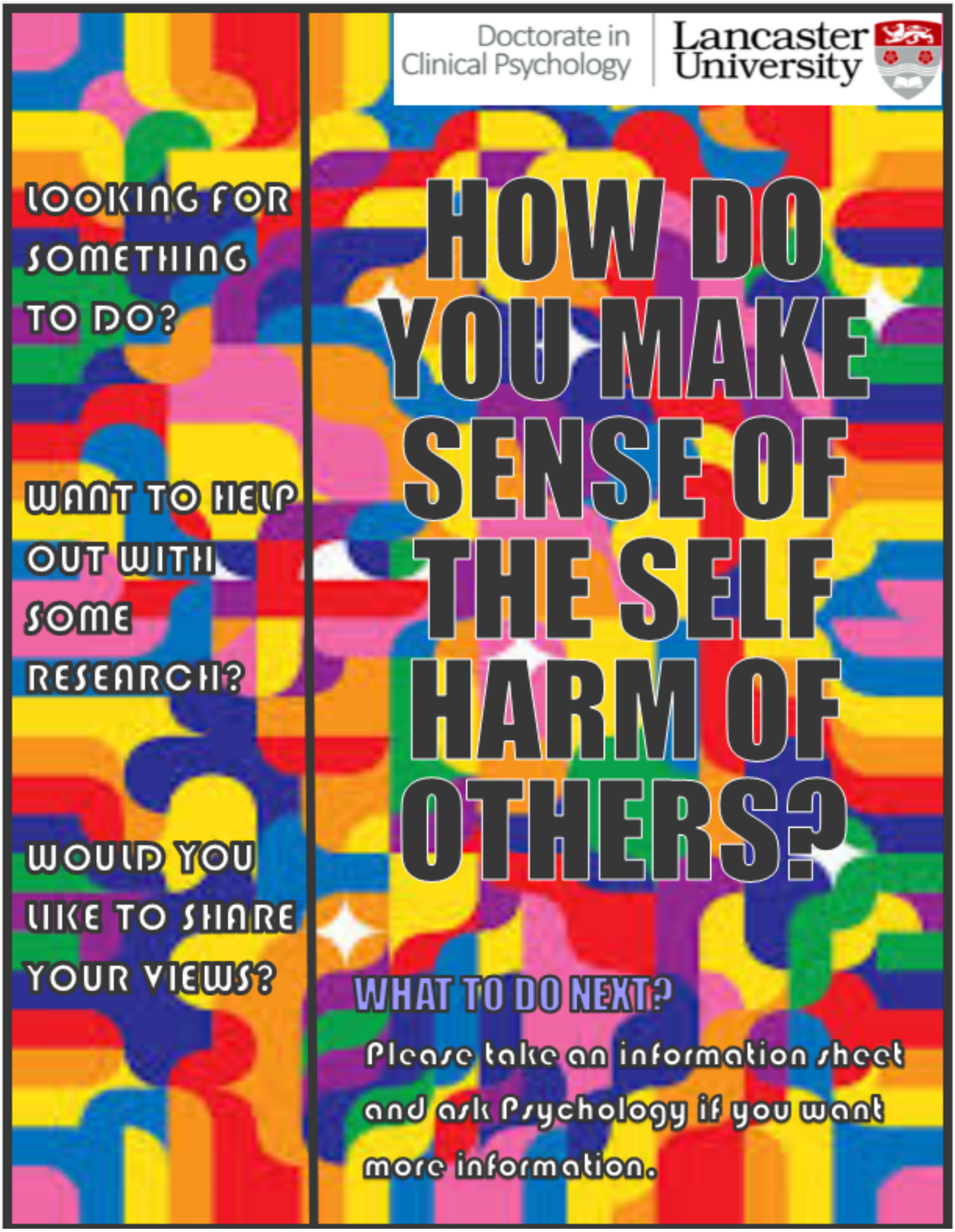
Joiner, T. E. (1999). The clustering and contagion of suicide. *Current Directions in Psychological Science*, *8*(3), 89-92.

Prinstein, M. J., Heilbron, N., Guerry, J. D., Franklin, J. C., Rancourt, D., Simon, V., & Spirito, A. (2010). Peer influence and nonsuicidal self injury: Longitudinal results in community and clinically-referred adolescent samples. *Journal of abnormal child psychology*, *38*(5), 669-682.

Robbins, D., & Conroy, R. C. (1983). A cluster of adolescent suicide attempts: Is suicide contagious?. *Journal of Adolescent Health Care*, *3*(4), 253-255.

Taiminen, T. J., Kallio-Soukainen, K., Nokso-Koivisto, H., Kaljonen, A., & Helenius, H. (1998). Contagion of deliberate self-harm among adolescent inpatients. *Journal of the American Academy of Child & Adolescent Psychiatry*, *37*(2), 211-217.

Appendix 4-B: Advertising Poster



Doctorate in Clinical Psychology

Lancaster University

LOOKING FOR SOMETHING TO DO?

WANT TO HELP OUT WITH SOME RESEARCH?

WOULD YOU LIKE TO SHARE YOUR VIEWS?

HOW DO YOU MAKE SENSE OF THE SELF HARM OF OTHERS?

WHAT TO DO NEXT?

Please take an information sheet and ask Psychology if you want more information.

Appendix 4-C Interview Topic Guide

Doctorate in
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Interview Topic Guide

Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs

Opening questions:-

'Could you start by telling me a little bit about yourself and how long you have been at the service?'

'Before you came to the service, did you have any experience of other people self-harming?'

'What have been your experiences of other people self-harming since being at the inpatient unit?

Exploratory questions:-

'What are your thoughts about their self-harm?'

'How did their self-harm make you feel?'

'What did you do?'

'Has the self-harm of others impacted upon you? If so, how?'

'Has it affected your own wellbeing? If so, how?'

'What support around this, if any, have you received?'

'What would have been helpful?'

Additional prompt questions:-

'What was that like for you?'

'What did you think about that?'

'Could you tell me more about that?'

Appendix 4-D : Participant Information Sheet

Doctorate in
Clinical Psychology

Lancaster University

Participant Information Sheet

Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs

My name is Claire Smith. I am conducting this research as a Trainee Clinical Psychologist in the Doctorate in Clinical Psychology programme at Lancaster University. I do not work for the unit that you are staying in but I do have contact with INSERT NAME OF LOCAL COLLABORATOR (Clinical Psychologist) who is helping me with this research.

What is the study about?

This study aims to find out about young people's experiences of other people's self-harm (including peers, parents and adults) and the impact that this can have upon them. Not many studies have looked at this in inpatient settings. This research aims to find out more about your experiences so that services can make sure that they think carefully about how to best support young people in their care. We hope that what we find out from the research will give us a better understanding of how being exposed to other people's self-harm cam affect young people. We also hope that this research can be used in the development of prevention and early intervention programmes for self-harm.

Why have I been approached?

I am asking young people who are currently staying in one of two young person's inpatient units if they would like to take part in the research. However, it is possible that we won't be able to include everyone who would like to take part in the research. A range of young people from two inpatient units will be chosen to participate to make sure that the research represents the experiences of young people in both units.

Do I have to take part?

No. It is your decision whether you wish to take part in the study. Whether you decide to take part in the study or not, your care will not be affected in any way.

What will I be asked to do if I take part?

- A psychologist on the unit will check if you are eligible to take part.
- Then, if it is ok, and you decide you would like to take part we will arrange to meet at the unit to carry out an interview.
- The interview will last approximately 1 hour but we can stop for breaks if you need to.
- During the interview we will talk about your experiences of the self-harm of others. I am particularly interested in hearing about your experiences of other people's self-harm and the impact it has had upon you and your own well-being.
- The interview will be recorded and a transcript of our conversation will be typed up and analysed.

Will the information I give be kept confidential?

The information you provide will be made anonymous, this means that nobody will be able to identify you from the research. This piece of work will include quotes taken from the interviews with young people. However, I will do my best to make sure that nobody can identify you from the quotes used. The results will also be submitted for publication in an academic or professional journal. The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data. There are some limits to confidentiality. If what is said in the interview makes me think that you or someone else might get hurt I will have to break confidentiality and speak to my Supervisors about this. If I am worried about your safety I might need to talk to your care team too. If possible, I will talk to you about my concerns I have before I speak to anyone else about them.

What will happen to the results?
The results will be written up into a thesis, which is part of the Lancaster University Doctorate in Clinical Psychology.

Can I change my mind about taking part?
Yes, you can decide not to take part at any point before or during the interview. You do not have to give a reason for changing your mind. You can also change your mind about taking part in the study for up to two weeks after the interview has taken place. If you do change your mind within two weeks of your interview, all information about you will be taken out of the study and destroyed. If you change your mind after two weeks it might not be possible to remove all the information about you from the study.

Are there any risks?
Whilst I don't think that taking part in this study will cause you any harm, we might talk about things that are upsetting during the interview. If you get upset during the interview you can ask to take a break or we can stop the interview.

Are there any benefits to taking part?
Although you may find taking part interesting, there are no direct benefits in taking part.

Who has reviewed the project?
This research has been checked by the INSERT NAME Research Ethics Committees and Lancashire Care NHS Foundation Trusts and by members of staff from the Clinical Psychology course at Lancaster University.

Where can I obtain further information about the study if I need it?
If you have any questions about the study, please contact me on the number or email address below.
Claire Smith (Trainee Clinical Psychologist) Email: c.smith9@lancaster.ac.uk
Mobile: [INSERT MOBILE NUMBER ALLOCATED BY PROGRAMME]

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

XXXXXXXXXXXXXXX (Research Director)
Doctorate in Clinical Psychology Division of Health Research Furness College
Lancaster University Lancaster
LA1 4YG
Tel: XXXXXXXXXXXXXX
Email: XXXXXXXXXXXXXXXXXXXXXXX

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Professor XXXXXXXXXXXXXXXXXX (Head of the Division for Health Research)
Faculty of Health and Medicine
Lancaster University
Lancaster LA1 4YD
Tel: XXXXXXXXXXXXXXX
Email: XXXXXXXXXXXXXXXXXXXXXXXXXX

Resources in the event of distress
These contacts might be helpful if you need any support either following taking part in this study or in the future.

Young Minds – The voice for young people's mental health and wellbeing Web: http://www.youngminds.org.uk/
Phone: 020 7089 5050

Rethink –
Web: http://www.rethink.org/living-with-mental-illness/young-people Phone: 0300 5000 927 (Monday – Friday, 10-2)

Childline –
Web: www.childline.org.uk
Phone: 0800 1111

Thank you for taking the time to read this information sheet.

Appendix 4-E: Consent Form (16+)

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Consent Form (For young people over 16)
Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs

I am asking if you would like to take part in a research project which aims to explore adolescent's experiences of others self-harm and the impact that exposure to self-harm can have upon young people. Before you consent to participating in the study we ask that you read the participant information sheet and the statements below. If you agree with the statements put your initials in the box. If you have any questions or queries before signing the consent form please speak to the principal investigator, Claire Smith (Trainee Clinical Psychologist).

I have read the participant information sheet and understand what is expected of me within this study.	
I have had the chance to ask any questions and to have them answered.	
I understand that my interview will be audio recorded and that what I say will be typed up with the names and places changed so people won't be able to tell it was me.	
I understand that the words I use will be used in the final research but that people won't be able to tell who said what.	
I understand that the audio recordings will be kept until the interview has been typed up.	
I understand that I don't have to take part and that I can change my mind at any time without giving a reason. I know that if I change my mind the care I get won't change.	
I understand that I can change my mind about taking part at any point before or during the interview and that my data can be withdrawn from the study up to two weeks after the interview. I understand that after this point it might not be possible for what I say to be taken out of the research.	
I understand that the information from my interview will be mixed in with what other young people say and that people won't be able to tell who said what.	
It is ok for the words I say and some general information about me (but not my name) to be used in reports, publications, conferences and training events.	
I know that any information I give will be kept private and that people won't be able to tell what I said unless there is a chance that I, or another young person, might get hurt. If this happens I know that the researcher will need to share this information with her research supervisor.	
It is ok for Lancaster University to keep the typed up document of my interview on a safe computer for 10 years after the study has finished.	

Please sign if you agree to you taking part in the study.

Name ___________________________ **Signature**_________________________ **Date**_________________

Appendix 4-F: Assent Form (<16)

Assent Form (For young people under 16)
Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs

I am asking if you would like to take part in a research project which aims to explore adolescent's experiences of others self-harm and the impact that exposure to self-harm can have upon young people. Both you and your parent or guardian need to read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the assent form please speak to the principal investigator, Claire Smith (Trainee Clinical Psychologist).

My parent / guardian and I have read the participant information sheet and understand what is expected of me within this study.	
I have had the chance to ask any questions and to have them answered.	
I understand that my interview will be audio recorded and that what I say will be typed up with the names and places changed so people won't be able to tell it was me.	
I understand that the words I use will be used in the final research but that people won't be able to tell who said what.	
I understand that the audio recordings will be kept until the interview has been typed up.	
I understand that I don't have to take part and that I can change my mind at any time without giving a reason. I know that if I change my mind the care I get won't change.	
I understand that I can change my mind about taking part at any point before or during the interview and that my data can be withdrawn from the study up to two weeks after the interview. I understand that after this point it might not be possible for what I say to be taken out of the research.	
I understand that the information from my interview will be mixed in with what other young people say and that people won't be able to tell who said what.	
It is ok for the words I say and some general information about me (but not my name) to be used in reports, publications, conferences and training events.	
I know that any information I give will be kept private and that people won't be able to tell what I said unless there is a chance that I, or another young person, might get hurt. If this happens I know that the researcher will need to share this information with her research supervisor.	
It is ok for Lancaster University to keep the typed up document of my interview on a safe computer for 10 years after the study has finished.	

Please sign if it is ok for your parent / guardian to agree to you taking part in the study.

Name ___________________________ **Signature**________________________**Date**____________________

Appendix 4-G: Parent information sheet

Doctorate in
Clinical Psychology
Lancaster University

Parent / Carer Information Sheet

Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs

My name is Claire Smith. I am conducting this research as a Trainee Clinical Psychologist in the Doctorate in Clinical Psychology programme at Lancaster University. I do not work for the unit that your child is currently admitted to but I do have contact with INSERT NAME OF LOCAL COLLABORATOR (Clinical Psychologist at NAME OF SERVICE) who is helping me with this research.

What is the study about?

This study aims to find out about young people's experiences of other people's self-harm (including peers, parents and adults) and the impact that exposure to self-harm can have upon them. Not many studies have looked at this in inpatient settings. This research aims to find out more about your child's experiences so that services can make sure that they think carefully about how to best support young people in their care. The research findings may help to increase understanding of the potential impact that the self-harm of others may have on adolescents and help inform prevention and early intervention programmes for self-harm at the service.

Why has my child been approached?

I am asking young people who are currently staying in one of two young person's inpatient units if they would like to take part in the research. However, it is possible that not everyone who decides to take part will be chosen for the research. A range of young people from two inpatient wards will be chosen to participate to make sure that the research represents the experiences of young people in both hospitals.

Does my child have to take part?

No. This is a decision for you and your child to make together. Whether your child decides to take part in the study or not, his or her care will not be affected in any way.

What will my child be asked to do if they take part?

- A psychologist on the unit will check if your child is eligible to take part.
- If your child decides they would like to take part we will arrange to meet at the unit for an interview.
- The interview will last approximately 1 hour but we can stop for breaks if necessary.
- During the interview we will talk about your child's experiences of the self-harm of others. I am particularly interested in hearing about the impact it has had upon them and their own well-being.
- The interview will be recorded and a transcript of the conversation will be typed up and analysed.

Will my child's data be confidential?

The information your child provides will be made anonymous, this means that nobody will be able to identify your child from the research. The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data. There are some limits to confidentiality. If what is said in the interview makes me think that your child or someone else is at

significant risk of harm I will have to break confidentiality and speak to my Supervisors about this. If I am worried about your child's safety or wellbeing I might need to talk to the care team too. If possible, these concerns will be shared you're your child prior to being passed on.

What will happen to the results?
The results will be summarised and reported as part of a Thesis, an academic requirement of the Lancaster University Doctorate in Clinical Psychology. This piece of work will include quotes taken from the interviews with young people. However, I will make sure that nobody can identify your child from the quotes used. The results may also be submitted for publication in an academic or professional journal.

Can my child change their mind about taking part?
Yes, your child can decide not to take part at any point before or during the interview. Your child does not have to give a reason for changing his / her mind. Your child can withdraw his / her data for up to two weeks after the interview has taken place and his / her data will be taken out of the study and destroyed. If your child changes his / her mind after two weeks it might not be possible to withdraw your child's data completely from the study.

Are there any risks?
Whilst I don't think that taking part in this study will cause your child any harm, we might talk about things that are upsetting during the interview. If your child gets upset during the interview they can ask to take a break or we can stop the interview.

Are there any benefits to taking part?
Although your child may find taking part interesting, there are no direct benefits in taking part.

Who has reviewed the project?
This research has been checked by the INSERT NAME Research Ethics Committees and XXXXXXXXXXXXXXXX NHS Foundation Trusts. It has also been peer reviewed by the Department of Clinical Psychology research team at Lancaster University.

Where can I obtain further information about the study if I need it?
If you have any questions about the study, please contact me on the number or email address below. Claire Smith (Trainee Clinical Psychologist) Email: c.smith9@lancaster.ac.uk Mobile: [INSERT MOBILE NUMBER]

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

XXXXXXXXXXXXXXXXX (Research Director)
Doctorate in Clinical Psychology Division of Health Research Furness College
Lancaster University Lancaster
LA1 4YG

Tel: XXXXXXXXXXXXXXX
Email: XXXXXXXXXXXXXXXXXXXXXX

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Professor XXXXXXXXXXXXXXXXXXX (Head of the Division for Health Research)
Faculty of Health and Medicine
Lancaster University
Lancaster LA1 4YD
Tel: XXXXXXXXXXXX
Email: XXXXXXXXXXXXXXXXXX

Resources in the event of distress
These contacts might be helpful if you need any support either following taking part in this study or in the future.

Young Minds – The voice for young people's mental health and wellbeing Web: http://www.youngminds.org.uk/
Phone: 020 7089 5050

Rethink –
Web: http://www.rethink.org/living-with-mental-illness/young-people Phone: 0300 5000 927 (Monday – Friday, 10-2)

Childline –
Web: www.childline.org.uk
Phone: 0800 1111

Thank you for taking the time to read this information sheet.

Appendix 4-H: Parent consent form

Doctorate in Clinical Psychology | Lancaster University

Parent / Guardian Consent Form (For young people under 16)
Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs

I am asking if you would like to take part in a research project which aims to explore adolescent's experiences of others self-harm and the impact that exposure to self-harm can have upon young people. Before you consent to participating in the study we ask that you read the participant information sheet and the statements below. If you agree with the statements put your initials in the box. If you have any questions or queries before signing the consent form please speak to the principal investigator, Claire Smith (Trainee Clinical Psychologist).

I confirm that I have read the participant information sheet and fully understand what is expected of my child within this study.	
I confirm that I have had the opportunity to ask any questions and to have them answered.	
I understand that my child's interview will be audio recorded and then made into an anonymised written transcript.	
I understand that direct quotes will be used in the final research and that these quotes will be anonymised so that my child is not identifiable.	
I understand that audio recordings will be kept until the data has been transcribed.	
I understand that my child's participation is voluntary and that he/she is free to withdraw at any time without giving any reason, and without their medical care or legal rights being affected.	
I understand that my child's data can be withdrawn from the study up to two weeks after the interview. I understand that after this point it might not be possible for my child's data to be taken out of the research.	
I understand that the information from my child's interview will be pooled with other participants' responses, anonymised and may be published.	
I consent to information and quotations from my child's interview being used in reports, conferences and training events.	
I understand that any information my child gives will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to my child or others, in which case the principal investigator will need to share this information with her research supervisor.	
I consent to Lancaster University keeping anonymised, written transcriptions of the interview in a locked cabinet for 10 years after the study has finished.	

Please sign below if you consent for your child to take part in this study.

Name ___________________________ **Signature**_________________________**Date**____________________

Appendix 4-I : Demographic Information

Doctorate in
Clinical Psychology

Lancaster University

Demographic Information Sheet

Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs

Participant Number:	
Pseudonym (chosen by participant):	
Age (years and months):	
Gender:	
Duration of stay on the ward when the interview is completed:	

Appendix 4-J: NHS REC Approval Letter

NHS
Health Research Authority
National Research Ethics Service

NRES Committee XXXXXXXXX - XXXXXXX
XXXXXXXXXXXX
XXXXXXX
XXXXXXXXXXX
Telephone: XXXXXXX
Fax:XXXXXXXXXXXX

07 July 2015

Miss Claire Smith
Trainee Clinical Psychologist
5 Catlow Court
Southfield Lane, Southfield, Burnley
Lancashire
BB10 3RN

Dear Miss Smith

Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs
REC reference: XXXXXXXX
IRAS project ID: XXXXXX

Thank you for your letter of 01 July 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, XXXXXXXXXXXXXXX. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below:

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Research Advertising Poster]	v.1	20 April 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor insurance]	1	02 June 2015
Interview schedules or topic guides for participants [Interview topic guide]	v.1	20 April 2015
IRAS Checklist XML [Checklist_05062015]		05 June 2015
Letter from sponsor [Letter from sponsor]	1	02 June 2015
Other [Local Collaborator CV]	v.1	20 April 2015
Other [LCFT lone working policy]	v.1	20 April 2015
Other [Demographic Information Sheet]	v.1	20 April 2015
Other [Sponsor liability]	1	02 June 2015
Participant consent form [XXX - Parent / Guardian For Young People under 16]	3	01 July 2015
Participant consent form [XXX Parent / Guardian for Young People Under 16]	.3	03 July 2015
Participant consent form [XXX - Young People Over 16]	2	03 July 2015
Participant consent form [XXX - Assent Young People Under 16]	2	03 July 2015
Participant consent form [XXX - Assent Young People Under 16]	2	01 July 2015
Participant consent form [XXX - Chlidren and Young People]	2	01 July 2015
Participant information sheet (PIS) [XXX - Parent / Carer]	3	01 July 2015
Participant information sheet (PIS) [XXX - Children and Young People]	3	01 July 2015
Participant information sheet (PIS) [XXX - Children and Young People]	3	03 July 2015
Participant information sheet (PIS) [XXX Parent / Carer]	3	03 July 2015
REC Application Form [REC_Form_05062015]		05 June 2015
Research protocol or project proposal [Thesis research protocol]	v.2	20 May 2015
Response to Request for Further Information		01 July 2015
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	v.1	20 April 2015
Summary CV for supervisor (student research) [Academic Supervisor CV]	v.1	20 April 2015

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/NW/0515 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

pp.

Dr XXXXXXXXXXXXX
Chair

Email: XXXXXXXXXXXXXXXXX

Enclosures: "After ethical review – guidance for researchers"

Appendix 4-K: NHS R&D Approval Letters

[redacted]
Mental Health NHS Foundation Trust

Standardised Process for Electronic Approval of Research

Research & Development Office
XXXXXXXXXXXXXXXXXX
XXXXXXXX
XXXXXX
XXXXXXXXXXXXXXX

Tel: XXXXXXXXXXXXXXXXX
Email: XXXXXXXXXXXXXXX

Web: XXXXXXXXXX

WE ARE SOCIAL

7 July 2015

Miss Claire Smith
5 Catlow Court
Southfield Lane, Southfield, Burnley
BB10 3RN

Information for ID Badge if required:
Research Project Ref No: XXX
Expiry Date: 31/01/2016
You must take this letter with you.

Dear Miss Smith

Re: NHS Permission for Research

Project Reference: XXX
REC Reference Number: XXXXXXX
Sponsor: Lancaster University
Project Title: Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs
Date of Permission: 7 July 2015

Further to your request for permission to conduct the above research study at this Trust, we are pleased to inform you that this Trust has given NHS permission for the research. **Your NHS permission to conduct research at this site is only valid upon receipt of a signed 'Conditions for NHS Permission Reply Slip' which is enclosed**.

Please take the time to read the attached conditions for NHS permission. Please contact the R&D Office should you require any further information. You will need this letter as proof of NHS permission. Please note when contacting the R&D office about your study you must always provide the project reference numbers provided above.

NHS permission for the above research has been granted on the basis described in the IRAS application form, Protocol and supporting documentation.

The documents reviewed were:

Document	Version	Date
Protocol	2	20/05/2015
Participant Information Sheet - XXX - Parent / Carer	3	01/07/2015
Participant Information Sheet - XXX – Children and Young People	3	01/07/2015
Participant Consent Form - Parent / Guardian For Young	3	01/07/2015

People under 16		
Participant consent form - XXX - Assent Young People Under 16	3	01/07/2015
Participant consent form - XXX - Children and Young People	3	01/07/2015
Interview Topic Guide	1	20/04/2015
Research Advertising Poster	1	20/04/2015
IRAS R&D Form		
IRAS SSI Form		
REC letter giving favourable ethical opinion		07/07/2015

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (if applicable), and NHS Trust policies and procedures. Permission is only granted for the activities for which a favourable opinion has been given by the Ethics Committee.

Permission covers all locations within the Trust, however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research.

We would like to point out that hosting research studies incurs costs for the Trust such as: staff time, usage of rooms, arrangements for governance of research. We can confirm that in this instance we will not charge for these. However, we would like to remind you that Trust costs should be considered and costed at the earliest stage in the development of any future proposals.

May I wish you every success with your research.

Yours sincerely

Dr XXXXXXXXXXXXXX
Medical Director and R&D Lead

cc : Sponsor: Lancaster University

Enc: Approval Conditions Leaflet
Induction & ID Badge Information

[redacted]
Mental Health NHS Foundation Trust
NHS

Our Ref: XXXXXX

Research & Development Department
XXXXXXXXXXXX
XXXXXXXXXXXXXX
XXXXXXXXXXXXX
XXXXXXXXXXX

Tel: XXXXXXXXXXXX
Fax: XXXXXXXXXX
Email: XXXXXXXXXXXXXXXXXXXXX

Date: 7th July 2015

Claire Smith
Trainee Clinical Psychologist
Faculty of Health and Medicine
Furness College
Lancaster University
LA1 4YF

Dear Claire,

Re: NHS Trust Permission to Proceed

Project Reference: XXXX

Project Title: **Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs**

I am pleased to inform you that the above project has received research governance permission.

Please take the time to read through this letter carefully and contact me if you would like any further information. You will need this letter as proof of your permission.

Trust R&D permission covers all locations within the Trust; however you will only be allowed to recruit from the sites/services you have indicated in section 3 of the SSI application form. If you would like to expand recruitment into other services in the Trust that are not on the original SSI then you must contact the R&D department immediately to discuss this before doing so.

You also must ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing recruitment in that service and you must contact the relevant service/ward managers prior to accessing the service to make an appointment to visit before you can commence your study in the Trust.

Please make sure that you take your Trust permission letter with you when accessing Trust premises and please include the Trust reference number on any correspondence/emails so that the services are assured permission has been granted.

Recruitment

Researchers must recruit the first participant to XXXXXXXXXXX NHS Foundation Trust within 30 days of being granted Trust permission and ensure that studies recruit to time and target.

National guidelines expect Trusts to report the date when the first participant is recruited to the study, therefore please can you provide this information at that point to the R&D department at XXXXXXXXXXXXXXXXXX

If you have any concerns with recruitment please contact the R&D team immediately for assistance.

Monitoring

If your study duration is less than one year, you will be required to complete an end of study feedback report on completion. However if your study duration is more than one year, you will be required to complete a short electronic progress report quarterly and an end of study report on completion. As part of this requirement, please ensure that you are able to supply an accurate breakdown of research participant numbers for this Trust (recruitment target, actual numbers recruited). To reduce bureaucracy, progress reporting is kept to a minimum; however, if you fail to supply the information requested, the Trust may withdraw permission.

Honorary Research contracts (HRC)

All researchers with no contractual relationship with any NHS body, who are to interact with individuals in a way that directly affects the quality of their care, should hold Honorary Research NHS contracts. Researchers have a contractual relationship with an NHS body either when they are employees or when they are contracted to provide NHS services, for example as independent practitioners or when they are employed by an independent practitioner (*Research Governance Framework for Health and Social Care,* 2005). If a researcher does not require an HRC, they would require a Letter of Access (LoA). For more information on whether you or any of your research team will require an HRC or LoA please liaise with this office. It is your responsibility to inform us if any of your team do not hold Honorary Research NHS contracts/Letters of Access.

Staff involved in research in NHS organisations may frequently change during the course of a research project. Any changes to the research team or any changes in the circumstances of researchers that may have an impact on their suitability to conduct research MUST be notified to the Trust immediately by the Principal Investigator (or nominated person) so that the necessary arrangements can be put in place

Research Governance

The Research Governance Sponsor for this study is **Lancaster University.** Whilst conducting this study you must fully comply with the Research Governance Framework. This can be accessed at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv

For further information or guidance concerning your responsibilities, please contact your research governance sponsor or your local R&D office.

Risk and Incident Reporting

Much effort goes into designing and planning high quality research which reduces risk; however untoward incidents or unexpected events (i.e. not noted in the protocol) may occur in any research project. Where these events take place on Trust premises, or involve Trust service users, carers or staff, you must report the incident within 48 hours via the Trust incident reporting system. If you are in any doubt whatsoever whether an incident should be reported, please contact us for support and guidance.

Regardless of who your employer is when undertaking the research within 5 Boroughs Partnership NHS Foundation Trust you must adhere to Trust policies and procedures at all times.

Confidentiality and Information Governance
All personnel working on this project are bound by a duty of confidentiality. All material accessed in the Trust must be treated in accordance with the Data Protection Act (1998). For good practice guidance on information governance contact us.

Protocol / Substantial Amendments
You must ensure that the approved protocol is followed at all times. Should you need to amend the protocol, please follow the Research Ethics Committee procedures and inform all NHS organisations participating in your research.

Final Reports
At the end of your research study, we will request a final summary report so that your findings are made available to local NHS staff. The details from this report may be published on the NHS Trust internet site to ensure findings are disseminated as widely as possible to stakeholders.

On behalf of this Trust, may I wish you every success with your research. Please do not hesitate to contact us for further information or guidance.

Yours sincerely,

Dr XXXXXXXXXX
Research & Development Manager