Suicide and Self-Harm in Adolescents

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The NZ Early Intervention in Psychosis Training Forum

Christchurch, November 2017
Outline of the day

1. Terminology/epidemiology
2. Risk factors
3. Assessment
4. Formulation
5. Safety planning
6. Management/interventions
Terminology and epidemiology of youth suicide and self-harm
Definitions & terminology

• **Suicide**: The deliberate act of killing oneself. It must also be established by a coronial enquiry that the death resulted from a deliberate act of the deceased with the intention of ending his or her own life *(ABS 2008:3303.0 Causes of death. Australia, Canberra, Australia 2008)*.

• **Suicide attempt**: “a non-fatal, self-inflicted potentially injurious behaviour with any intent to die as a result” *(Crosby 2007)*, which may or may not result in injury, or death *(Silverman et al. 2007)*.

• **Suicidal ideation**: “thoughts of engaging in behaviour intended to end one’s life” *(Nock et al. 2008)*. These can be broken down further to encompass ideation with some intent, ideations where intent is undetermined, and ideation with no intent *(Silverman et al. 2007)*.

• **Self-harm (SH)**: The harming of oneself regardless of intention or purpose

• **Non-suicidal self injury**: Self harm with no intent to die as a result
# Definitions & terminology

<table>
<thead>
<tr>
<th></th>
<th>Self-harm</th>
<th>Suicidal Behaviour</th>
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<tbody>
<tr>
<td><strong>Intent</strong></td>
<td>To manage distress</td>
<td>To die</td>
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<td></td>
<td>To die?</td>
<td></td>
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<tr>
<td><strong>Methods</strong></td>
<td>Cutting, burning, scratching, hitting ones’</td>
<td>Hanging, overdose, jumping</td>
</tr>
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<td></td>
<td>body on a hard surface, hitting oneself,</td>
<td></td>
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<td></td>
<td>self-poisoning</td>
<td></td>
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<tr>
<td><strong>Lethality</strong></td>
<td>Usually not life-threatening</td>
<td>High lethality</td>
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</table>
Suicide-related behaviour in young people

Suicidal ideation
Lifetime: 29.9%
Past year: 24%

SH / suicide attempt
Lifetime: 16-23%
Past year: 5-10%

NZ: 2017
Age 10-25 N=130
Australia: 2015
age 10-25 N=405
i.e. ~25 to 40% of deaths

Orygen
The National Centre of Excellence in Youth Mental Health
Contagion & clusters

• For every young person who dies by suicide, **significantly more** are negatively affected
• Suicide clusters are common among young people, as well as Aboriginal & Torres Strait Islander people, prisoners & people with mental illness
• > 5% of youth suicides in Australia are part of a cluster – compared to just over 2% of adult suicides *(Robinson et al, 2016)*
• Larkin & Beautrais 2010: Geospatial mapping identified 9 clusters; ~⅓ were aged <25 years
• Operates via a process of contagion whereby one person’s suicide influences another person to attempt
• Those most susceptible are those who are already vulnerable, those who were close to the deceased – geographically, socially & psychologically
Circles of vulnerability model
(Adapted from Zenare, 2009)

- **Geographical proximity**: the physical distance a person is from the suicide, e.g. those who witnessed or discovered the death or those exposed to the immediate aftermath.

- **Social proximity**: the relationship one has with the deceased e.g. family members, friends, peers or others who are part of the same social circle.

- **Psychological proximity**: the extent to which an individual can relate to the deceased e.g. cultural or subcultural connections, joint victims of bullying, team members, classmates, or others who see themselves as somehow similar to the deceased.
Rates of self-harm in young New Zealanders

Community prevalence data:

• Australia: Around ¼ of young women (16-24 year olds) and 11.6% (11 to 16 year olds) and 18.1% (20 to 24 years olds) report self-harming in their lifetime (Martin et al, 2010; Young Minds Matter: Child and Adolescent Mental Health Survey, 2015).

• New Zealand: 4.7% of males and 10.6% of females reported attempting suicide in previous 12 months (Watson et al -Youth 2000, NZMJ 2003)

Hospital admission data (NZ):

• 2866 young people aged 15-24 years were hospitalised for self-harm in 2013.

• Nearly 1/2 of hospital admissions for self-harm are young women aged 15-19 years (n=1391).

Non-suicidal self-harm

• Lifetime history of NSSI was 48.7 % (females 49.4 %, males 48 %) (Garisch & Wilson 2015)
Why rates of self-harm are difficult to obtain

- Variability in measuring tools
- Lack of reliable data collection & monitoring systems
- Understanding of self-harm by young people and transient suicidal intent
- People often switch methods of self-harm (especially younger people)
- Young people do not seek help
Impact of self-harm

There are a number of short term and long term consequences of self-harm including:

- Distress
- Poor treatment responses
- Repeat episodes of self-harm, suicide attempts, suicide & premature mortality
- Mental ill health
- Physical ill health
- Substance misuse
- Traffic accidents
- Poor educational, vocational & economic participation outcomes

“I have been stapled without anaesthetic, just like terrible things that people do to you just ‘cause you did it to yourself.”
Risk and protective factors
Risk factors for suicide & self-harm in young people

Underlying risk factors

**Psychiatric**
- Depression
- Substance use
- Anxiety disorder
- Personality disorder
- Conduct disorder
- Psychosis
- Antisocial behaviour
- Disordered eating

**Social, demographic, familial**
- Childhood adversity/trauma (abuse)
- Interpersonal difficulties
- Poor peer relationships
- Family history
- Attachment; parent/child relationships

**Psychological**
- Impulsivity
- Poor problem solving
- Hopelessness
- Anger/hostility

**Behavioural**
- Past suicide-related behaviour

Situational risk factors

**Adverse life events**
- Relationship difficulties
- Interpersonal losses
- Poor school performance and exclusion
- Conflict (parents; peers; boy/girl friends) (above 4=isolation)
- Legal problems
- Suicide-related behaviour in others, especially in school settings

**Intoxication**

**Availability of means**

**Certain types of media reporting**
Key risk factors for suicide

Past suicide-related behaviour:
• Significant indicator of future suicidality in general & clinical populations
• Suicidal ideation and attempts can begin as young as 10 years of age, and show the highest hazard ratios at age 15
• While 60% of transitions along the continuum from suicidal ideation to subsequent attempt occur within 1 year of initial ideation onset, risk remains elevated for much longer.

Psychiatric disorder:
• 60 - 80% of young people have a diagnosis of depression at the time of a suicide attempt
• Risk is also high in other disorders e.g. psychotic illness; substance use & personality disorder
• However, not all young people with SI report symptoms of mental disorder & interpersonal stressors are especially significant for youth
• Not all people experiencing psychiatric disorder will develop suicide risk

Hopelessness:
• Hopelessness has long been linked to an increased risk of suicide-related behaviour even when depression, is controlled for
• Not only is hopelessness one of the key factors mediating the relationship between depression and suicidal ideation but it also increases risk among already suicidal patients and can increase overall risk of eventual suicide by at least three-fold
• Hopelessness has also been postulated as a mediating factor between problem-solving ability and suicidal ideation.

> Clinicians need to be vigilant to the risk of suicide and suicide related behaviour in those with depression
> Clinicians need to recognise and treat depression
High risk groups

Females

• 4x more likely to report SH than males
• Increased risk at the onset of both puberty & sexual activity
• Suicide rate NZ overall 2016=2017 3.06:1 (male 19.36: female 6.12)

LGBTQI+

• 2x more likely to engage in self-harm
• Highest rates amongst those who had experienced homophobia
• Same sex attracted: 13.9% attempted suicide; 36.9% self-harm (previous 12 months)
• Both sex attracted: 21.7% attempted suicide; 57.9% self-harm (previous 12 months)
High risk groups

Maori

• Rate 2016-2017: 21.73 (vs 12.64 overall)
• 10-25 year olds: 47 out of 130 (36%)
  – 28% of suicide deaths were Maori young men
  – 57% of suicide deaths were Maori young women

• 2013 Self-harm presentations (2013 rates per 100,000):
  – Male youth Maori: Non Maori: 264.2: 217.3
  – Female youth Maori: Non Maori: 685.8: 695.8
High risk periods & contact with services

• Many people at risk of suicide & self-harm do not seek help, but some do. Schaffer et al 92% of people who died by suicide had had some form of healthcare contact in the previous 12 months
  • 54% had seen a GP
  • 40% had an outpatient psychiatric appointment
  • 31% had visited an ED
• The period following discharge from psychiatric services is also one of elevated risk; risk is highest in the 1st week after discharge but remains high for several years (Chung et al 2017)
• For some people risk can elevate during treatment (FEP) & on initiation of anti-depressants
• Risk is also high following release from prison, discharge from the military and at times of transition between education – i.e. change in school, or transition from school to tertiary education
Psychosis

- 10 to 14% report self-harm prior to presentation for treatment.
- Rates remain high after presentation: suicide rate 2.9 to 11% at 1 year post presentation, 11.3% at 2 years, 18.2% at 4 years and 21.6% at 7 years.
- 2017 survey of 33,370 adults across 19 countries: lifetime prevalence of suicidal ideation, plans, and attempts was 28.5%, 10.8%, and 10.2% in those with psychotic experiences (Bromet et al 2017)
- Risk factors = substance use disorder, the presence of depressive symptoms, younger age, female gender and greater illness insight but best predictor is previous self-harm.
- In those with FEP, odds of suicidal behaviour during follow-up were significantly higher among patients with depressive symptoms during FEP compared to those without (McGinty et al 2017)
Self-harm

- Acts of self-harm may have a variety of motives or intentions
- Escape from a terrible state of mind
- Finding one’s thoughts unbearable
- Wanting to get away from an unbearable situation
- Wanting to die
- To communicate to others the extent of current distress
- Motives are relatively consistent across the life-span
- Some differences according to the method of SH
- Adolescents who took overdoses more often said they wanted to die
- Those who cut themselves more often reported self-punishment and escape from a terrible state of mind
- Wanting to die is associated with depression and hopelessness
- Assessing the motives of an episode with adolescents is notoriously difficult
### Possible reasons for NSSI

<table>
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<tr>
<th>Responding to distress</th>
<th>Self-harm as a positive experience</th>
<th>Defining the self</th>
</tr>
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<tbody>
<tr>
<td>• Managing painful/</td>
<td>• Self-harm as comforting or</td>
<td>• As a way of exploring ones own boundaries</td>
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<tr>
<td>unpleasant emotions or</td>
<td>enjoyable</td>
<td>• Validating self</td>
</tr>
<tr>
<td>personal memories</td>
<td>• Sensation seeking</td>
<td>• To fit in/belong to a group</td>
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<tr>
<td>• Managing dissociation</td>
<td>• Experimenting with something</td>
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<tr>
<td>• Averting suicide</td>
<td>new</td>
<td></td>
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<tr>
<td>• Punishment of the self</td>
<td>• Developing a sense of personal mastery</td>
<td></td>
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<tr>
<td>• Means of help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>seeking/communicating</td>
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<td></td>
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<tr>
<td>distress to others</td>
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Adapted from Edmonson, Brennan & House, 2016
Young people don’t seek or get professional help!!

• Only 13% of young men and 31% of young women access professional mental health care
• Young men aged 16-24 have the lowest professional help-seeking of any age group
• Professional help-seeking for self-harm is less than 50%.
• International studies indicate that only 10-20% of young people who have self-harmed present to hospital
• If people do present and have a negative experience they are less likely to re-present

“I didn’t really discuss it at all with my friends or family...I felt I would be burdening them”
Best practice in understanding risk of self-harm and suicidal ideation in young people
Why not ‘risk assessment’?

*Risk assessment for the purpose of a) risk stratification, and b) as a basis for the allocation of treatments, should not be done*

- Risk assessment has long been a standard part of clinical practice
- The aim is to determine the risk of death by suicide or future suicidal behaviour
- **However**......Suicide is a rare
- High sensitivity (proportion of true positive cases correctly identified)
- Inadequate positive predictive ability (defined as the proportion with a positive screening result that will truly repeat) (due to prevalence)
- May provide false reassurance
Studies looking at predictive value of risk factors ...

**Large et al, 2011**
- A systematic review of risk factors for suicide among psychiatric in-patients
- Despite the apparently strong association between high-risk categorization & subsequent suicide, the low base rate suicide means that predictive value of a high-risk categorization is < 2%.
- Safer hospital environments & improved systems of care are more likely to reduce the suicide than risk assessment.

**Chan et al, 2016**
- Systematic review of risk factors & Ax scales to predict suicide after SH
- 4 risk factors emerged = SH, suicide intent, male gender, physical ill-health
- Predictive value of all scales was low
- Risk factors are so generic that they are of little help in the clinical determination of suicide risk for an individual patient
- No scales have sufficient evidence to support their use.
- The use of these scales, or an over-reliance on the identification of risk factors in clinical practice, may provide false reassurance & is potentially dangerous.
Studies looking at predictive value of assessment scales...

Carter et al, 2017

- **Aim**: To identify studies of predictive instruments & calculate their +ive predictive value
- **Method**: A systematic review & meta-analysis (N=70)
- **Key findings**: For all scales PPV were poor for suicide & self-harm. Therefore no high-risk classification was clinically useful
- **Conclusion**: Treatment should focus on modifiable risk factors & effective interventions

Quinlivan et al, 2017

- **Aim**: To evaluate performance of risk scales & both patient & clinician assessment of risk in identifying risk of repeat SH in 6 months
- **Method**: A multi-site prospective cohort study in the UK
- **Key findings**: Clinicians & patients are better able to predict risk than standardised scales. Most scales had ltd predictive utility & **should not be used** to determine clinical management & predict SH
What do young people think?

• “‘Risk’ makes me feel I am a risk to other people, or I am some kind of deviant”
• “No one is the same. Engage as appropriate.”
• “A lot of people still feel stigma around suicide. They might have received a negative response in the past”
• “Professionals are mostly strangers to people. It’s about having a voice and feeling comfortable talking about it”
• “I don’t want an ambulance to be called for me when I express a thought and make it clear I have no intent. It says the service doesn’t have any faith in the YP’s ability to cope and is incredibly disempowering”
Why ‘assessment’?

1. To identify risk and protective factors
2. To inform your treatment and management plan

Assessment components

• Engagement
• How to ask?
• What information to collect?
• Which format/structure to follow?
• How to document outcome?
Collaborative approach
Psychosocial assessment

- The headspace psychosocial assessment (Parker et al., 2010)
- is an adaptation of the HEADSS
- It is a tool of engagement
- Provides a sensitive approach to asking about self-harm and suicidal ideation

**HEADS** psychosocial assessment style questioning:

1. Does this situation make you feel sad/down/depressed?
2. Do you feel hopeless about this situation/life and like things are never going to get better?
3. Have you ever felt so low/hopeless that you had thoughts that you would be better off dead or that you wished you were dead or have harmed yourself?
HEADSS Probing Questions

• Have you ever tried to hurt yourself (e.g., cutting) to calm down or feel better?
• Have you started using alcohol or drugs to help you relax, calm down or feel better?
• Have you thought you would be better off dead or wished you were dead?
• Have you thought about suicide?
• Do you have a suicide plan?
Understanding suicidal ideation & self-harm

Columbia Suicide Severity Rating Scale: http://www.cssrs.columbia.edu

Suicidal ideation:
- Nature of thought and intent (motivation for self-harm)
- Frequency and intensity of thoughts
- When they have these thoughts, who they tell, how they resolve
- How long they have had these thoughts: chronology
- Have they got a plan

History of suicide attempts & self-harm:
- Number, nature i.e. lethality of method, rescuing/others available, strength (e.g. knowledge of means)

Family history & recent self-harm/suicide in peer group
Access to means
Risk and protective factors & reasons for living
Enhancing face-to-face assessment

• Young people won’t necessarily disclose
• Paper and pencil and/or web-based assessments may provide you with more information
• Sally Bradford’s *myAssessment* Web-based headspace psychosocial assessment was acceptable and increased disclosure
• Some useful paper and pencil tools include:
  • PHQ-9
  • PHQ-A
  • Suicidal Ideation Attributes Scale (SIDAS)
  • Brief Suicidal Ideation Screening Measure
  • Reasons for living inventory for adolescents
  • Beck Hopelessness Scale
Brief Suicidal Ideation Screening Measure

Thinking over the last week, how often have you thought about killing yourself?

0 – Not at all [go to Question 4a]
1 – Several days
2 – More than half the days
3 – Nearly everyday
4 – Every day for most of the time

When you have thought about killing yourself, did you feel like you had the control to stop yourself from making the suicide attempt?

0 – No doubt I have absolute control
1 – A very strong sense of control
2 – Quite a strong sense of control
3 – Some sense of control
4 – No sense of control

When you have thought about killing yourself, how strong have those thoughts been?

0 – Not at all strong
1 – Somewhat strong
2 – Quite strong
3 – Very strong
4 – Really intensely strong
How to assess young people: Case formulation

- Case formulation has two elements:
  1. Descriptive information on which hypothesis is based
  2. Prescriptive recommendations which are based on the hypothesis

- Descriptive facts include:
  - Presenting problem
  - History of problem
  - Biopsychosocial stressors and risk factors
  - Family history
  - Previous treatment etc.
  - The “initial assessment”
Case formulation

- Predisposing Factors
  - Personal & contextual

- Precipitating Factors

- Psychological problem

- Personal & contextual maintaining factors

- Personal & contextual protective factors
A psychosocial approach to risk assessment

- Remember, although there are a number of structured tools, their ability to accurately predict future self-harm or suicidal behaviour is questionable.
- Assessment of suicidal ideation and self-harm is an ongoing process and gives only a ‘snap shot’ of a young person’s risk at any one time.
- Risk is dynamic and changes; assessing the motives of an episode with adolescents is notoriously difficult.
- A psychosocial approach which takes into account an individual’s current and historical risk factors is essential.
The Integrated Motivational-Volitional Model of Suicidal Behaviour

Case formulation
Pre-Motivational Phase: Background Factors & Triggers

- Diathesis
- Environment
- Life Events

Motivational Phase: Ideation/Intention Formation

1. Defeat & Humiliation
2. Entrapment
3. Suicidal Ideation & Intent

Volitional Phase: Behavioural Enactment

- Suicidal Behaviour

Threat to Self Moderators (TSM)
- e.g., Social Problem-solving, Coping, Memory biases, Ruminative processes

Motivational Moderators (MM)
- e.g., Thwarted belongingness, Burdensomeness, Future Thoughts, Goals, Social Support, Attitudes

Volitional Moderators (VM)
- e.g., Capability, Impulsivity, Implementation Intentions (planning), Access to Means, Imitation (social learning)
Case Study – Jess: Reason for referral/precipitating factors

Jess, is a 20 year woman who self-referred to headspace following an unexpected break up with her boyfriend of one year. Jess had been experiencing distress, increased suicidal ideation, low mood and described feeling ‘numb’. Has poor body image, restricted food intake but currently normal weight. Jess has had previous contact with mental health services since the age of 14.
Jess: Initial assessment history

• Studying physics and Japanese; She hopes to be accepted for a Masters program
• Lives with much older sister and sisters partner since acrimonious separation of parents when she was 18
• Describes being emotionally abused as a child by parents (possible mood disorder in father, sister may have also experienced depression)
• Reluctant to involve sister (only have old phone no of mother on file)
• Depressed since 14; Diagnosed with MDD and EDNOS age 16: episodes of care at Orygen, headspace service, AMH
• On various antidepressants since diagnosed with MDD
Jess: Presenting concerns & perpetuating factors

- Low mood, scores in the severe range on the PHQ-9
- Poor sleep
- Anxiety symptoms (GAD scores in moderate range); panic symptoms
- MS deteriorated approaching exams: missing classes, overwhelmed by assignments and study, studying all night, not eating
- “I’m stupid”; “I can’t do it”, “no one will ever love me”
- Self-hatred, particularly appearance/weight: “disgusting”
- Profound sense of hopelessness (“have been like this for years”; “will it ever be different”; “it’s always the same”).
- Perfectionistic traits
- Felt unloved and a burden as a child loved. Was told she was a drama queen
- Socially isolated; little contact with friend; no one knew extent of her distress
Jess: Risk/issues

- Increasing suicidal ideation/crisis calls
- Hopelessness
- Difficulty with emotional regulation
- Withdrawal/social isolation
- Previous and current difficulty in engaging in services

Protective

- No previous self-harm
- No substance use
- High functioning; some insight/awareness
Integrated Motivational-Volitional Model

**Pre-Motivational Phase: Background Factors & Triggering Events**
- Diathesis
- Environment
- Life Events

**Motivational Phase: Ideation/Intention Formation**
- Defeat & Humiliation
- Entrapment
- Suicidal Ideation & Intent

**Volitional Phase: Behavioural Enaction**
- Suicidal Behaviour

**Moderators**
- Threat to Self Moderators (TSM)
- Motivational Moderators (MM)
- Volitional Moderators (VM)

**Moderator Examples**
- TSM: e.g., Social Problem-solving, Coping, Memory biases, Ruminative processes
- MM: e.g., Thwarted belongingness, Burdensomeness, Future Thoughts, Goals, Social Support, Attitudes
- VM: e.g., Capability, Impulsivity, Implementation Intentions (planning), Access to Means, Imitation (social learning)
Activity: Formulation using the IMV model

On your table, please:

• Read the case study/use one of your own and:
  • Keeping in mind the IMV model, what steps need to be taken; what is the salient information to be mindful of
  • Use the IMV model to help develop a formulation
  • Feedback to the large group
Integrated motivational-volitional model: Pre-motivational

- Emotional abused/neglected as a child
- Possible family history of mental illness
- Poor family functioning
- Interrupted development of self soothing/emotional regulation
- Perfectionism (internalised self-criticism)
- Unrelenting standards (internalised standards)
Integrated motivational-volitional model: Motivational

Defeat/humiliation
Due to stressors:
- Unexpected break-up with boyfriend
- Not achieving as had previously done in Japanese; missing classes due to mood/anxiety/sleep
- Ongoing stress of need to achieve particular grades to get into Masters in Physics
- MDD and eating psychopathology

Entrapment
“I have always felt like this; this will never get better”

Suicidal ideation/intent

Threat to self moderators
- Coping
- Memory biases
- Ruminative processes

Motivational moderators:
- Impaired positive future thinking
- Thwarted belongingness
- Burdensomeness
- Social disconnection
- Goal regulation
Case Study: Treatment plan

- History of poor engagement; initially engaged well then MS interfered
- Team plan – included management of crisis phone calls
- 10 headspace MBS funded sessions, but aim was for long term psychotherapy (which she was requesting)
- 10 headspace MBS sessions using CBT: psychoeducation including CBT formulation/’my model of depression’; chain analysis; activity schedule; early stages of cognitive restructuring
- Medical monitoring with GP.
- Psychiatric review re medication.
- Regular ‘check-in’ with Enhanced Care Co-ordinator
- Ultimately referral to adult mental health services for crisis management
- Target perceptions of defeat and brooding rumination via behavioural activation/activation of goal directed behaviour as well as identifying unrealistic goals and challenging with cognitive restructuring approach (?CBT-E)
- Target entrapment via cognitive restructuring; initial explanations with CBT model of depression helpful
- Target social support via cognitive restructuring and ? Social skills
- Target emotional stability by increasing distress tolerance
CBT model of depression

From the Cognitive Behavioural Therapy for Young People manual Available at:

Jess: Progress

• Escalation of risk due to deterioration in MS; increase sense of defeat and entrapment leading to more severe suicidal ideation and increased intent

• Failure to attend; increase in crisis calls due to more severe suicidal ideation (unable to guarantee safety; angry with self for not having already attempted to take her own life)

• Referred to adult mental health services due to need for crisis care; shared care till MS settled

• Referred and successfully engaged in long-term treatment with psychiatrist
‘Safety planning’, management and interventions
Immediate interventions for a suicidal person (1)

➤ Refer to Mindmatters - Educating for Life, 2002 (*Appendix Tool 2*)

• If actively suicidal, **do not leave them alone!**
  • If they leave call police
• Consult with senior staff/supervisor
• Reduce access to means of suicide
• Inform and gain support from
  • Doctor, crisis team, MH service, hospital etc.
  • Family members, carers or other support
Immediate interventions for a suicidal person (2)

- Provide a **clear explanation** to young person
- **Never** agree to keep a plan for suicide **a secret**
- Do not use guilt or threats
- Find out **what** and **who has helped** in the past
- Establish a ‘**safety plan**’
Safety plan/self-management plan

Should be done collaboratively with the client. Initially, explain that a safety plan:

- Aims to prevent the escalation of very distressing & painful thoughts and emotions
- Is designed to ensure the young persons safety in a time of crisis
- Can explain how to prevent future self-harm or suicidal crises
- Illustrates the seriousness of self-harm /suicidal behaviour & that it is worthy of attention
- May help the young person develop an increased sense of control over their emotions and resulting behaviour
- Highlights that self-harm/suicidal behaviour is manageable.

Safety plan/Self-management plan

In the plan include:

1. The client’s ‘early warning signs’
2. Coping strategies they could try to feel better
3. Identify potential obstacles to coping strategies
4. People & social settings that provide distraction
5. People they can contact for help including:
   • Personal supports (e.g. friends)
   • Professionals (e.g. school welfare worker, clinician)
   • Agencies (e.g. kids helpline)
6. How they can make the environment safe (e.g. removing access to paracetamol, sharp objects or rope).
# Safety Plan

**My early warning signs**

- I feel....
- I think....
- I notice....
- I do these things....

**Things I can do that may provide distraction or help soothe my distress**

**Things my friends and/or family do to support me**

**Things that will make my environment safer**

**People and social settings that provide a distraction**

<table>
<thead>
<tr>
<th>Name</th>
<th>Place</th>
<th>Phone</th>
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**People I know I can rely on who can call for help**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
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**Professionals or agencies I can call during a crisis**

<table>
<thead>
<tr>
<th></th>
<th>Phone</th>
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<tbody>
<tr>
<td>School welfare worker:</td>
<td></td>
</tr>
<tr>
<td>Clinician:</td>
<td></td>
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</tbody>
</table>

**Emergency Services 000**

- Lifeline 13 11 14
- Kids helpline 1800 55 1800
- beyondblue support service 1300 22 4636

Online and app based safety plans

- Young people are often on the go and using technology
- Consider an electronic safety plan so that they can easily access it any time any where.
Self-management plan

- Where possible, include parents or another trusted adult/support person in the development of the plan and provide them with a copy once completed.

- Although it is important to respect confidentiality, depending on their level of risk, this confidentiality may have to be breached.

- Regularly review the plan, it is not a static document.
Ongoing management

• Monitoring of treatment progress and symptoms, including self-harm and suicidal ideation is critical
  o Based on formulation treatment targets (what is driving behaviour)
  o Weisz top problems
  o ORS/SRS
  o PHQ-9*
  o SIDAS/Brief Suicidal Ideation Screening Measure*

• Self management: Monitoring of the self harm/suicidal ideation: log includes time of day, actual behaviour, behavioural/emotional/cognitive/environmental antecedents and consequences; settings goals; reward planning; identifying function of behaviour and goal setting for alternative behaviour

*as a prompt for further discussion, assessment, and intervention i.e. not risk assessment for the purpose of categorisation and allocation of treatment
Evidence based interventions: Psychosis: RANZCP DSH guidelines

• Clozapine may reduce suicidal behaviours in early psychosis/ early-onset schizophrenia.
• CBT may reduce suicidal behaviours in early psychosis/early-onset schizophrenia.
• The organisation of mental health services to ensure early detection and treatment for patients with first-episode psychosis and availability of specialist early psychosis services may reduce non-fatal suicide attempts.
Evidence based interventions

• Any age: Meta-analysis showed any psychological/psychosocial intervention effective: CBT and short term psychodynamic psychotherapy most promising (Carter et al 2016; Hetrick et al 2016)
• Young people: smaller evidence base.
  o Carter et al guideline: CBT, MBT and DBT promising; timeliness of initiating intervention critical given repetition often within 1-4 weeks
• Technology-based interventions?
• Five factors key to interventions (Brent et al., 2013)
  ✓ Motivation to change;
  ✓ Maintenance of sobriety;
  ✓ Familial or non-familial support;
  ✓ Promotion of positive affect;
  ✓ Healthy sleep.
Key points in supporting young people at risk

• Engagement & consistency of care
• Risk assessment is a dynamic, compassionate conversation; do not rely on a single ‘risk assessment’ measure or prediction
• Individual safety/self-management planning
• Engage systems of support
• Engender hopefulness
• Develop adaptive coping skills
• Manage acute risk
• Consultation & supervision
We now know more about:

- Understanding terms and appropriate use of language around suicide and self-harm
- Identifying risk and protective factors (detect signs)
- How best to approach risk with young people – individual interventions
- How to apply a theoretical model to client work
- Managing, planning, and monitoring suicidal behaviour and self-harm
- Evidence based interventions
Any questions?
Useful resources

– Royal Australian and New Zealand College of Psychiatrists
  https://www.ranzcp.org/Home.aspx
– “Understanding self-harm for professionals”
  https://headspace.org.au/health-professionals/understanding-self-harm-for-health-professionals/
– Mental Health Foundation https://www.mentalhealth.org.nz
  • Looking the other way: Young people and self-harm
  • Raising the Bar for youth suicide prevention
Useful reading

Books:

Papers:
• Hogan, M.F. (2016). Better suicide screening and prevention are possible. JAMA Psychiatry. Published online.
• Zenare, F. (2009). Suicide Clusters and Contagion. Student Services, National Association of School Psychologists
Thank you

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