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Research Brief

Preventing self-harm among young people in out-of-home care

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It should be noted that reading about and engaging with material that explores the issue of self harm and suicidality may lead to experiences of distress. This should be acknowledged and support sought if required.

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Introduction

Many young people in out-of-home care are at an elevated risk of self-harm and suicidality. The reasons range from early exposure to abuse, disconnection from family, instability of their living arrangements and poor self-image (Furnivall, 2013; Taussig et al., 2014; Hamilton et al 2015). In the Australian context, there is still little knowledge of which factors lead to the behaviour and just how widespread the problem actually is (National Children's Commissioner 2014).

Importantly, there is a lack of evidence about the effectiveness of programs designed to prevent suicide and self-harm in the out-of-home care population. The number of programs being offered that target these issues appear to be small. Brown (2020) suggested that suicide prevention is not a focus of any programs for those in out-of-home care for which published literature can be located. Whilst there may be limited published literature available, staff and carers working with young people who self-harm, need information and guidance about ways to identify, assess and intervene to keep young people safe.

This Research Brief seeks to provide an overview of

- why young people in out-of-home care self-harm
- what are the predictors of suicide and self-harm
- how to best intervene to stop attempts at suicide and self harm
- what out-of-home care providers need to know to prevent self-harm and suicide.

Defining suicide and self-harm

In the literature, 'suicide' refers to the act of taking one's life, and 'suicidality' to thinking and actions related to, or consistent with, a desire to take one's life. 'Self-harm' refers, in some contexts, to any of a broad set of behaviours that have pain or self-injury as the intended outcome, including self-maiming, risk-taking and substance abuse. Other literature adopts a concept of self-harm that is referred to as Nonsuicidal Self-Injury

(NSSI). This term refers to more direct physical self-abuse such as cutting, burning and punching. Not all research literature, however, makes clear how their central terms have been defined.

Prevalence of suicide and self-harm

Limited Australian research suggests that self-harm and suicidal behaviour is more common amongst children and young people in out-of-home care than the broader population under 18 years of age (National Children's Commissioner, 2014). One Australian study involving 326 young people in home-based out-of-home care found that 6.7% of those aged 13-17 made a suicide attempt that required medical treatment in the previous twelve months (Sawyer et al., 2007; Carbone, 2009). The same study found that suicide attempts by those in foster care were also of a more 'serious nature' than those made in the broader population (Carbone, 2009).

International evidence also indicates that the risks of self-harm and suicide are higher for out-of-home care populations. A systematic review by Evans et al (2017) of articles published between 2001 and 2011 found that the prevalence of suicidal ideation and suicide attempts by young people in care were 24.7 per cent and 3.6 per cent, respectively, compared with 11.4 percent and 0.9 per cent for non-care populations. In the US, Taussig et al (2014) found that suicidal ideation for youth in out-of-home care ranges from 7% to 27% and attempts from 8% to 15% - 3 to 9 times higher than for the broader population. Young people in out-of-home care have been found to be between four and five times more likely to require hospitalisation following a suicide attempt (Vinnerljung et al., 2006). More recent research has found that the rates of suicidality and self-harm amongst those in out-of-home care across locations such as California, Spain, Germany and Ireland are high, or greater than 20% of the populations studied (Okpych & Courtney, 2018; Aguilla-Otero, 2020; Ludtke et al., 2018; Hamilton et al., 2015). This is consistent with findings that the prevalence of risk factors such as depression are also much higher amongst those in out-of-home care compared to the broader population (Chavez-Hernandez, 2014).

The risks of self-harm are generally greater for young people in residential care. Kim et al (2019) found that the number of suicide attempts amongst children and adolescents in residential care in Korea were much higher than for those cohorts in other out-of-home arrangements. Anderson (2011) found that, at the baseline point in his research, young people in group homes were five and seven times more likely to be suicidal than those in foster and kinship care. Gabrielli et al (2015) also found that young people in residential care and staff report intentions to self-harm (on the part of the young people) with greater frequency than do carers for those in other forms of out-of-home care. The authors speculated, however, that this may be due to the greater scrutiny and reporting requirements in residential care given that other research has found no differences in risk among those in different forms of out-of-home care.

Canadian research has uncovered important differences in self-harming behaviour amongst 252 young people involved with child welfare according to gender. Females comprised the majority of repeat incidents and were more likely to require medical attention after attempts (Grenville et al 2012). There is also an important unresolved question about how models of care and cultural influences affects the likelihood of those in care self-harming. For example, Taveres-Rodrigues et al (2019) found, in comparative samples of young people in residential care Spain and Portugal that 5% in the former location claimed to have attempted suicide compared to 13.3% in the latter with a lack of clarity about the discrepancy.

Okpych et al (2019) found through interviews with 706 adolescents who had been in the out-of-home care system that 25.2% had attempted suicide

The risk of self-harm and suicide remains elevated after young people leave care. An Australian longitudinal study found that 71 per cent of participants had considered or attempted suicide before or leaving care (Cashmore 2007 in Robinson et al., 2016).

Theories of why young people in out-of-home care self-harm

There are a number of ways to understand self-harm and suicidality amongst young people in out of home care. Developmental perspectives on self-harm amongst young people broadly highlight that those who have been exposed to abuse struggle with emotional regulation (Brown et al., 2018). Some research has found that emotional regulation difficulties vary by abuse type (Muehlenkamp et al., 2010). Additionally, suicidal behaviour can emerge due to family or peer conflict, struggles with achievement at school and a desire for autonomy, all of which are bound up with the broader task of identity development (Daniel & Goldston, 2009). Young people who spend time in care have the additional burden of having had exceptionally challenging life experiences, transient home placements, and disruptions in their social networks (Gabrielli et al., 2015).

Carers have attributed a wide range of motivations to self-harming acts by those in their care, including attempts to gain greater control, to be moved to a different placement, manage or gain respite from the anxiety of being in care and recreate a familiar sense of disorder. As seen through the lens of one particular group of carers interviewed by Evans and colleagues (Evans, 2018), acts of self-harm can be divided into those designed to cause genuine injury or those meant to draw the attention of carers. Some research participants noted that episodes of self-harm escalate when the young person felt there was someone nearby who was able to help them (Evans, 2018). Some carers believed that young people self-harmed in order to reintroduce particular individuals back into their lives (Evans, 2018).

Young people in care in the UK stated that they sometimes self-harmed in order to distract themselves from emotional pain or to prevent them from, instead, hurting others (Wadman et al., 2018). Research with young women accommodated in residential care settings in Sweden indicated they were more likely to self-harm as a means of regulating emotion or punishing themselves as opposed to, for example, demonstrating control or bonding with peers (Lindholm et al., 2011).

Earlier research with young people who self-harm in the UK – including those who were in care – found that while young people claimed they did not self-harm to gain attention, they did feel that it could help them communicate distress that they otherwise found difficult to articulate. They also found it a useful way to convert emotional into physical pain (Bywaters & Rolphe 2002 in Furnivall, 2013). Of concern is that the out-of-home care cohort felt that self-harm had become almost normalised in residential care settings.

Predictors of Suicidality and Self-harm

One of the strongest predictors of suicidality is depression. Anderson (2011), in examining data for over 2,000 young people in the US, 10% of whom were in out-of-home care, found that clinical depression was eight times more common in those who indicated suicidal ideation than in those who did not. A study involving youth in institutional care in Jordan found that the odds for suicidality were 3.6 times higher for young people with depression (Gearing et al 2015). Chavez-Anderson et al (2018), comparing a sample of young people in residential foster care in Mexico with a group of young people who lived in the community, found that the link between depression and suicide risk was largely mediated by negative self-concept. Furnivall argues that signs of depression such as poor sleeping and loss of interest in activities that usually appeal may need to be watched for carefully by carers and staff (Furnivall 2013).

Other research has found that multiple types of maltreatment predict suicidality and that physical abuse and chronicity of abuse were the strongest predictors (Taussig et al., 2014). Another important predictor is a statement by young people of their intention to suicide. Around 90% of young people who attempt suicide communicate their intention before acting (Granello, 2010). Hamilton et al (2015) found, in a case file survey of young people leaving care in Ireland that there was a correlation between expression of suicidal thoughts and subsequent incidents of self-harm.

Suicide in young people in out-of-home care is also associated with placement experience. Placement instability, or a higher number of placements, has been found to increase the risk of suicide (Okpych & Courtney, 2018; Hamilton et al., 2015). Some research has found that older age at the time of first placement raised risk (Hamilton et al., 2015). Others have found that total number of number of years in care makes suicidality more likely (Taussig et al., 2014). In research involving 61 young people living in residential care centres in Barcelona, Bonet et al (2010) indicated that decreased emotional intelligence, and a reduced sense of competence may influence suicidality.

Non-suicidal self-injury amongst those in various types of out-of-home care has been found to be associated with depressive disorders, behavioural problems, and substance abuse (Ludtke et al., 2018). Aggressiveness was also found by Gallant et al (2013) to predict self-harm. Submissions received from various mental health and not-for-profit organisations by an Australian inquiry into self-harm in young people identified history of abuse, family disruption, mental ill health and attachment challenges as increasing the vulnerability of young people in out-of-home care to self-harm (National Children's Commissioner, 2014).

Trew and colleagues (2020) recently undertook research to identify other factors pertinent to out-of-home care populations that have been found to predict suicide in the broader youth population. In addition to the predictors mentioned above, they found that drug and alcohol abuse, suicidality in family members and poor school performance and relationships with peers were both associated with suicidality and common amongst those in out-of-home care.

Interventions

In their systematic review, Evans et al (2017) found that they were unaware of any intervention that had been proven effective for preventing suicidal thoughts and behaviour for populations in care. The evidence for programs designed to prevent suicide more broadly are also lacking. A systematic review of the literature on programs designed to address suicidality in Indigenous populations, concluded that there is no persuasive evidence for any one particular approach (Clifford et al 2013). Some researchers have concluded that there are no proven treatments for decreasing suicide risk in the broader population of young people (McCauley et al 2018). In contrast, two recent reviews, however, have found the evidence for **Dialectical Behavioural Therapy for adolescents** (discussed further below) to be well established (Kothgassner et al 2020; Glenn et al., 2019). The following section explores programs that have claimed some success in relation to reducing suicidality or the incidence of self-harm among young people with care experiences.

Bonet et al (2020) recently presented the results for 19 participants of a program designed to reduce suicide risk for young people in residential care through bolstering **emotional intelligence**. The suicide risk for participants decreased significantly (as assessed through self-report), as did levels of hopelessness, inability to control emotions and suicidal ideation. The program consists of four components focused on: emotional perception, use of emotions to facilitate thinking, emotional understanding, and emotional regulation. The first phase focused on identifying emotions in self and others and, in particular, those that cause emotional conflict. In the second phase, participants identified the needs that underlie emotions and behaviours. In the third phase, participants are taught how emotions affect individuals. Interventions are aimed at integrating reason or understanding with emotion. The fourth stage integrated the learnings of the first three phases to teach strategies for emotional regulation.

Sng (2009) presents a case study by way of discussing the effectiveness of a program implemented in an Australian residential care context for young people with

high-level needs, including those who self-harmed. The model was premised on the belief that physical and emotional safety should be provided a young person before interventions are implemented in earnest. Interventions focussed on bolstering a young person's capacity for reflection on behaviour and motivations, leading to improved emotional and behavioural functioning. Clinicians viewed their role through the lens of **attachment theory**. The subject of the case study, an 11 year old girl, showed complete reduction in her self-harming behaviour between her first and sixth month of treatment. This success was attributed to residential staff responding to her incidents of self-harm in understated manner that increased their engagement with her around undertaking more positive activities and explaining to her the link between her behaviour and her attachment fears. This led to warm bonds developing between the young woman and staff.

Rhoades et al (2013) has identified a range of outcomes of **Multidimensional Treatment Foster Care** program that were achieved with young women in foster care in England and in the US, one of which was reduction in self-harm. The cornerstones of MTFC program include: frequent contact with parents; weekly foster parent group meetings; individualised behaviour management programs for the young person in OOHC; therapy for the young person; skills training for the young person; family therapy; close observation of school performance; and, on-call availability of program staff to parents and foster parents. Mental health consultation was provided when needed.

Andrew et al (2014) noted findings related to the implementation of a program combining **Dialectical Behaviour Therapy and Dyadic Developmental Psychotherapy** with care leavers who were especially prone to self-harm. Participants in the program, which achieved a high retention rate, reported reductions in their self-harm behaviour and suicidal ideation in addition to reduced relationship difficulties and drug use (including use of psychotropic medication). The combined model focused on trust building and teaching young people skills relating to better understanding and managing their emotional distress and developing resilience.

Dialectical Behavioural Therapy (DBT) is one of the few interventions concerned with curbing suicide risk in the broader youth population for which robust evidence exists (Kothgassner et al, 2020). As an example, a recent randomised clinical trial at four academic medical centers involving 173 adolescents found that the approach was significantly more effective at reducing suicide attempts, non-suicidal self-injury and self-harm after treatment (McCauley et al 2018) than a comparison intervention (Individual and Group Support Therapy). Both therapies provided weekly and individual group therapy for six months and involved parents. The DBT program, and DBT as a whole, is described as enhancing emotion regulation, increasing distress tolerance, and promoting the sense of building a life worth living (McCauley et al., 2018). The only other approaches to have been found, in systematic reviews and meta-reviews, to have notable effect sizes on self-harm and suicidal thinking and behaviour in the broader adolescent population are cognitive-behavioural therapy, mentalisation-based therapy and interpersonal psychotherapy (Ougrin et al., 2015; Kothgassner et al 2020).

Of note, Glenn et al (2019) found that treatment models found to be successful with adolescents have in common that **they involve family, provide skills training and are of longer duration.** A systematic review of psychosocial suicide prevention interventions for young people additionally found that programs that include both individual and group components influenced both suicidal ideation and the number of suicide attempts made by youth. The authors concluded that individual work may most effectively target ideation and group work, suicide attempts (Calear et al., 2015).

Issues to consider in helping young people

The following section discusses recommendations and important points for consideration arising from research on young people in out-of-home care and self-harm.

Brown et al (2020) have recently made a strong argument for implementing universal suicide risk assessment for all young people in out-of-home care. Allied to this, Evans (2018) argued that foster carers should be aware of stressors coming up for young people and invite discussions with them about the events and their feelings about them.

Furnivall (2013) maintained that a primary consideration should be how to focus relieving the pain and distress a young person is experiencing as opposed to focusing on the self-harming behaviour itself. Facilitating this, as suggested by several researchers, will not only be a greater understanding on the part of foster carers and residential care staff of self-harming practices and matters like emotional regulation, but also their ability to create an environment in which emotional distress can be openly discussed (Kim et al 2019: Johnson et al 2017; Wadman et al., 2018). Johnson et al (2017) in interviews with young people living in residential care found participants believed there to be a lack of information available to both themselves and staff on self-harm. The young people interviewed also conveyed that a caring attitude by staff was crucial to their ability to discuss their self-harming and that they were reasonably happy to accept even surveillance where they could tell it was undertaken with the right intention. By contrast, judgmental attitudes drove their self-harming 'underground'.

Chavez-Hernandez et al (2018) have argued that interventions aimed at improving young people's self-concept may be a way of reducing depression and, thus, their risk of self-harm. Other individual skills that researchers are considered to be important for young people to develop include emotional regulation and problem-solving skills (Furnivall 2013). Researchers such as Evans (2018) argue that self-harm can be understood as a relational phenomenon and, as such, can be prevented through carers strengthening their relationships with young people.

Wadman et al (2018) have identified that it is crucial for professionals to spend time establishing proper relationships with young people prior to addressing their self-harm. Furnivall (2013), also recognising that good relationships act as a protective

factor, asserted that residential care workers should help young people engage positively with school and peers. Kim et al (2019) similarly argued that self-harm in residential care may be reduced where bullying and violence in both the care environment and school are reduced. Also reflecting the need for consistent relationships, Wadman et al (2018) want it acknowledge that any necessary changes in a young person's placement need to be thought through with maximum sensitivity.

Wadman et al (2018) argued that it is crucial to involve young people in out-of-home care in the design of services aimed at reducing their self-harm. Young people who they interviewed identified practices such as art, listening to music and going for a walk as those that helped them reduce the urge to self-harm. Practitioners need to be aware of those activities young people find most helpful.

A core activity that young people need be involved in is the development of their personal Safety Plans. Safety Plans are discussed below with specific reference to the Intensive Therapeutic Care environment.

Safety Plans

Practice in the ITC system prioritises both the promotion of recovery from trauma and abuse, which emphasises individual autonomy and control, as well as the minimisation of risk. In a report of the Royal College of Psychiatrists UK (2008), consumers reported *'… their preference for safety enhancement rather than risk reduction as a more empowering approach to discussing risk….'*

A recovery focus in the therapeutic care of young people who may be suicidal is achieved through the sharing of responsibility and decision-making among stakeholders, including the young people themselves and, where appropriate, their families. The approach is dependent on a therapeutic alliance in which there is clear communication among parties, transparency around decision-making and good understanding of respective roles regarding promotion of the young person's recovery and self-determination.

An important component of a recovery focus is the development of a **Safety Plan.** Safety Plans, as commonly discussed in the literature, are a relatively new but promising strategy for preventing suicide amongst those at risk. The purpose of a Safety Plan is generally to provide an individual with '*personalized, appropriate, and specific coping strategies and contacts for use during times of crisis*' (Gamarra et al. 2015, p.433). Existing evidence suggests that Safety Plans can reduce the severity and intensity of suicidal ideation and overall risk of suicide (Knox et al 2012; Melvin et al 2019). A majority of evaluations which have focused on Safety Plans have detailed six different types of information which is critical including that pertaining to: identifying signs of encroaching suicidal crisis; coping strategies; relevant social contacts for distraction and or assisting with the resolution of a crisis; formal sources of support; and, strategies for how to restrict access to means of harm (Brown 2012).

Safety Plans with the above structure and content – Personal Safety Plans – have applicability within Therapeutic Care settings. Young people at risk of self-harm may benefit from possessing their own plan – in digital or hard copy from – which they can refer to in times of distress. Young people at risk of suicide will also benefit from the development of an Organisational Safety Plan. Such a plan requires collaboration among, and the contribution of, clinicians, Therapeutic Specialists, residential youth workers, the young person themselves and, where appropriate, family members. These Plans should take into account the views of all parties, and particularly the young person, with respect to interventions that are most appropriate and/or likely to be successful. Plans should also reflect good understanding of the young person's strengths and their goals for recovery and/or their broader ambitions.

Organisational Safety Plans should specify:

- risks to safety – ie triggers and circumstances – specific to the young person
- strategies to reduce risk and enhance safety
- how responsibilities for agreed upon actions and roles will be managed among the young person, their family, ITC staff and clinicians.
- actions to be taken at crisis points, and
- how and by whom the plan will be monitored and reviewed.

The Care Team should conduct reviews of the Safety Plans both at regularly scheduled intervals and at times of heightened risk for a young person. For some young people, risk can never be eliminated. Positive risk management, which recognises all decisions carry some element of risk, should be integral to the process of safety planning.

Conclusion

Young people in out-of-home care are a highly vulnerable population and include a proportion of whom are at risk of self-harm. Appropriate attention to establishing an atmosphere of safety, including proactive encouragement for young people to participate in the creation and review of their Personal Safety Plan, is an important and useful strategy. Providing consistent and genuinely interested care; identifying and working from the strengths, interests and goals of young people; and, developing clear, individualised strategies for reducing risk and addressing crises are all instrumental in mitigating this risk.

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