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Your Health in Mind

Child and Adolescent Mental Health – Suicide and self-harm in adolescents

Associate Professor Sandra Radovini

Dr Leeanne Fisher

Webinar outline

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- Introduction & Housekeeping
  - **Dr Greg Young**, Clinical Senior Lecturer, Department of Psychological Medicine, Otago University and member of the RANZCP Rural Psychiatry Working Party.
- Working with High Risk Young People: An approach to Self Harm & Risk Assessments
  - **Associate Professor Sandra Radovini**, Director of Mindful, Department of Psychiatry, University of Melbourne and Clinical Director of headspace National Office
  - **Dr Leeanne Fisher**, Clinical Director of Austin Health CAMHS, Melbourne
- Questions and Answers
  - Participants (that's you!) & presenters

Housekeeping

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- The presenters can't see or hear you, so if you are experiencing technical problems please telephone **1800 733 416** for IT assistance.

- Please dial in and listen via telephone

  Australia - Dial 1800 896 323

  New Zealand – Dial 0800 441 984

  then enter the pass code **31995035#**

- Use the chat box to ask for assistance

Audience participation

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- Let us know who's participating

- Send in your questions. Use the chat box!

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Your Health in Mind

Working with High Risk Young People: An approach to Self Harm & Risk Assessments

Assoc Professor Sandra Radovini

Dr Leeanne Fisher

Managing risk

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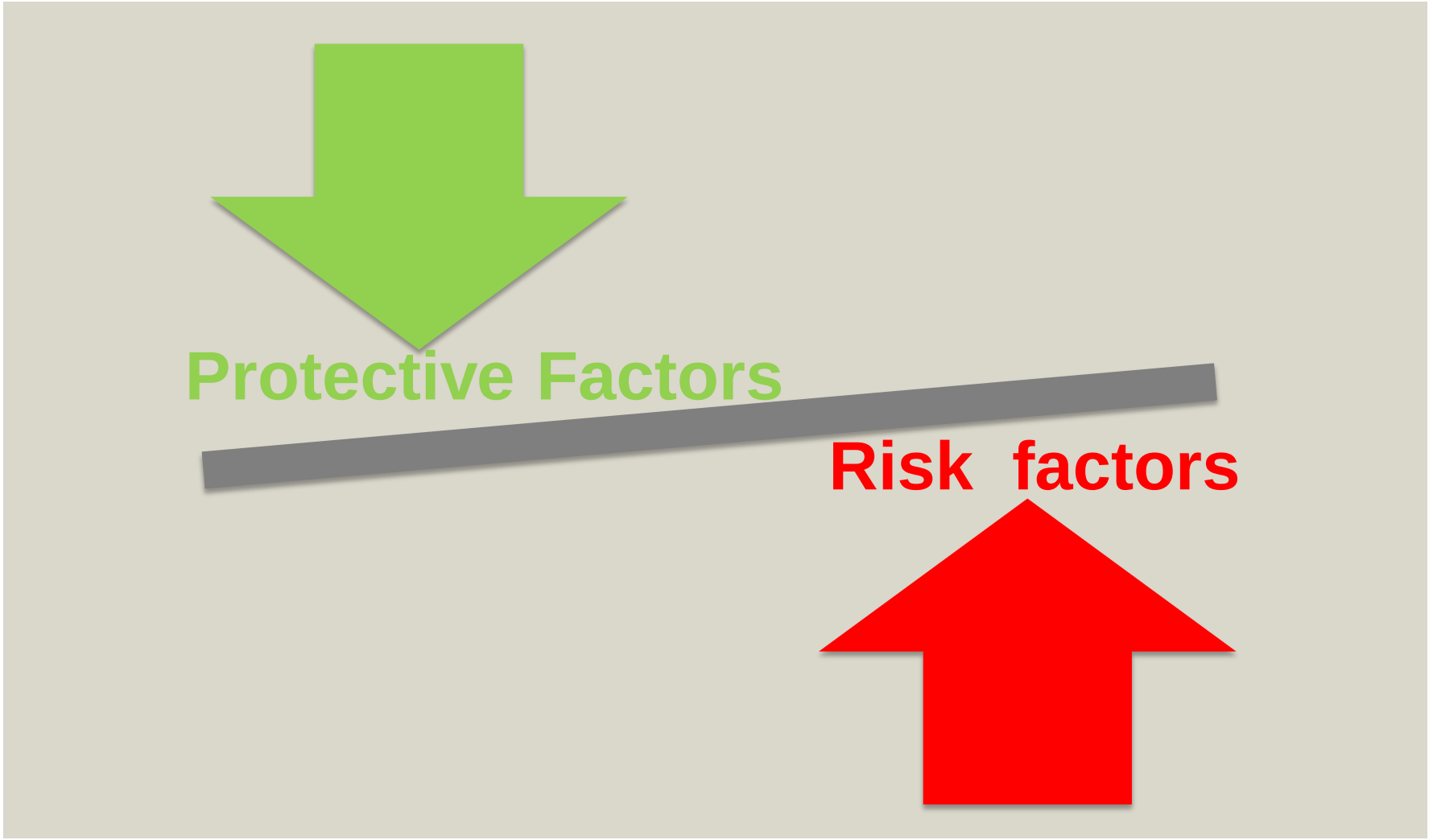

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- Understanding & identifying **risk** and **protective** factors is vital in assessing a young person's risk and in identifying appropriate interventions.

Selected risk factors for adolescent mental health problems

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Individual:

- Low self esteem
- **Poor social skills**
- **Poor problem solving**
- Difficult temperament
- Birth injury/disability/low birth weight

School:

- **School failure / dropout**
- **Bullying**
- **Peer rejection**
- Deviant peer group

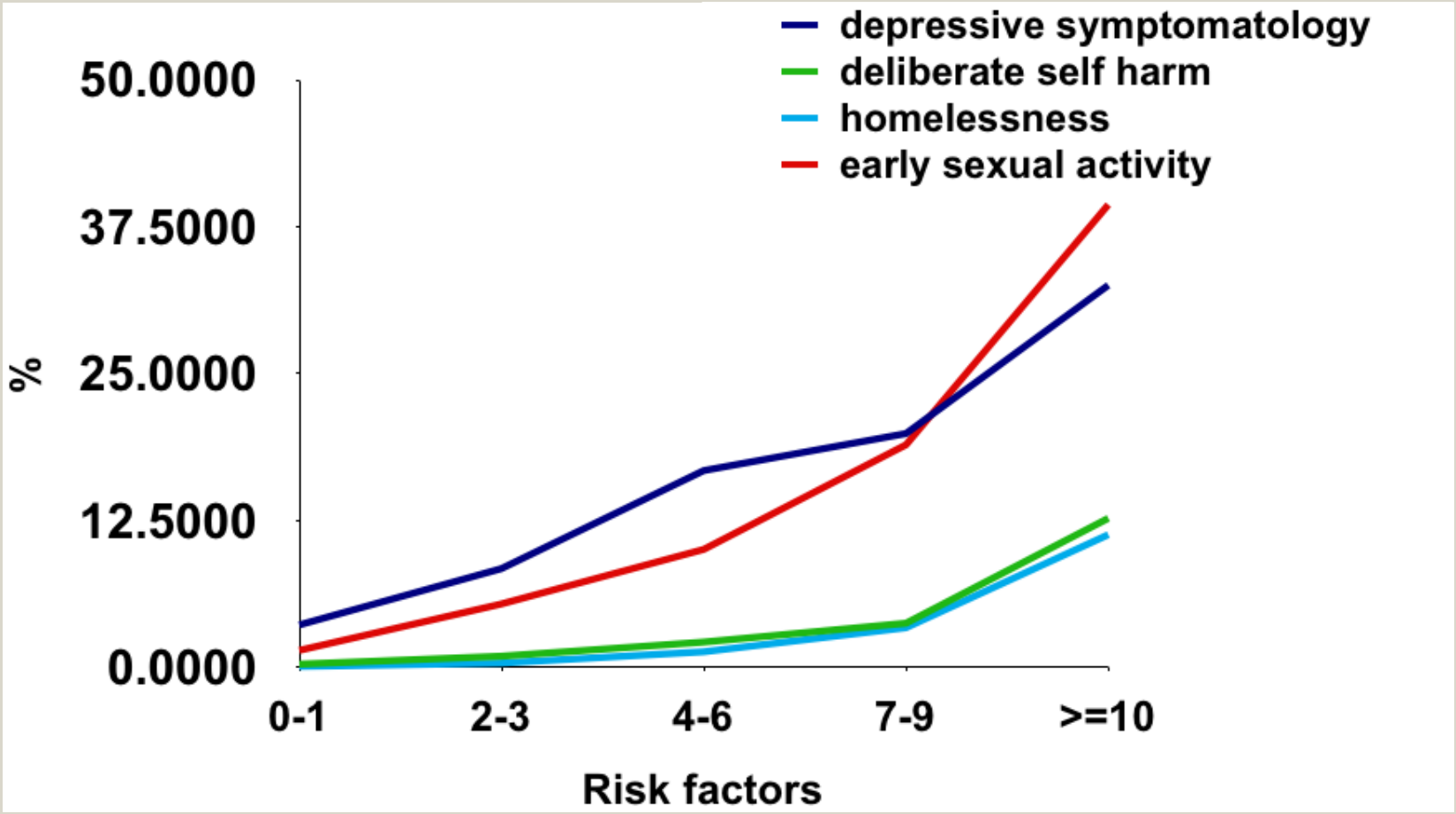
Family:

- **Family conflict/breakdown**
- Inconsistent discipline
- Lack of warmth and affection
- Abuse and neglect
- Parental substance abuse

Community:

- Socio-economic disadvantage
- **Exposure to violence and crime**
- Homelessness
- Refugee experience
- Racism / discrimination

Cumulative effect of risk factors



Bond et al. (2000)

Selected protective factors for adolescent mental health problems

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Individual:

- **Social competence**
- **Problem solving skills**
- Optimism
- Good coping style
- **School achievement**
- Healthy physical development

School:

- Pro-social peer group
- **Positive achievements and sense of belonging at school**
- Opportunities for participation & success

Family:

- Supportive caring parents
- **Secure and stable family**
- **Supportive relationship with other adult**
- Attachment to family

Community:

- **Sense of belonging**
- Access to support services
- Participation in community
- **Strong cultural identity / pride**
- Secure home/ housing

Cumulative effect of protective factors

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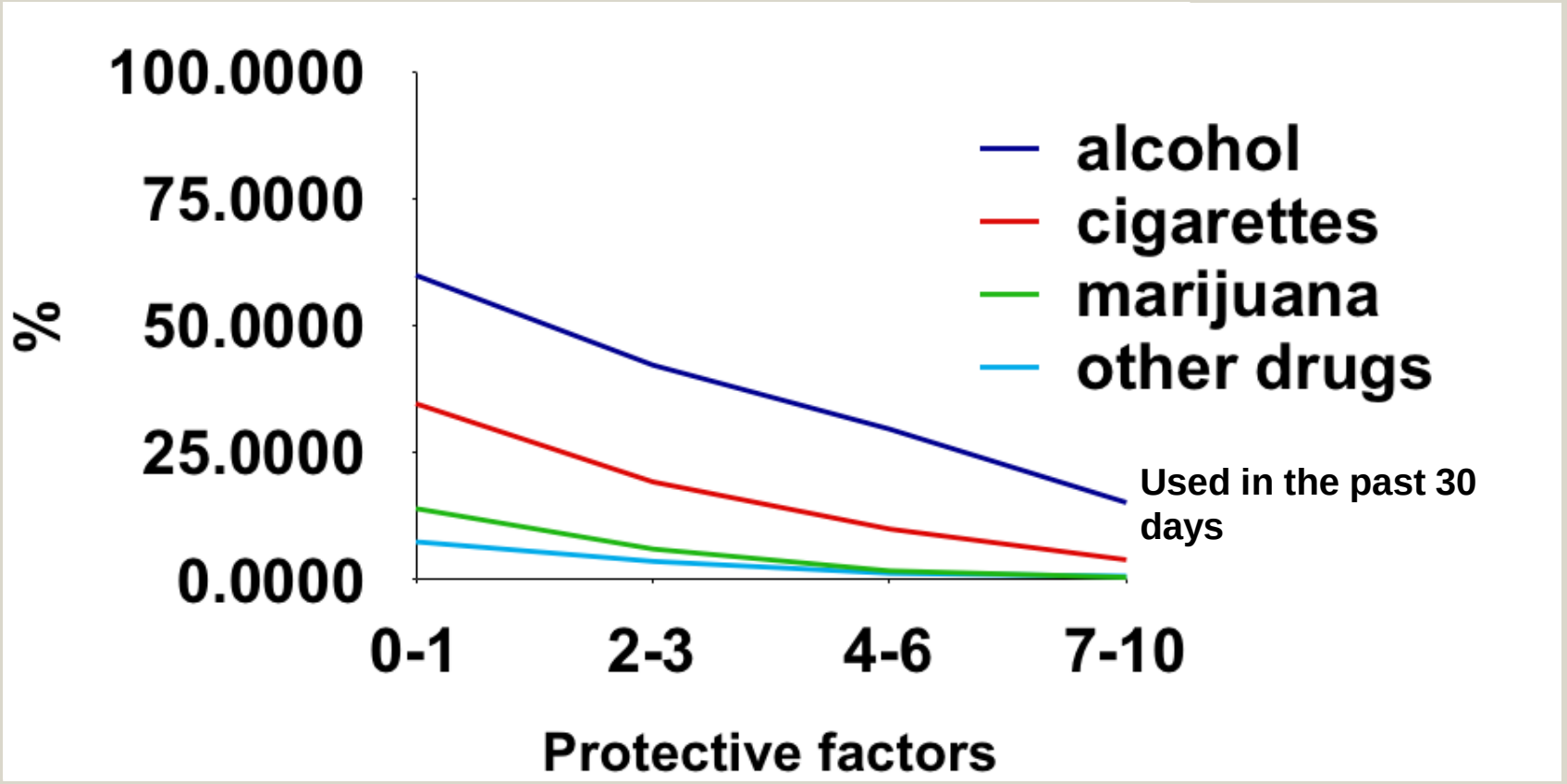

Bond et al. (2000)

High Risk Young People

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1. High-Risk Behaviours
   - Deliberate self-harm (80%)
   - Suicide attempts (58%)
   - Interpersonal violence (58%)
   - Risk-taking behaviour (53%)
   - Criminal behaviour (40%)
   - Problematic substance use (63%)

Based on 60 clients seen between 2005-09 By IMYOS Team Orygen Youth Health.

High Risk Young People (continued)

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2. Problematic Histories
   - Family breakdown prior to age 4 (67%)
   - Family mental illness (78%)
   - Attempt/ suicide in family (33%)
   - Exposure to domestic violence (60%)
   - Childhood abuse (70%)
   - Poor school attendance (77%)
   - Multiple accommodation changes (48%)

High Risk Young People

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3. Complex mental health issues

- On average, clients have 2 principal diagnoses
  (typically mood, substance related, and/or anxiety disorders)

- Additionally, 45% of clients have personality difficulties
  (most commonly Borderline Personality Traits)

- 13% of clients have limited cognitive abilities
  (Borderline IQ and mild ID)

Deliberate self-harm: definitions

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- "The deliberate harming of oneself regardless of intention or purpose"
  - **Deliberate self-harm**
  - Deliberate self-poisoning
  - Attempted suicide
  - Parasuicide

- 'Non Suicidal Self Injury'

Deliberate self-harm: prevalence

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- 12 - 20% lifetime prevalence
- 1.2 – 5% of hospital admissions are due to self-poisoning

Deliberate self-harm and suicide risk

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- 50% who die from suicide have previously histories of DSH
- Rate of suicide is hundreds of times *higher* in those who DSH than among the general population
- Risk greatest in first 5 years but remains high throughout lifetime

Suicide – 2012 snapshot

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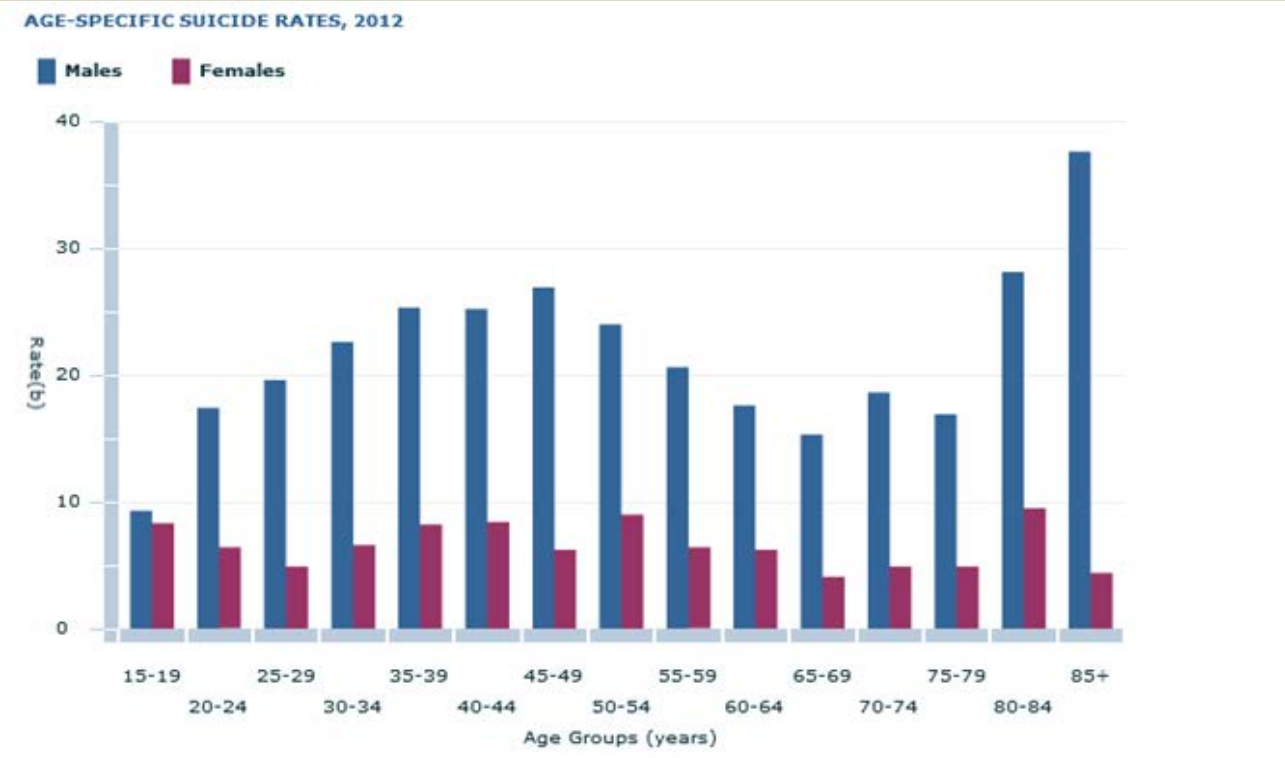
- 2,535 deaths from suicide (1.7% of all deaths)
- 14th leading cause of death in Australia
- 75.0% are male → 10th leading cause of death for males.
- Deaths due to suicide occurred at a rate of 11.0 per 100,000 people in the population.

Gender

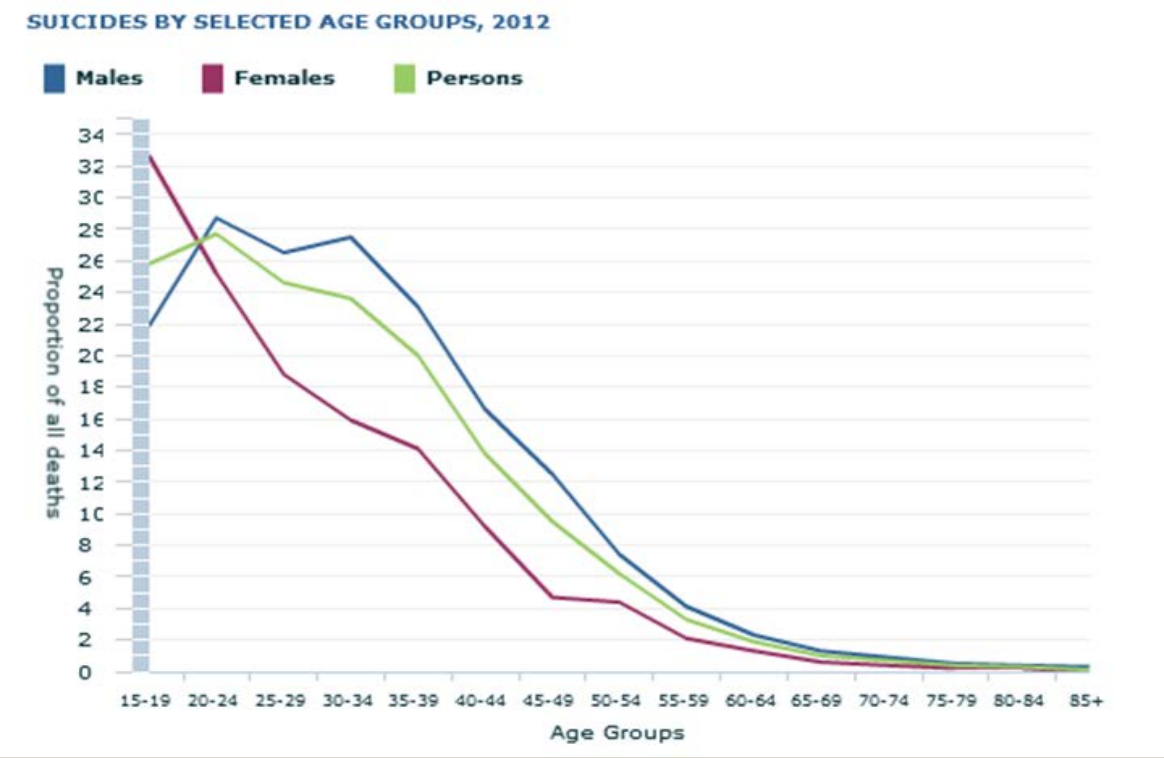
- Much more common in **males** than females → in 2012, 16.8 per 100,000 males; 5.5 per 100,000 females.



→ Gender difference can be seen across all age groups but smallest in 19 y/o and under.

Age

- Suicide accounts for 1.7% of all deaths in Australia, but the proportion is higher in certain age groups:



Females

- **32.6%** of deaths of 15-19 y/o's
- **25.2%** 20-24 y/o's

Males

- **28.7%** of 20-24 y/o's
- 26.5% of 25-29 y/o's
- 27.5% of 30-34 y/o's

School-aged children

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- The **number of deaths** of school-aged children is small, but is significant in terms of the **proportion of deaths** in this age group

- In 2012, **15-19** year age group:
  - 9.3 males per 100,000 people; **21.9%** of all deaths
  - 8.3 females per 100,000 people; **32.6%** of all deaths

- In 2012, 5-14 year age group:
  - 0.4 males & females per 100,000 (0.8% of deaths)

Aboriginal and Torres Strait Islander

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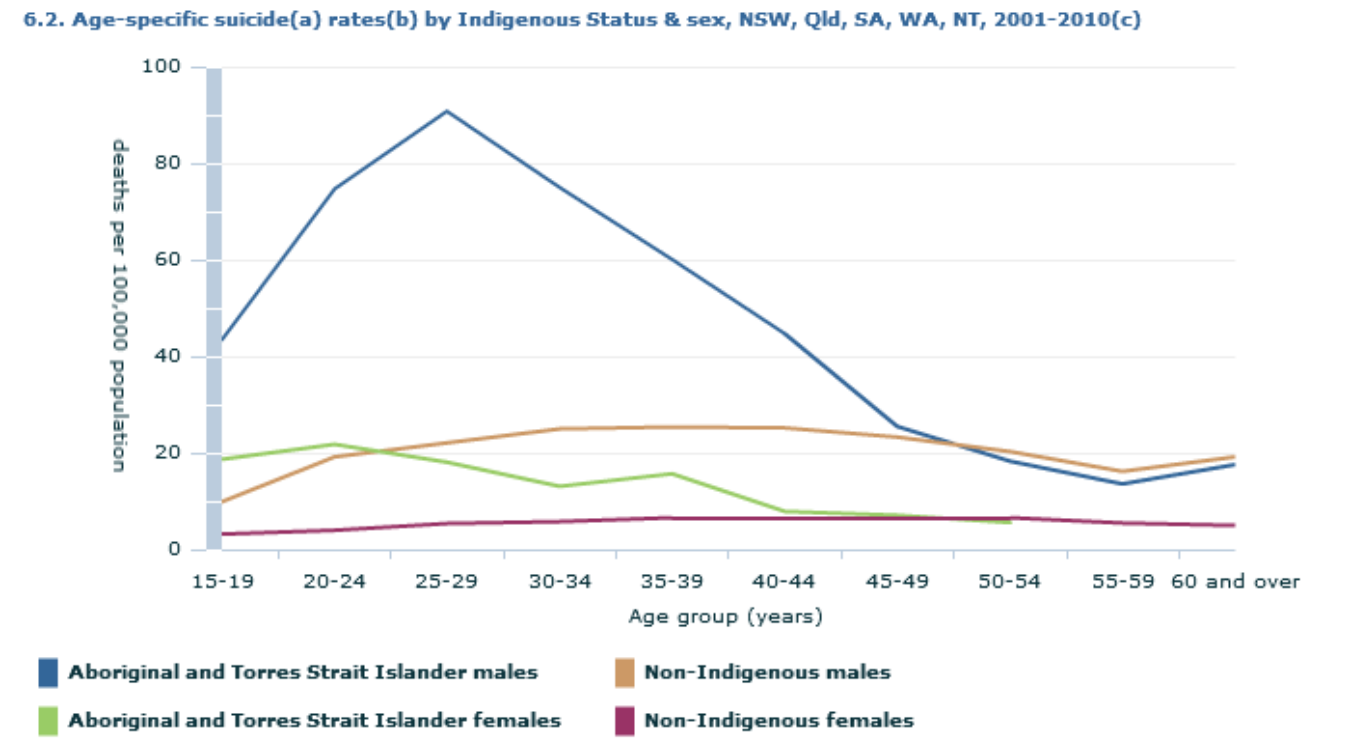

ABS Catalogue 3309.0 Suicides, Australia, 2010

Change over time – 15-19 years

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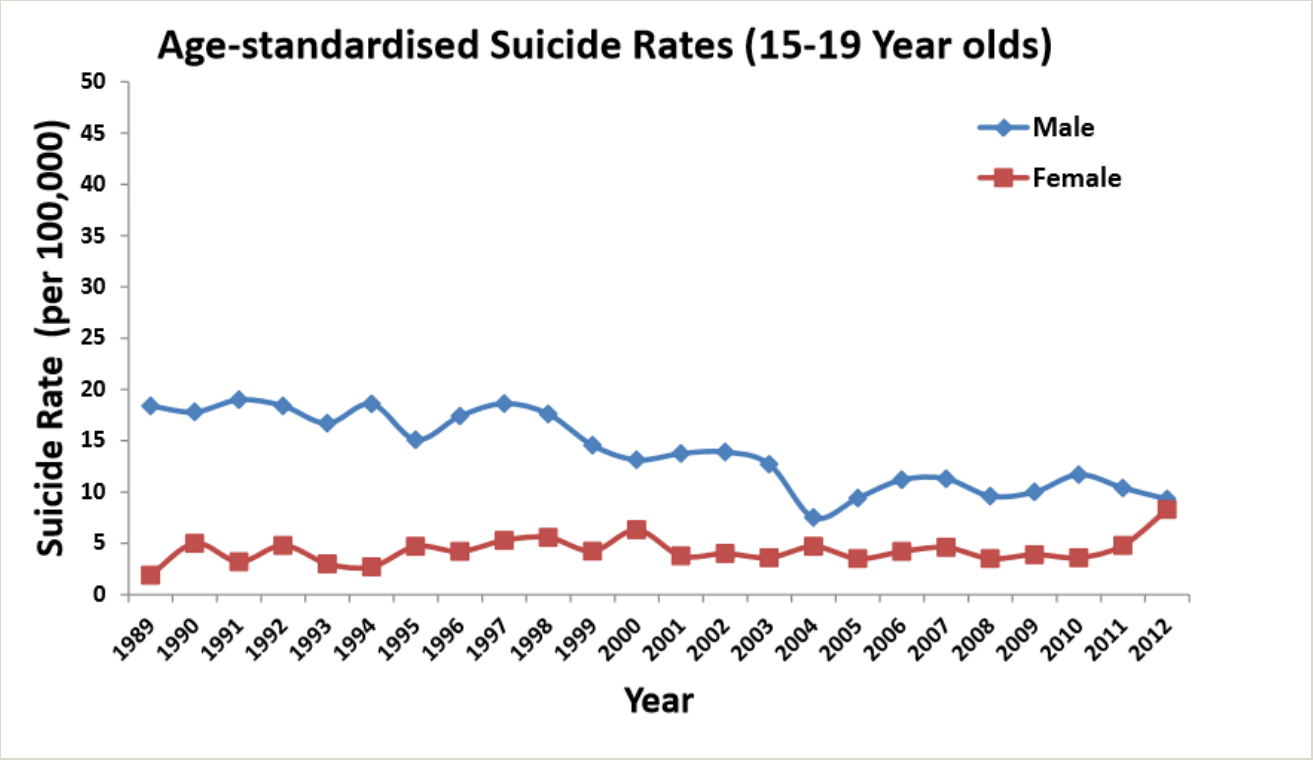

ABS Catalogue 3303.0 Cause of Death Australia, 2012 (via **Mindframe**)

Deliberate Self Harm (DSH)

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- WHO?
- WHEN?
- WHY?

Deliberate Self Harm – Who? Predisposing

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- Mental illness - greatest risk
  - Depression*
  - Substance misuse
  - Conduct disorders
- Social & childhood adversity
- Personality difficulties
- **CUMULATIVE!**

Deliberate Self Harm – When?
Precipitants

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- Relationship difficulties
  - With peers-being bullied
- Stressful life events
  - Interpersonal losses
  - Conflict (parents; peers; boy / girl friends)
  - Legal problems
- **Cumulative**

Deliberate Self Harm– Why?

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- To reduction/ manage distress
- To express anger towards self or others
- To express hate towards the body
- To feel heard
- To communicate the intensity of subjective distress
- To elicit behaviours from others which will decrease the pain/distress
- In response to psychotic symptoms

* We don’t usually include AOD and Eating Disorders as Deliberate Self Harm

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Your Health in Mind

Risk Assessment

Young people and risk

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- In adults (>20yo)
  - Lethality is related to suicidal intent
- In young people lethality NOT related to suicidal intent
  - Perhaps due to naivety
  - Perhaps due to limited access to lethal means
  - The finality of death is difficult for them to understand
  - They do not know their intentions (confused)
  - Their intentions change
- So the risk of accidental death can be high
  - All risk behaviour should be taken **seriously**

Self harm and suicidal behaviour: A continuum of risk

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	Self Harm	Suicidal Behaviour
Intent	E.g. To manage distress To feel something To die?	To die
Method	Cutting, burning, overdose	Hanging, overdosing, jumping
Lethality	Usually not life threatening	High lethality

3 important steps

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- Assessment
  - Assessing risk AND broader psychosocial formulation
- Management of risks
  - Safety planning
  - Containment
- Intervention
  - Promote good mental health
  - Ease suffering from mental health problems
  - Interventions to decrease risk
  - Longer term therapy to address underlying issues

Assessment – Risk of What?

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- Suicide, Deliberate Self Harm, accidental death
- Violence, abuse, neglect (to others, by others)
- Disorganisation and poor self care
- Offending behaviour
- Deterioration in mental and/or physical state
- Exposure to trauma (e.g. by absconding, prostitution)
- Loss of social networks/schooling, homelessness
- Problematic drug and alcohol use
- Impulsivity, accidental injury/death

Assessment – How Risky is Risky?

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- Risk is specific to each individual,
  - Their *current* mental state
  - Their *current* physical state
  - Their *current* stressors
  - Their *current* supports
  - Their appraisal of these factors

- Risk needs to be assessed regularly – it is not static

Assessing risk

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- PLAN: What plans and thoughts do they have?
- MEANS: What does the young person have access to?
- INTENT: How likely does the young person think they are to act on these thoughts?

Risk assessment – PLANS

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- CURRENT thoughts of self harm/suicide:
  - What
  - How often
  - Who knows
  - How elaborated is the planning?

Risk assessment – MEANS

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- Access to means:
  - Is this a dangerous method?
  - Are the means easy to access?
  - Do they understand the lethality?

Risk assessment – INTENT

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- Intent to act on thoughts:
  - Does the young person experience active or passive thoughts
  - What's the likelihood that they will act on these thoughts
  - Do they have a history of impulsivity?

Risk assessment – DOCUMENTATION

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- **Consider and Document**
  - Risk of what- DSH, suicide, accidental harm/death
  - Acute vs chronic
  - Predisposing vs precipitating factors
  - Dynamic vs static factors
  - Protective
- **Management plan**
  - Must reflect the above
  - Document the decision making process- **'why' & what**
  - Seek second opinion
  - Get higher organisational support for the management plan of very high risk YP

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Your Health in Mind

Management

1. Immediate/crisis intervention

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- **Safety First** – Call security, police and ambulance if immediate danger/risk

Prior work….

- **Develop Safety Plan** – what can a Young Person do to keep themselves safe and what the clinician is going to do, when and why. No surprises!
- **Appropriate help seeking** – Talk to the young person about utilising services and other supports to help them cope with difficulties and manage distress
- **Appropriate communication of risk** – Inform relevant family members/significant others of risk.

If risk to others, notify person at risk or/& police

Safety plan

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- Safety plan is a working agreement with the young person about how to manage future risk issues.

- Aim to do this *collaboratively* with the young person

Example

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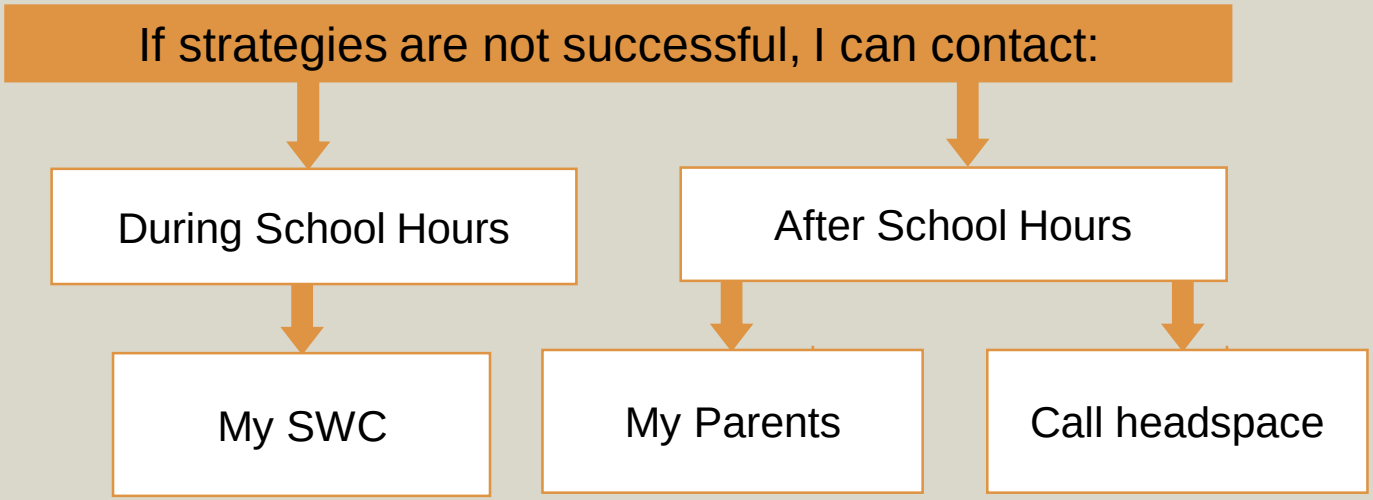
Safety Plan for: **Date:** **Review Date:**

These signs tell me that things are getting worse:

1) 2)…

When I'm feeling distressed or upset I have choices and strategies to keep myself from harming myself:

1) 2)…



2. Ongoing work

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- **Understand the meaning/triggers of the behaviour** – (fear of abandonment, seeking care/ conflict….)
- **Learn appropriate self soothing** – Make a plan about what to do to help minimise self harm.
- **Learn appropriate help seeking** – Ask a Young Person what they would find helpful. e.g.. Practical assistance with schoolwork, talking with the SWC, etc.

  - **Be clear** about your role and capacity to help
  - **Be consistent** in your response
  - **Organize case conference** with other professionals and build in reviewing of plan

2. Exploring suicidal thoughts

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- Useful to find out about the **process leading to suicidal thoughts**, including:
  - Precipitating event (real or perceived)
  - Increase of intolerable emotions
  - Attempts to stop self
  - What works
  - What doesn't help

2. Interventions: things to consider

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Possible areas for skill development:

- Problem-solving
- Social skills
- Assertiveness
- Interpersonal effectiveness
- Anger management
- Self awareness/soothing
- Relaxation/mindfulness

Tracking the self harm ‘triggers’

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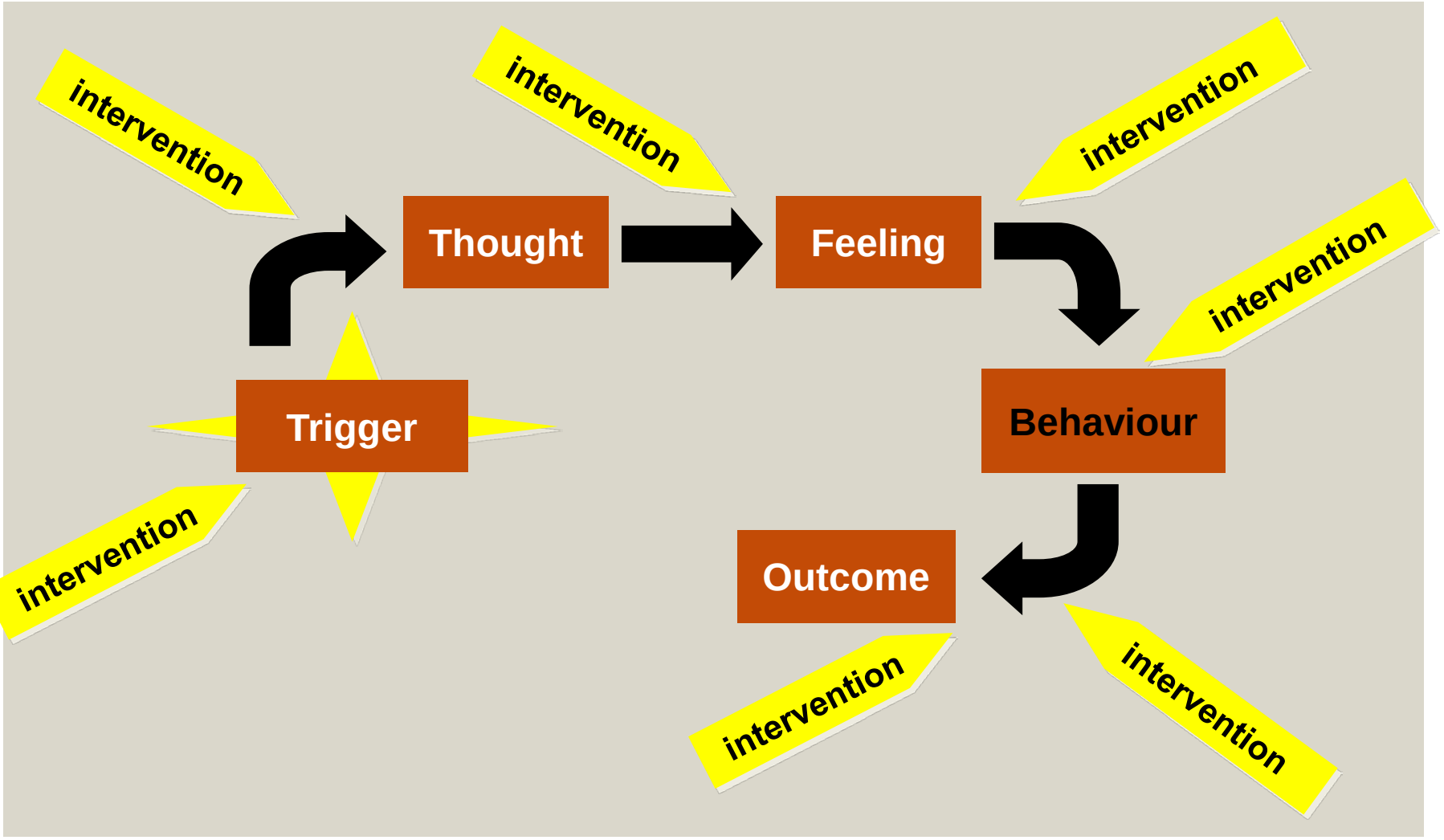

Cognitive Behavioural Therapy intervention strategies

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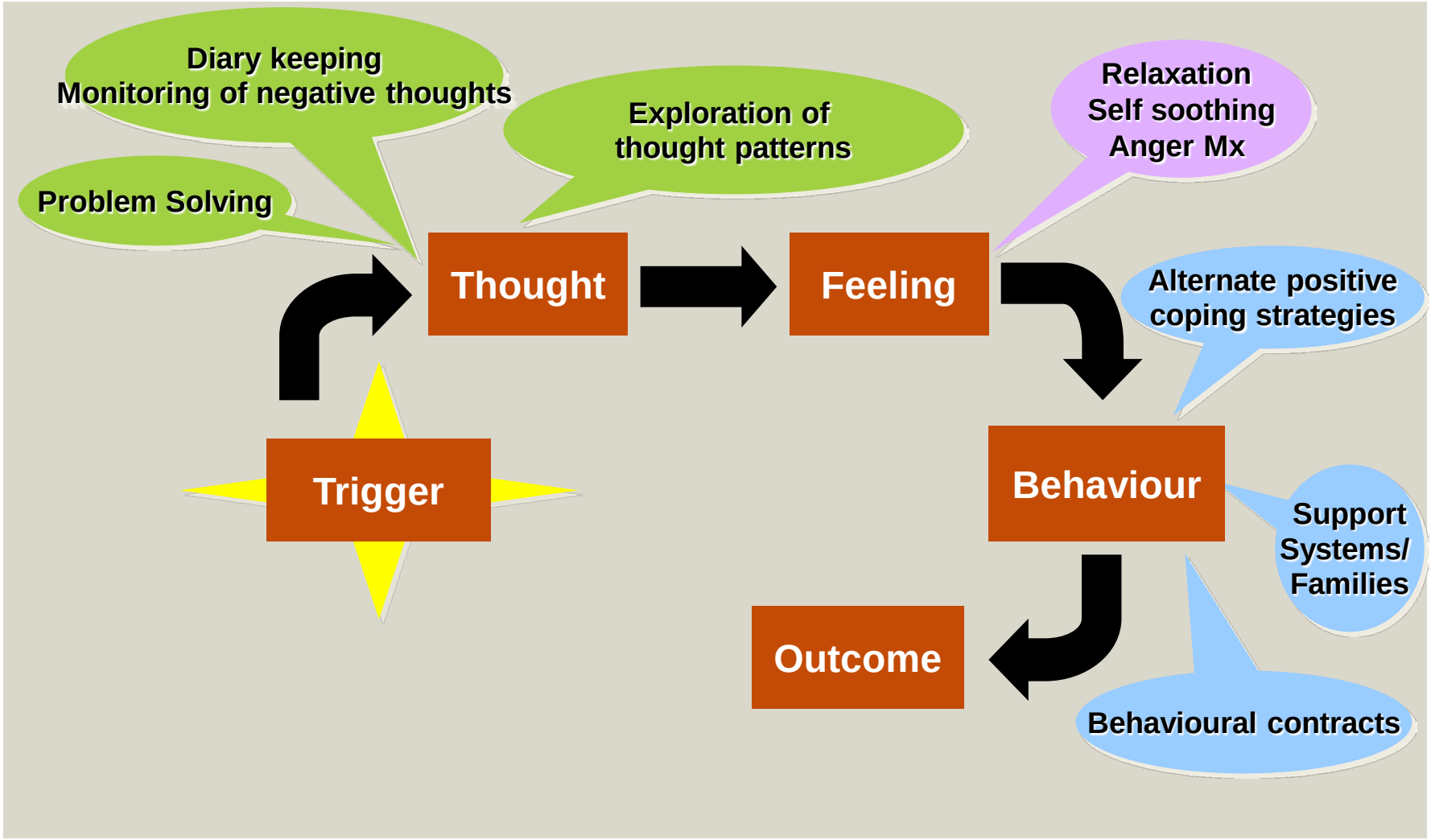

3. Supporting families

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- Families may be shocked, scared, angry
- Provide psychoeducation to the family
- What things can be done to ensure the health and wellbeing of the young person
- Handouts can be useful e.g. Safety plan

Ethical decision making

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1. Confidentiality

2. Clinically indicated risk taking

1. Confidentiality: informing parents and others

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- Balancing act between **privacy** and **safety**
- Explain limits of confidentiality to Young People and family
- Important to consider what is **helpful support** and how will people react to the information.
- When deciding to talk with the family, talk with the young person about **what you are going to say and how you will say it**.
- Give them the option to be there or not

Working with families

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- Be clear and transparent with the Young Person & family early on about when and why you need to involve care givers.
- Consider:
  - Superficiality vs severity
  - Age
  - Intent

2. Duty of care vs Clinically indicated Risk Taking

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- If a Young Person is chronically at risk of self harm short term strategies to ensure safety (e.g. hospitalisation) can stop them from finding ways to make change in the long term.
- Need to be able to learn and practise strategies for managing distress.
- This is a difficult clinical situation and requires supervision and sign off.

The impact of this work on us

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Self Harm evokes a range of thoughts and reactions…

- Unexpected emotions
  - Why do I feel so angry? Irritated? Frustrated? Unsure? Sad? Distressed?
- Self-doubt
  - Am I doing enough? Am I doing the right thing
- Wanting to help
- Wanting to ‘rescue’
- Identifying with the client
  - I know just how that feels

The impact of this work on the team

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- Team Conflict
  - We all have different ideas about how to help – feel convinced of the ‘best’ response
- What can these reactions tell us about
  - Responsibility for change – who is carrying this?
  - Ambivalence about change – why don’t they try new ways?
  - Our boundaries
  - Client’s boundaries/client’s fragmented self

Working with YP who self harm

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- Collaboration
- Communication
- Consistency

- A parallel process with:
  - the young person
  - the family/carer
  - the team
  - the broader system.

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Your Health in Mind

RANZCP Examinations

RANZCP Examinations

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- Written examination comprises 2 papers marked at a junior consultant level
- MCQ paper comprises EMQ’s and CAP’s covers foundational knowledge from stage 1 & 2 syllabuses
- Essay-style paper comprises MEQ’s and a CEQ

RANZCP examinations – Writtens

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- Could this topic be examined in all question types?
- Probably, but most likely in MEQ's as these are based on clinical vignette's and then ask you to describe clinical aspects of your work i.e. approach, assessment and management
- E.g. Scene could be set by involving the Emergency Department presentation of a 15 year old girl, accompanied by friends, who receives medical treatment for DSH wounds and asks that her parents aren't informed

RANZCP examinations – Writtens (continued)

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- A CAP might be based on a paper in the subject area but what is being examined for is not content knowledge but ability to critically appraise the paper
- Specific factual knowledge could be examined for in EMQ's
- Epidemiology, risk factors, outcomes etc.

RANZCP examinations – Writtens (continued)

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- CEQ
- A topic that might identify particularly vulnerable groups i.e. either end of the age spectrum, a topic that looks at capacity and consent issues, ethics of compulsory treatment of a child etc.
- Attend to the marking schedule

RANZCP examinations – Clinical

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- OSCE format
- Highly likely to come across a station on this topic
- Why?
- All the syllabus can be examined for, so if there is way to construct a station around a topic that looks at, for example, risk in young people and working with parents & carers then it addresses a number of syllabus areas
- A summative examination testing competence in skills, knowledge and attitudes and set at the junior consultant level

RANZCP examinations – Clinical (continued)

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- Possible to construct a station where the actor is either a young person and playing the role of the suicidal or self-harming young person, or
- An actor plays the role of a parent/carer/teacher etc. or
- An examiner plays the role of a referring professional e.g. someone from another agency (concerned child protection worker) or your concerned colleague (case manager wanting a psychiatric opinion)

RANZCP examinations

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- In conclusion, there are many ways in which this material might be examined for
- C & A psychiatrists are active members of the CFE
- All CFE members recognise the importance of developmental aspects of presentations and management

Question and answer

Upcoming events:

The next webinar in this series will be **Side effects of antipsychotic medication** webinar on **Tuesday 10th of November,** chaired by A/Prof Ravi Bhat and with speakers A/Prof David Menkes and Prof Tim Lambert. To register for this webinar click here.

Closing comments

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- Thank you for your participation
- Help us by completing the exit survey for this webinar
- Continue the conversation on the College online forums www.ranzcp.org/forums
  - Use your College membership details to login
  - Agree to the Terms and Conditions
  - Find our thread in the Clinical Practice issues section titled ‘Child and Adolescent Mental Health – Suicide and self-harm in adolescents webinar’

References

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