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Article

The “Supporting Adolescents with Self Harm” (SASH) Intervention Supporting Young People (And Carers) Presenting to the Emergency Department with Self-Harm: Therapeutic Assessment, Safety Planning, and Solution-Focused Brief Therapy

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Abstract

Background: Self-harm is a growing public health concern and the strongest predictor of suicide in young people (YP). The “Supporting Adolescents with Self-Harm” (SASH) intervention was developed with YP with lived experience and expert clinicians. It involves rapid follow-up after ED attendance and up to six intervention sessions. The intervention has three components: Therapeutic Assessment (TA) of self-harm; an enhanced safety plan (SP); and Solution-Focused Brief Therapy (SFBT). Depending on the YP’s preference, carers can join sessions. Carers can also receive two individual sessions. The clinical and cost-effectiveness of SASH is being evaluated in a randomised controlled trial across nine emergency departments in three NHS Trusts in London, England. A total of 154 YP were recruited between May 2023 and March 2025 and randomised on a 1:1 ratio to SASH alongside Treatment As Usual (TAU) or TAU. A logic model describes the SASH inputs, activities, mechanisms, outcomes and longer-term impacts. The aim of this paper is to (1) illustrate how TA, SP, and SFBT were implemented in practice by presenting intervention materials and session recordings for four YP cases and one carer case and (2) explore how the case study materials/recordings reflect the intervention mechanisms in the SASH logic model. **Methods:** Each case focused on a different component of the intervention. Intervention materials (TA self-harm diagram and completed SP) and recorded SFBT sessions with four YP and one carer were analysed using a descriptive case study approach. The TA diagram and SP were extracted from medical records. Audio/video recordings of intervention sessions were identified. Recordings of intervention sessions and qualitative interviews were transcribed. Quotes from qualitative interviews with the same participants were included where relevant. **Results:** Across the four YP cases, some core themes emerged. The role of friendships for young people, particularly at school, was important in both negative and positive ways. Experiencing difficulties with friends at school led to feelings of sadness and stress, which could become overwhelming, leading to thoughts of self-harm (“I just need to hurt myself”), triggering self-harm behaviour. YP described mood changes and signs that they were becoming stressed, which improved their self-awareness and understanding of the link between their feelings and self-harm behaviour. They reflected on what kept them feeling calm and overcoming their fear of burdening others by sharing how they were feeling, as this helped them not to self-harm. They also described difficult feelings stemming from a need to please everyone or needing validation from others. Overcoming these feelings led to less social anxiety and more



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confidence. This made it easier to go to school and to be more social with friends/student peers, which in turn improved their mood. **Conclusions:** These case studies demonstrate how YP improved their self-awareness and understanding of the link between feelings and self-harm behaviour and identified personal strategies for managing difficult feelings and situations. The carer case study demonstrates how sessions with carers can facilitate carers better supporting their YP's mental health. Supporting YP and carers in this way has the potential to reduce the risk of future self-harm.

Keywords: self-injurious behaviour; suicide prevention; adolescent; emergency service; crisis intervention; carers

1. Introduction

Self-harm is a growing public health concern. Self-harm is defined as any “intentional self-poisoning or injury irrespective of the apparent purpose of the act” [1]. The 2023/24 UK government figures show that in young adults (ages 16–24 years old), 31.5% reported lifetime suicide thoughts, 24.6% reported having self-harmed and 10.3% reported a lifetime suicide attempt [2]. Self-harm is the strongest risk factor for suicide in young people (YP), which is one of the leading causes of death in YP [3]. Over 50% of those under 20 who die by suicide have a history of self-harm [4]. YP who visit the emergency department (ED) with self-harm have up to a 50-fold risk of future suicide. This makes the ED a crucial opportunity for intervening as early as possible with YP presenting with self-harm.

In England, the National Institute for Health and Care Excellence (NICE) recommends a psychosocial assessment by specialist mental health practitioners in the ED for YP who present with self-harm and a 7-day follow-up [1]. Practitioners from Child and Adolescent Mental Health Services (CAMHS) crisis teams conduct psychosocial assessments to assess mental health, risks, care needs, and agree on a management plan. Follow-up within 7 days seeks to provide appropriate aftercare, including reviewing the risk and onward referrals. However, evidence from a meta-synthesis found that YP often report that ED treatment for self-harm exacerbates their distress and that EDs are unable to meet their needs [5]. Difficult experiences of ED deter future help-seeking and contribute to vicious cycles of repeat ED attendances and escalating suicidality [6]. A recent review found that the international picture is consistent with that in the UK; globally, many YP receive neither assessment in the ED nor follow-up, and only around half are referred on for further input from community mental health services [7].

While there are few psychological interventions for YP presenting to the ED with self-harm, different activities have been investigated. A novel approach to the assessment of self-harm in YP is Therapeutic Assessment (TA). It involves describing the YP's personal cycle of self-harm to help the YP understand their emotions and self-harm behaviour, along with possibilities for breaking the cycle [8]. TA is a promising approach that is therapeutic in seeking to understand the complex reasons and psychological “core pain” that drives self-harm in young people. A previous non-randomised study found that YP who received TA were more likely to engage in follow-up care after attending the ED and less likely to harm themselves [9].

Safety plans (SPs) have been investigated and found to be effective for suicide prevention in adults. However, research on safety plans with YP is limited [10]. A non-randomised study evaluating an intervention that included safety planning in a mixed sample of adolescents partially recruited from emergency departments saw reductions in suicidal ideation and behaviour at 6-month follow-up [11]. Support for YP after discharge is lacking due to underfunding and increasing rates of CAMHS referrals [12]. As a result, many YP who

have presented to the ED with self-harm may require further support and are referred to CAMHS but end up on lengthy waiting lists for treatment: YP are typically waiting over one year for CAMHS treatment in the UK [13]. The gap between demand and availability of services is an international problem, as data from North America reveal a similar picture of YP facing lengthy waits to access treatment [14]. Long wait times prolong distress and exacerbate YP's mental health difficulties [15]. A recent report found that 26% of YP attempted suicide while waiting for CAMHS treatment [16]. Deteriorating mental health also has wider impacts on school absence and poorer social and educational development.

Solution-focused brief therapy (SFBT) is a strengths-based intervention where YP are considered experts in their own lives. In other settings, SFBT is as effective as other evidence-based treatments, but progress happens in fewer sessions: This requires fewer resources, making it potentially more cost-effective (average 4–5 sessions, compared to 8 for other talking therapies) [17,18]. As it is a brief systemic approach, it has the potential to support YP and families in a mental health crisis.

To address the current gap in rapid interventions for YP in crisis, we developed the Supporting Adolescents with Self-Harm (SASH) intervention with the input of YP/carers with lived experience and mental health clinicians. The SASH intervention aims to provide rapid follow-up within 1–2 weeks after attending the ED. It includes up to six sessions over approximately 2 months with YP and parents/carers. The intervention comprises the following: (1) TA of self-harm, addressing the YP's core pain, their cycle of self-harm, and identifying how to break this cycle; (2) an enhanced SP based on the Stanley and Brown model; and (3) SFBT where the YP/carer identifies their future hopes and resources to help them move forward in their lives. Depending on the YP's preference, parents/carers are invited to join sessions with the YP. Carers can also receive two individual sessions focused on psychoeducation around self-harm and their best hopes for themselves and their child. Evidence shows that involving families and the system supporting the YP improves outcomes for YP [18].

The clinical and cost-effectiveness of the SASH intervention in addition to TAU is currently being evaluated in a randomised controlled trial in England. It is being compared to Treatment As Usual (TAU), and the primary outcome is repeat self-harm after 6 months. Full details are described in the trial protocol [19] (<https://sashstudy.co.uk/>, accessed on 19 December 2025). Secondary outcomes include symptoms of depression and anxiety, ED reattendance, death by suicide, school attendance, and psychological wellbeing (see [19] for all outcomes), collected at baseline and 6-month follow-up. A total of 154 YP were recruited into the trial and are currently being followed up, with follow-up data collection having recently been completed. SASH draws on existing components of self-harm interventions that have been tested in previous studies, including Therapeutic Assessment (TA), safety planning, and SFBT. The aim of this paper is to (1) illustrate how TA, safety planning, and SFBT were implemented in practice by presenting intervention materials/recordings for four YP cases and one carer case and (2) explore how the case study materials/recordings reflect the intervention mechanisms in the SASH logic model. A future publication will report on the clinical and cost-effectiveness of the SASH intervention.

2. Materials and Methods

2.1. Setting

We present intervention materials and recordings from the SASH trial. SASH is a multicentre parallel group individually randomised controlled trial (RCT). YP and carers were recruited across nine ED departments in west, north, central, and east London. The trial has been described in full elsewhere [19]. CAMHS practitioners working with YP in crisis were trained in the SASH approach across 1.5–2 days. A manual, training videos,

and handouts were provided to practitioners to support the delivery of the intervention and adherence to the approach. Practitioners were invited to weekly group supervision with senior members of the research team to discuss cases and discuss the delivery of the intervention in line with NHS Trust clinical processes and policies.

2.2. The Intervention

The intervention comprises up to six sessions with YP and their carers. The first session is delivered within approximately seven days of ED attendance. Subsequent sessions are delivered at approximately two-week intervals. Sessions are primarily delivered face-to-face, though remote delivery is possible where permitted by clinical services. Intervention delivery is designed to be flexible to maximise engagement. In response to changes in risk or worsening of presentation, clinicians can refer YP on for more support or for specialist assessment. The first session includes TA and safety planning, while follow-up sessions are SFBT sessions. To ensure consistency in intervention delivery across sites, the research team met regularly with practitioners (aiming for every two weeks), encouraged attendance at weekly supervision, and provided top-up training in specific areas (e.g., working with parents/carers). To assess intervention fidelity, two researchers independently applied a bespoke fidelity scale to a sample of practitioner intervention session notes. Bespoke logs were developed to monitor adherence to the intervention and record practitioner supervision attendance. We worked with senior leadership teams in services to support practitioner attendance at supervision alongside their clinical commitments.

2.3. Therapeutic Assessment

TA was developed by Ougrin et al. specifically for YP presenting with self-harm in crisis [8]. It is a novel approach to working with YP (and families), derived from solution-focused and systemic traditions. It involves joint production of a diagram of the self-harm cycle, with three elements: identification of core pain, maladaptive behaviours, and means to break the cycle. YP are asked to identify a previous episode of self-harm. Diagrams are constructed using the YP's language and aim to identify and understand the YP's difficulties, instil hope, and provide a foundation for therapeutic change. See Figure S1 in the Supplementary Materials for a schematic of the TA diagram.

2.4. Enhanced Safety Planning

The SP is an adapted version of the Stanley and Brown model of safety planning [20] and involves co-construction of an individualised safety plan in the YP's own words. This consists of two sections: the first section describes the YP when they are well and what they like to do, what helps them to stay well, and what might get in the way of this. The second section relates to warning signs of self-harm and means of managing thoughts of self-harm, including individual actions (distractions and changing environment), and support networks that can be drawn on (contacting trusted others and professionals). The SP can be in paper or electronic form and can be completed either by the YP, practitioner, or jointly. For enhanced safety plan template, see Figure S2.

2.5. Solution-Focused Brief Therapy

The follow-up sessions (up to five) involve SFBT. SFBT is a strengths-based intervention involving a paradigm shift from problem reduction to promoting strengths and new ways of thinking and behaving. SFBT is as effective as other evidence-based treatments but is achieved in fewer sessions (average 4–5 sessions). A systematic review and meta-analysis found that SFBT is effective for YP and adult depression, low self-esteem, family dynamics, relationship problems, and parental stress in community settings [21]. SFBT for carers has been found to improve YP mental health [22]. SFBT's focus on the therapeutic relationship

empowers YP to experience a more hopeful future through collaboratively formulating solutions and how to move forward [23–26]. For SFBT templates, see Figures S3 and S4.

2.6. Parent/Carer Involvement

According to the YP's preference and consent, parents/carers may join sessions with the YP. Parent/carers involvement can support the YP emotionally, improve their understanding of the YP's experience, and increase awareness of strategies that can be used by the YP. Parents/carers may be invited to participate in a joint SFBT session with the YP, where a shared understanding of what the YP and parent/carers may be generated. In addition to joining the sessions with their YP, parents/carers are offered 1–2 of their own individual sessions (these may involve more than one parent/carers) where clinicians take a solution-focused approach and offer psychoeducation for self-harm. We will explore the effects of parent/carers involvement systematically in statistical analyses in the randomised controlled trial.

2.7. Data Collection

2.7.1. Participants

Participants were identified from the group of YP in the SASH intervention arm ($n = 78$), who had either intervention session recordings available or intervention-related materials uploaded to their medical records. Parents/carers of YP in the intervention arm were selected if they had an individual or joint intervention session recording available.

2.7.2. Procedure

Participants provided informed consent for audio/video recording for intervention sessions and qualitative interviews and specified consent for the use of this data as part of consent for participating in the trial. Audio/video files were transcribed using a two-step procedure; firstly, a secure auto-transcription tool was used to capture the live interaction and was downloaded, after which auto-transcripts were manually checked and corrected for accuracy. Before recording, practitioners reaffirmed the participants' consent to be recorded. Recordings were made on secure, encrypted devices and were securely transferred to approved electronic storage. All identifying details were removed from transcripts, and participants were assigned pseudonyms.

2.7.3. Sampling

1. Intervention sessions and documents

Of the pool of young people assigned to the intervention arm ($n = 78$), we reviewed all available intervention session transcripts ($n = 16$) and intervention-related materials (TA diagrams $n = 7$, SPs $n = 8$, SFBT handouts $n = 16$). The intervention manual and fidelity scale were used to guide the selection of cases with acceptable fidelity to the intervention manual. Selections were made by reviewing transcripts of intervention sessions and intervention materials to identify exemplars of each of the three intervention components. We also aimed to capture variation across the type of session (YP only and parent/carers session only). All data were anonymised prior to analysis. Assessments of fidelity to the intervention will be published alongside the main trial results.

2. Qualitative interviews

Purposive sampling was used in the SASH trial to invite YP from the intervention arm and practitioners who delivered the intervention to take part in a qualitative interview as part of the process evaluation. Full transcripts were reviewed, and excerpts were identified that corresponded to that person's TA, SP, and SFBT sessions. Practitioner qualitative

transcripts were reviewed for reflections on the implementation of the intervention relating to the activities and mechanisms of change.

2.8. Data Analysis

A descriptive case study approach [27] was taken when analysing the intervention materials and recordings. Activities and mechanisms of change from the SASH logic model were used as a framework to guide the presentation of each component of the intervention.

The logic model in Figure 1 was developed based on existing evidence of how the different components of the SASH intervention are intended to influence outcomes, informed by literature review, expert input, and refined iteratively during intervention delivery. Inputs, activities, mechanisms of action, outcomes, and impact outline the theory of change underpinning the intervention. Inputs relate to resources and assets which support the intervention, for example, practitioner training and supervision; activities relate to actions or processes which are both specific to the different components of the intervention and generic across the approach; mechanisms of change relate to how and why the intervention achieves its intended outcomes; outcomes relate to the intended consequences of the intervention and impact relates to the longer term effects of the SASH intervention on key stakeholders. In the trial, we administered a measure of the quality of the therapeutic relationship post-intervention (or TAU), as we hypothesise that this outcome may mediate the effect of the intervention. Other mechanisms in the logic model will be explored in qualitative and quantitative analyses.

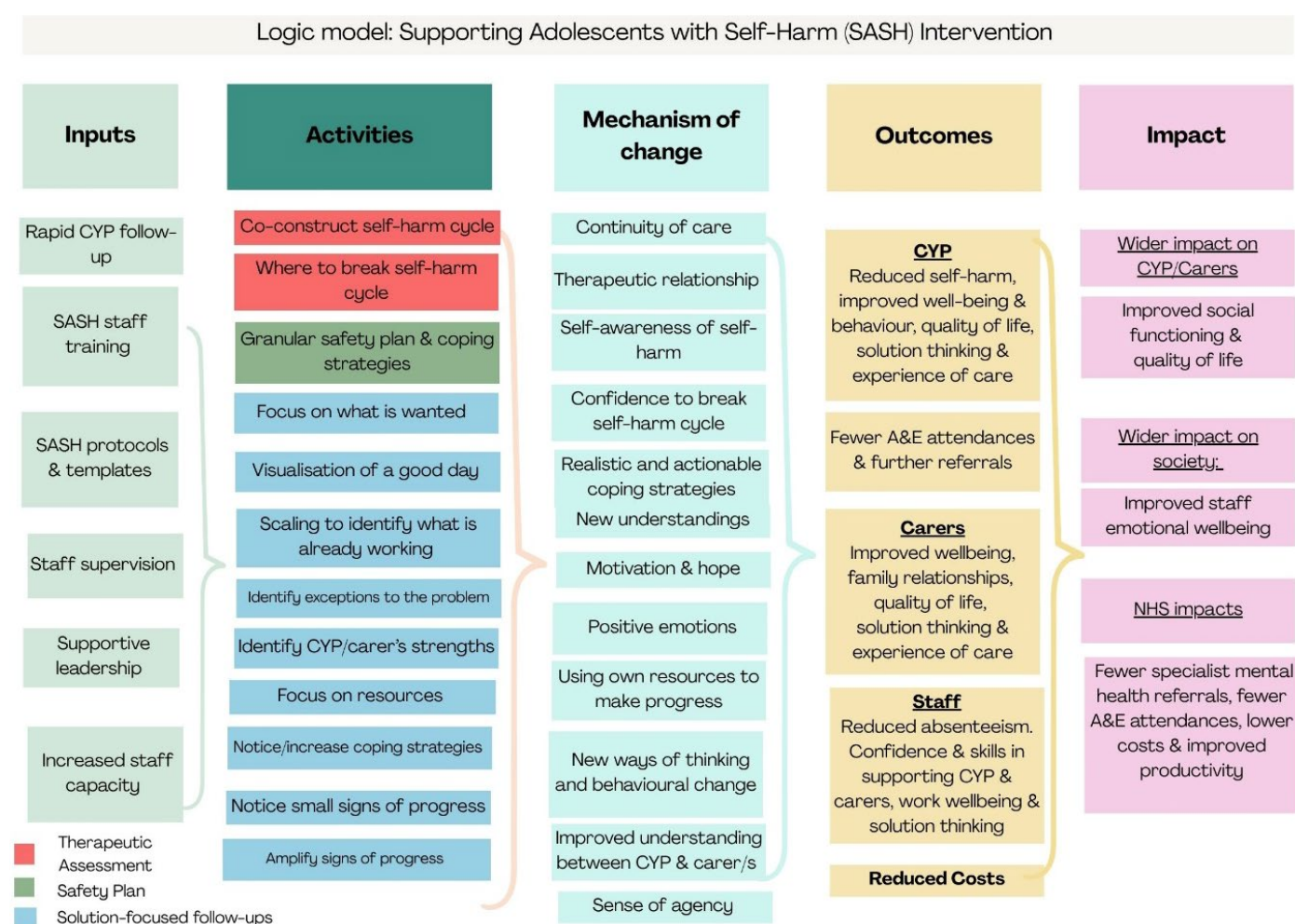


Figure 1. SASH intervention logic model.

2.9. Ethics

The SASH study was approved by the London-Riverside Research Ethics Committee (Ref: 22/LO/0400). Fully informed written consent was sought from YP, parents/carers, and practitioners. For YP under the age of 16 years, written assent was sought in addition to fully informed written parental consent. YP, carer, and practitioner consent forms included optional items for audio/video recording of sessions: When this optional consent was obtained from all parties, sessions were recorded where possible by the practitioner. Pseudonyms have been used and identifying details changed to preserve anonymity in the presentation of the case studies.

3. Results

Five case studies are presented, as shown in Table 1. The case studies include four YP who received the SASH intervention, each focusing on a different component of the intervention (TA, SP, and SFBT) and one parent/carer (mother) of a YP who received the SASH intervention.

Table 1. Participant characteristics.

Pseudonym	YP/Carer	ED Presentation	Age	Gender	Neurodiversity	Ethnicity	No. Sessions Attended
Adah	YP	Suicide attempt	13	F	N	Mixed ethnic background	5
Eliana	YP	Suicide attempt	15	F	N	Black British	5
Charlotte	YP	Suicidal ideation (and recent self-harm)	14	F	N	White British	5
Wai	YP	Suicide attempt	16	F	N	Other—Hong Kong and Indonesia	4
Michelle	Carer	N/A	53	F	N	Black British	1

3.1. Case Study 1: Therapeutic Assessment of Self-Harm with Adah

In most cases, the TA was conducted in person in the first session, within one week of ED attendance. As the SASH intervention was provided in addition to TAU, this session also typically included a reassessment of risk, mental state, and a check-in around referrals and contact with other agencies, e.g., social care, which is what would be provided in the TAU routine 7-day follow-up. The practitioner report suggests that TA took longer on average with early teens and with YP who are neurodivergent, taking longer to identify feelings and link behaviours together in a chain. Practitioners could use the “Feelings Wheel” [28] from the intervention manual to help YP identify emotions, consider relevant adaptations such as using emoji scales instead of numbers, and were advised to spend additional time building rapport with YP if needed.

Case study 1 focuses on the TA of Adah, who presented to the ED with a suicide attempt. She received five sessions in total across 3 months. During the first session, the YP and practitioner *co-constructed the self-harm cycle* (see Figure 2). The YP began by describing the events leading up to her suicide attempt and explained that she had been feeling stressed and sad (core pain) while at school due to issues in her friendship group (trigger) and felt the only way to deal with these overwhelming feelings was to take an overdose. When she took the overdose, she described experiencing a clear mind (short-term relief). She then started to reflect on what she had done, felt panic and worry, started crying, and had a panic attack. This led to disclosure about the overdose to school staff, who called an ambulance. When she reached the hospital, she felt safe because she was in the ED but described feeling worried about herself and what she had done, which led to feelings of confusion and sadness and disbelief at her actions (long-term negative consequences). She identified that she would choose to *break the self-harm cycle* by noticing when she is feeling stressed or has mixed emotions, for example, after friendship conflict, and identified a

range of things as part of safety planning that she can do instead of self-harming, building a sense of confidence in alternative means of coping.

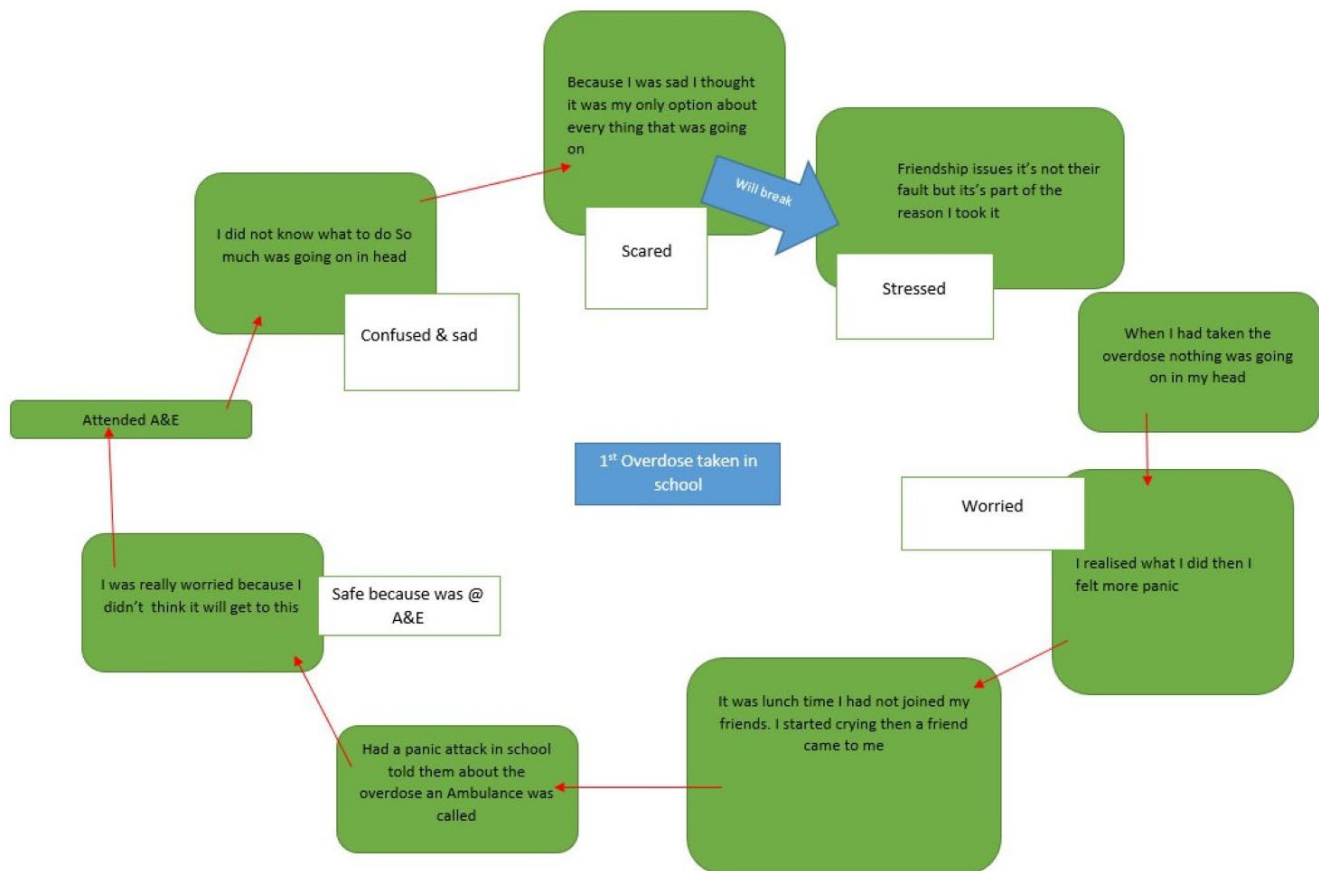


Figure 2. Self-harm cycle for Adah.

3.2. Case Study 2: Enhanced Safety Planning with Eliana

In most cases, the practitioner and YP conducted safety planning in the first session after completing the TA cycle. In some situations where more time was needed, the YP took the safety plan home to complete, while others completed it at the beginning of the second session. In routine care (or Treatment As Usual in the trial), a SP is discussed in the psychosocial assessment in the ED. SASH practitioners were advised to incorporate any previous elements of the ED safety plan into the SASH SP where relevant. Parents/carers were often brought into the session to discuss the safety plan with the practitioner and YP to support its use.

Case study 2 focuses on Eliana, who attended five sessions (one TA/SP session and four SFBT follow-up sessions). Eliana's issues were centred around school—they were not regularly attending school and found it difficult when they did. They were being seen by a broad range of professionals, including a family therapist.

The first section of the SP involves getting to know the YP, exploring what they are like when they are well and what they like to do, what helps them to stay well, and what might get in the way of this. This begins to build a picture of the YP's life, where they feel safe, who they trust, and what they feel their barriers are to feeling well (difficulties in their life). Getting to know the YP fosters a *therapeutic relationship* and helps to personalise the intervention. This YP commented on its comprehensiveness: "I liked how it's more detailed and I was able to add more to the plan rather than the one in the A&E one where it was just like more basic. ...". SPs in the ED tend to focus on means restriction and generic signposting to crisis lines/support.

In the first section of the SP, the YP identified positive attributes of themselves, to begin to engender *positive emotions* and *identify their own strengths*. They described themselves as loud, confident, fun, easy to talk to, caring, reliable, funny, loyal, honest, and beautiful when they feel okay. When feeling okay, they described their preferred activities as drawing/art, listening to music, watching TikTok/shows, spending time with cousins, and taking a nap. To feel okay, the YP described that she needed sleep, to watch comfort shows, TikTok, and to talk to cousins on the phone. Reflecting on this helps the YP to begin to recognise that they can *use some of their own resources to make progress*. Barriers to feeling okay were identified as arguments, [feeling] physically unwell, bad relationships with friends, not being able to regulate emotions, and being around too many people.

Practitioners then support the YP to create a *granular safety plan with multiple coping strategies*. Eliana began by identifying warning signs of escalating distress, *building self-awareness of self-harm*, and the onset of thoughts of self-harm. Practitioners are encouraged to use a traffic light system to help the YP identify early warning signs before self-harm becomes too challenging to avoid. Eliana identified physical sensations (feeling extremely hot, head twitching slightly, mini panic attacks, fidgeting, picking fingernails, squeezing the palms of hands, negative thoughts (worthlessness, failure, and “don’t deserve to be here”), and emotional changes (sudden mood changes and angry). Eliana was usually in her bedroom or in public when this started and described a range of ways to distract herself: by watching a comforting show on Netflix, listening to music, drawing, and spending time with cousins. She felt she was likely to do this only sometimes, as she would be thinking, e.g., “I just need to hurt myself” and that her distress may burden others who are close to her. Eliana identified small steps to overcome these barriers, *building motivation and hope*, and ensuring the *strategies are realistic and actionable*. Small steps included managing low self-esteem with positive affirmations, building her confidence more by speaking to her parents, and talking to others. She noted new ways of thinking about herself and the importance of building herself up: “I can’t please everyone, therefore the best person I can please is myself”, suggesting a developing *sense of agency*.

YP then consider *ways to break the cycle of self-harm* by distracting themselves from escalating distress, specific to the setting in which the warning signs typically emerge. This YP identified walking in the local area, going to a place they like, such as the cinema or their cousin’s house, or going to their bedroom. They described it as being very likely that they would use these techniques, but that feeling too distressed/overwhelmed, not wanting to ruin the fun, or pressure from the group might stop them. Small steps to overcome these barriers included improving self-esteem and confidence, limiting social anxiety, reading motivational quotes, and using countdown techniques.

In the final two sections of the SP, YP are prompted to *use their own resources to make progress* by identifying others whom they can contact as an alternative way of *breaking the cycle of self-harm* and increasing their *sense of agency*. This YP identified parents and family (cousins) as people to contact when feeling overwhelmed but noted that it was not very likely that they would contact them because they would feel like a burden, unheard, and judged. Small steps to overcome these barriers would be if close others were willing to listen and be understanding.

In the final stage, YP identify professionals whom they would contact when in distress, in order to build awareness of available *realistic and actionable coping strategies*. The YP described that they would be very likely to access a mixture of school (school counsellor and safeguarding network), healthcare (GP, A&E, and crisis line), and charity-based (Kooth, Young Minds, and Textline) professional support, but barriers would include the fear of being misunderstood or unheard. The YP reported that identifying what they would

discuss and imagining that the professional would be a listening ear would be ways to overcome these barriers.

3.3. Case Study 3: First Solution-Focused Brief Therapy Session with Charlotte

The first SFBT session follows the therapeutic assessment/safety plan session. Given the recent presentation to the ED with self-harm, this tended to also include a check-in on any self-harm/suicidal ideation or safeguarding issues that may have needed attention since the previous session.

The following session involves Charlotte, a girl, aged 14, who presented to the ED with suicidal thoughts (with recent self-harm). She was not attending school regularly.

- Best Hopes

The practitioner asks the opening question about *what is wanted by the YP*: “what are your best hopes from us talking?”. Charlotte answers, “I don’t know”. Often, YP respond in this way. This is permission to ask another question. The practitioner asks again in lines 4–5, “what are you hoping to see?”, and Charlotte responds, “Get better”. The practitioner asks for clarification (lines 7–8), “what does getting better mean?”, and Charlotte responds, “as in mentally”. The practitioner asks for some further information (lines 12–13), and Charlotte responds, “trying to communicate better”. This shows how the focus is on what Charlotte hopes to achieve (underlined text) rather than on the practitioner’s agenda. This increases engagement in the session as it defines the agenda for the whole session. It moves the talk away from the problem to what is wanted. In this session, Charlotte hopes to feel mentally better and to communicate better (Figure 3).

1. PRA: So let's start by thinking, **what would you say your best hopes are from**
2. **us talking together?**
3. YP: **Don't know**
4. PRA: what are you hoping to see? What are you hoping that happens with us
5. talking together? **What are you hoping to get from this?**
6. YP: **Get better**
7. PRA: To get better. What- tell me a bit more about you, what- how do you- **what**
8. **does getting better mean?**
9. YP: **Like as in mentally.**
10. PRA: Okay.
11.
12. PRA: **What did you think that you will gain from, from us chatting or from you**
13. **you participating?**
14. YP: **Trying to like communicate better.**

Figure 3. Transcript excerpt from Charlotte’s SFBT session: exploring best hopes.

The practitioner then asks a follow-up question below (lines 2–3) to the best hopes question, “what difference will it make?” if Charlotte is mentally better. This helps her to articulate the positive difference this will make in her life. Charlotte responds, “a lot of difference”, and the practitioner asks for a description. Charlotte states she would be happy to go to school, socialise with people in school, and participate in lessons (lines 6–7) (Figure 4).

- Miracle Question

After establishing the person’s best hopes, the next “miracle question” (lines 1–3 below) encourages Charlotte to *visualise a good day* when she is feeling mentally better. This prompts Charlotte to visualise a day when she is “mentally better” and provides descriptive details about what will be happening on this kind of day. Charlotte states she

would be “a lot happier” (line 4). By asking “how will you know you’re a lot happier”, the practitioner elicits a behavioural description: “if I have something to do, I would just get up and do it straight away” (lines 6–7). A further question, “How will you know that tomorrow is a day that you’re feeling mentally better?” elicits further detail from Charlotte, “I’d go to school”. Although this is a very similar question to the previous miracle question in lines 1–3, it elicits further behavioural description about how this will show in her life. The practitioner then asks a common SF question, “what else” (line 13), to encourage further description. The YP adds she would be “more social in general” (line 14) (Figure 5).

1. PRA: Then, let's say tomorrow. You woke up and you were no longer had any mental
2. health struggles. **What, what do you think would what difference do you think**
3. **that would make to you?**
4. YP: **A lot of difference.**
5. PRA: Tell me describe them.
6. YP: Like I'd be **happy to go to school. Probably like socialise with people in**
7. **school and participate in lessons.** That's all I can think of.

Figure 4. Transcript excerpt from Charlotte’s SFBT session: the difference achieving her best hopes would make in her life.

1. PRA: So **let's say you woke up tomorrow and life**
2. **was the same, but you felt you were mentally better, what's the first tiny**
3. **thing you might notice when you wake up?**
4. YP: **Be, like, a lot happier.**
5. PRA: Okay. And how will you know you're a lot happier?
6. YP: Because **if I have something to do, I would just get up and do it straight**
7. **away**
8. PRA: Okay Anything else?
9. YP: No.
10. PRA: Okay tell me about what you noticed about this particular day. **How will**
11. **you know that tomorrow is a day that you're feeling mentally better?**
12. YP: **I'd go to school.**
13. PRA: Okay. **What else?**
14. YP: **I just be like more social in general erm that's all I can think of.**
15. PRA: And **what difference do you think being more social would make?**
16. YP: **Be happier.**
17.
18. PRA: Okay. **Do you think if you're happier, generally, that means you will**
19. **continue to feel mentally better?**
20. YP: Yeah.
21. PRA: And stop you from feeling maybe sad or down?
22. YP: Mhm.
23. PRA: **Did you see how that was kind of an entire circle because you started**
24. **out with if you were to get mentally better, you'd be happier to go to school,**
25. **you'd socialise more. If you had something to do, you'd get up and do it**
26. **straight away. You'd be more productive and wouldn't be sleeping all day,**
27. **and you'd be more, you'd be participating more in school. Which will**
28. **ultimately lead you to be happier and I guess one great way of being mentally**
29. **better is being happier.**
30. Would you agree?
31. YP: **Yeah. Yeah.**

Figure 5. Transcript excerpt from Charlotte’s SFBT session: the miracle question.

The SF questioning prompts Charlotte to describe getting up straight away if she has something to do, going to school, being more social, and participating more in lessons, all of which would make her feel happier. Asking questions that elicit detailed descriptions translates what “mentally better” would look like in Charlotte’s day.

3.4. Case Study 4: Follow-Up Solution Focused Session with Wai

Follow-up SF sessions focus on what has been better and amplifying the person’s resources, coping skills, and strengths. This follow-up session is with a YP called Wai, who is aged 16. Reflecting on the impact of the solution-focused sessions, Wai said she has “been a lot more calm in stressful situations. . .” The opening question in a follow-up SF session is “What has been better?”. This directs Wai to *notice small signs of progress*, as described in the logic model. In the transcript below, Wai responds that she has become more comfortable with her surroundings, her school, and has got closer to people. The practitioner invites Wai to elaborate further in lines 5–6, “In what way?”. Wai describes meeting with a friend between classes and opening up to her about her self-harm and how she was feeling. Wai describes how it felt nice to share how she was feeling with her friend, as it was mutual because she usually worries about pushing people away or sharing too much (lines 21–24) (Figure 6).

1. PRA: **What’s been better since we last saw each other?**
2. YP: Erm I think I've gotten more comfortable with my surroundings because
3. obviously, I just moved here and I think I’ve gotten closer to people and more
4. comfortable with school and stuff.
5. PRA: **Feeling more comfortable with your surroundings and with school okay. In**
6. **what way?**
7. YP: Like a friend her name’s [name] we don't have any classes together
8. but during free period we meet up with each other and we’re fairly open with
9. each other, like when we first met we’ve just always been open with each other
10. because she opened up to me about her self-harm and her family situation and
11. I felt safe to tell her about mine.
12. PRA: Okay. And is this a recent friend, with (friend), a recent friendship or?
13. YP: Oh, yeah we met each other when I first got to the college.
14.
15. PRA: Okay, and then that kind of triggered you to open up?
16. YP: Yeah
17. PRA: And feel comfortable to open up about how you were feeling. And how was
18. that?
19. YP: Err it was nice yeah.
20. PRA: Yeah and how did you feel afterwards?
21. YP: Yeah it felt nice because usually when I tell someone about how I'm feeling,
22. I worry about maybe I'm pushing them away, or maybe that was too much to
23. share, but it was nice that she started sharing first. So I felt because she's doing
24. the same thing I was doing, so it felt like mutual.
25. PRA: Mutual?
26. YP: Yeah.

Figure 6. Transcript excerpt from Wai’s follow-up SFBT session: describing what has been better since the last session.

When the practitioner asks Wai what was there instead of worry (line 30), the YP responds that there was reassurance. This draws out *exceptions to the problem*, namely how Wai is able to share how she feels and feel reassured rather than worried. The practitioner asks what it was about how Wai’s friend responded that helped her feel reassured (33–34).

Wai describes how her friend tried to understand what she was going through rather than asking her why she felt that way or why she did what she did (Figure 7).

27. PRA: So that worry about kind of pushing people away, kind of putting people off, that wasn't there?

29. YP: No.

30. PRA: What do you think was there instead of that?

31. YP: Like reassurance

32.

33. PRA: Okay and what was it about [friend's] responses or the way she looked, anything that helped you to feel reassured?

35. YP: She asked questions to try to understand what I'm going through instead of

36. thinking, like why did you feel that way, why did you do that.

Figure 7. Transcript excerpt from follow-up SFBT session with Wai: exceptions to the problem.

The practitioner then returns to Wai's description of being better at the beginning of the session, "feeling more comfortable with my surroundings", and asks her to elaborate further. This activity is *amplifying signs of progress*. Wai describes feeling more comfortable with the area (as she had recently moved there), along with feeling more comfortable with her classmates and being around them and being able to talk to them. When Wai describes how other students were "strangers" at first (lines 46–47), the practitioner asks what she could call them now, rather than strangers. Wai responds, "peers, classmates". These questions elicit Wai's personalised descriptions of how "more comfortable" is happening in her life (Figure 8).

37. PRA: So it sounds like you're starting to feel a lot more comfortable in your surroundings and in school. When you said surroundings what- what else did you mean aside from school?

40. YP: Like I don't know, I feel more comfortable with the area.

41. PRA: Yeah.

42. YP: I know where the things are.

43. PRA: You've become used to it?

44. YP: Yeah and like with school in class with my classmates, I feel more

45. comfortable to be around them because obviously, when I first got here, they were strangers to me.

47. PRA: Yeah.

48. YP: But now, like, I, I know them more and I'm comfortable to be around them

49. and be able to talk to them.

50. PRA: What would you call them now if not strangers?

51. YP: Peers, classmates.

Figure 8. Transcript excerpt from Wai's follow-up SFBT session: amplifying signs of progress.

In the following excerpt, the practitioner asks Wai what she has learned about herself. Wai describes a specific set of events that led to her breaking point (lines 56–60) when her old best friend said he did not care about her. The practitioner then asks about *coping strategies*: "that sounds really challenging. Kind of when he approached you, and said what he said, how did you cope?" (lines 65–66). Wai describes that previously she felt that he was a person who cared about her and that she "realised that he's not and that, like, I don't mean much, if not anything to him now". She describes this realisation as helping her not to be pushed to her breaking point (Figure 9).

52. PRA: Peers, classmates? Okay. **And what have you learned about yourself in**
 53. **this, in this kind of short period, where you're becoming more comfortable**
 54. **with your surroundings in the school?** What have you been learning about
 55. yourself?
 56. YP: Erm I'm not sure. I think that I only, like, get to my breaking point when
 57. someone pushes me over it. So when I tried to commit, my breaking point was
 58. when- I didn't put myself in my breaking point, my old best friend pushed me
 59. over the edge by saying that he didn't care about me, even though I tried to ask for
 60. help.
 61. PRA: There was a very specific set of events that led to that kind of breaking
 62. point.
 63. YP: Yeah.
 64.
 65. PRA: **Okay, that sounds really challenging and kind of when he approached you**
 66. **that other time, and said what he said, how did you cope?**
 67. YP: For which time?
 68. PRA: For the more recent time.
 69. YP: Erm, I don't know, I just, at that point because the first time he was very
 70. important to me, and I felt like he was a person who would care about me most.
 71. This time I realized that he's not and that, like, I don't mean much, if not anything to
 72. him now.
 73. PRA: Okay and that and that helps in the situation, that helps you cope?
 74. YP: Yeah.

Figure 9. Transcript excerpt from Wai's follow-up SFBT session: identifying coping strategies.

- **Scaling Questions**

To identify what is already working is commonly used in SFBT. The practitioner asks in lines 2–4 below, “imagine that like on scale of 0 to 10, 10 means that your best hope has been realized so in this case, 10 completely, 0 the opposite where do you think you'd put yourself?”. Wai responds, “four”. The focus is on why Wai is where they are on the scale *and not lower*. Wai states that she understands her emotions quite well: She knows why she feels the way she does, and she overthinks. She is starting to accept it but has not fully accepted it fully yet. The practitioner reiterates that she is a “four” because of that “sense of understanding”, then explores *small signs of progress* by asking Wai what would be different if she were one point up—a five on the scale (lines 13–16). Wai describes not feeling like she needs validation or to talk to other people if she is feeling upset: Rather, she would be feeling okay by herself (lines 20–28) (Figure 10).

3.5. Case Study 5: Solution Focused Session with Carer Michelle

Sessions are offered to carers if they would like to avail of them. Sessions can be for one or more carers. In interviews, practitioners noted that these sessions gave a space for carers to talk, reflect on supporting themselves and their mental health, helped bridge understanding between them and their son/daughter, and sometimes were a space to reflect on their own experiences of growing up, their relationships with their parents/carers, along with diverse cultural approaches to parenting. Practitioners found that identifying where the YP and their carer have some shared aspect in their best hopes can provide a basis for improved relationships, which are often strained by the crisis. Given that relationship problems between family members are commonly reported problems in YP who self-harm [29], this may contribute to a reduction in the risk of repeated self-harm. A practitioner reflected on the impact of improved understanding among YP and carers and offering targeted support to carers: “every single dynamic of YP and parent I've

worked with have had a transformed dynamic by the end of the intervention. . . the YP may be the one who is self-harming, but the parent is often also in crisis”.

1. PRA: If we were to- do you remember that kind of rating question or the scaling
2. question....**imagine that like on scale of 0 to 10, 10 means that your best**
3. **hope has been realized so in this case, 10 being completely on top of your**
4. **emotions, 0 the opposite, where do you think you'd put yourself today?**
5. YP: Four.
6. PRA: Four. Why a four and not a three?
7. YP: Because I think I **understand my emotions quite well**, I think that I know why I
8. feel this way, I know the things- I like to overthink, so I like to connect things.
9. PRA: Yeah.
10. YP: So like I connect different events to what happened, how I feel this way why I
11. feel this way. I **think I understand that pretty easily, it's just trying to accept it. I**
12. **think I'm starting to accept but I haven't fully.**
13. PRA: Okay okay. **So you're four because, like, that sense of understanding is pretty**
14. **much there. And then the next step for you maybe is thinking about acceptance**
15. **and focusing on that. So if we would catch up again next week or a couple of**
16. **weeks if you answered by saying I'm five, what would need to be different?**
17. YP: I'm not sure
18. PRA: **What little things would need to be going on for you to think, yeah you know**
19. **what, I'm going in that direction, I'm getting closer to achieving that best hope?**
20. YP: I guess **not needing validation from other people**. And like, I know humans
21. aren't built to live in solitude and that's why we live as a community to help each
22. other, but I shouldn't be dependent on other people, and **I should be okay with**
23. **being alone.**
24. ...
25. YP: I think that with (friend), I like to be open with her and to be close with her, **but I**
26. **shouldn't need to depend on her to feel okay. Like if I, I am upset I shouldn't**
27. **need to talk to other people for me to be okay. I should understand how to make**
28. **myself like, how to kind of feel okay by myself.**

Figure 10. Transcript excerpt from Wai's follow-up SFBT session: scaling question.

In the following SFBT session with Michelle, she describes her best hopes of “having an outlet”, “being able to talk”, “get things off my chest”, “being able to speak about how it impacts on me”, and “process how I’m feeling and what I’m holding”. The practitioner also explores her best hopes for her daughter Wai (83–84), which are for her “to be safe” and “finish her education safely” (line 85) (Figure 11).

The practitioner then asks, “what difference do you think that would make to you if you were able to talk and have a safe outlet?” (lines 104–105). In SFBT, it is very important to use the person’s exact words. This question helps Michelle to describe how the desired changes would impact tangibly on her life: This would lead to her feeling better. The practitioner asks Michelle to describe “what better looks like”. Michelle responds that it would be “sleeping better” and “being calm in situations”. Again, the practitioner uses Michelle’s words (“if you were feeling better, sleeping better, able to remain calmer and deal with these situations better, what do you think that would lead to in your life?”). Michelle describes “less stress” (115) and “less anxiety” (117). Michelle then describes her morning after she has slept better, including that her daughter “works well when you’re

not on top of her" (135–136). If Michelle has slept better, this would also have an impact on her daughter in the morning before they start their (Figure 12).

68 PRA: **What your hopes are from, from us having this meeting, this session,**

69 CAR: Sometimes **it's just good to be able to talk. Just let out what I've got, cos**

70 **obviously I don't really have an outlet.**

71 PRA: Yeah

72 CAR: Sometimes it's just helpful for me I mean I find it helpful. We have family

73 therapy, but there are a lot of things obviously that I can't bring actually, because

74 that's not what that session is for. It's, **I guess it's just, it's just nice to be able**

75 **to get things off my chest.**

76 PRA: Yeah. And I guess what kind of things that you, that you would find

77 helpful to get off your chest?

78 CAR: **Just being able to speak about how it impacts on me.**

79 So I guess just being able to **process how I'm feeling and what I'm holding in**

80 because I do hold a lot in just because I need to be able to instil confidence.

81 PRA: Mm yeah. So I guess...

82 CAR: Ermmm

83 PRA: What would be, if, **what would be your best hope for [daughter], what are your**

84 **hopes for her?**

85 CAR: **Just to be safe. To be safe, to be able to finish her education safely.**

Figure 11. Transcript excerpt of parent/carer SFBT session with Michelle: Michelle's best hopes.

The practitioner then asks Michelle what she is already doing to get a good night's sleep (lines 300–301 below). This directs Michelle to *notice what is already working*. Michelle reports going to the gym and having an evening for herself. When the practitioner asks, "Anything else", this elicits further information about positive things Michelle is already doing: Michelle puts on calming music/YouTube and goes running. The practitioner then asks *strategy* questions: "how did you go about managing to implement these things? What did it take for you to do these things?" (lines 309–310). These questions elicit Michelle's resources ("I know it helps me so I just push myself"—line 320) and what she is already doing to achieve her best hope of "sleeping better" so that she is "feeling better" (Figure 13).

These brief SFBT excerpts illustrate some of the techniques and questions that are used to focus on what the YP or carer wants to be better (their best hopes) and what will be happening if their best hopes are achieved (their preferred future). The conversations show how practitioners attend closely to the YP/carer's exact words. This supports shared understanding and collaborating closely with the YP and carer in.

104 PRA **if you were able to talk and have a safe outlet of the things that you've kind of**
 105 **got built up within you, what difference do you think that would make to you?**
 106 CAR: Well I know before, I had counselling before, umm, that was helpful having
 107 that outlet every week **was making me feel a lot better** umm.
 108 PRA: When you mean **when you say feel better, describe what that better looks like.**
 109 CAR: **Sleeping better** I was able to sleep better. I was able to remain I wouldn't
 110 say remain calmer I was **calm in situations**, I was able to **deal with situations**
 111 **better.**
 112 PRA: Yeah, okay. And, I guess **if you were, feeling better, sleeping better, able to**
 113 **remain calmer and deal with these situations better. What do you think that**
 114 **would lead to in your life?**
 115 CAR: **Less stress, uh less stress.**
 116 PRA: Anything else?
 117 CAR: Maybe **less anxiety** as well.
 118 PRA: It would relieve, did you say it would relieve your anxiety?
 119 CAR: Yeah.
 120 PRA: Okay. So I know that you mentioned kind of five differences that you, that
 121 you could envision happening if you found this safer place to have an outlet
 122 and that being feeling better, sleeping better, remaining calm and dealing with
 123 situations better, having less stress and having more relief from your
 124 anxieties. Of the five, which one would you say is probably the most important
 125 or the most present for you at the moment?
 126 CAR: Maybe the sleep, sleeping better.
 127 PRA: Okay. So it would be nice to then think about. **If I was to say that you woke up**
 128 **tomorrow. And life was still the same. But you had a very good night's sleep.**
 129 **You had a very restful night. What's the first thing you will notice when you**
 130 **wake up?**
 131 CAR: **Just be waking up with less anxiety** more than anything. Or
 132 my brain, my brains not running so well trying to think of a million things.
 133 PRA: And tell me what a normal morning routine looks like for you.
 134 CAR: I'm usually up and then when I'm up I feed the cat straightaway, start doing
 135 my lunch, **usually um cos [daughter] works well when**
 136 **you're not like on top of her like, oh you need to do this, this and this today.** She
 137 works better when she's got it in the morning when I wake up, cos she's
 138 usually asleep when I wake up in the morning, I'll give her a text in the morning
 139 saying, morning you've got this, this and this today and you've got these
 140 appointments, do them today....

Figure 12. Transcript excerpt from Michelle's follow-up SFBT session: exploring the difference achieving her best hopes would make.

300 PRA **What would you say you're already doing that's supporting you with getting a**
 301 **good night's sleep?**
 302 CAR: I go to the gym. That helps. And on a Monday I make it my kind of evening
 303 on a Monday. Yeah. So I keep Monday free so I can make sure I can do
 304 that for myself.
 305 PRA: **Anything else you're doing to aid support your sleep.**
 306 CAR: Sometimes I put on my really, try and put some calming music on, or put
 307 YouTube on or like go running.
 308 PRA: Oh that's cute. Okay. And I guess **how did you manage to go about**
 309 **implementing these things? What did it take for you to do these things?** To
 310 notice that they had an effect to on you gaining better sleep?
 311 CAR: I've always I mean, I work with students, so, sometimes we have things like
 312 on for them. And then I will be like, oh, this is really calming space. Yeah. Its
 313 just things I've picked up along the way really. But I know that when I finish,
 314 like, gym, I know when I've done gym, I feel really good. I can feel
 315 super tired. I go to the gym or come back out like that, and I feel great.
 316 PRA: And I guess **how have you managed to continue upholding these things when**
 317 **it probably felt like you didn't want to,** but yet you kind of pushed yourself to
 318 do it anyway because you just...
 319 CAR: I just, yeah, **I know it helps me so I just push myself** to do it. Even though I
 320 don't get me wrong, there are days where I just go uh, I don't want to do gym
 321 today, but I still like you know feel good afterwards.

Figure 13. Transcript excerpt from Michelle's follow-up SFBT session: encouraging Michelle to notice what is already working.

4. Discussion

The intervention materials and session transcripts illustrate how the SASH intervention can support YP to (1) better understand *their personal* self-harm and identify ways of breaking the cycle of self-harm, (2) develop a highly *personalised and granular safety plan* with a range of coping strategies, and (3) identify their *personal hopes* for what they want to be better in their lives and how they are already moving in this direction. All three components prioritise the YP's or carer's language and use their words to formulate the cycle of self-harm, the safety plan, and hopes for/progress towards their preferred future. The collaborative approach fosters the therapeutic relationship and personalised care.

Across the sessions, some core themes emerged. The role of friendships for young people, particularly at school, was important in both negative and positive ways. Experiencing difficulties with friends at school led to feelings of sadness and stress, which could become overwhelming, leading to thoughts of self-harm ("I just need to hurt myself") and triggering self-harm behaviour. YP described noticing mood changes and signs that they were becoming stressed, which improved their self-awareness and understanding of the link between their feelings and self-harm behaviour. They reflected on what kept them feeling calm and overcoming a fear of being a burden on others by sharing how they were feeling, which helped them not to self-harm. They also described difficult feelings stemming from a need to please everyone or needing validation from others: Overcoming these feelings led to less social anxiety and more confidence. This led to finding it easier to go to school and being more social with friends/student peers, which in turn improved their mood.

In the TA case study of Adah, drawing the cycle of self-harm helped the YP to unpack the “core pain” behind their self-harm (sadness) and how this led to self-harm (“I thought it was only option”). Breaking down the chain of events and asking the YP to consider the positive short-term consequences (relief as “nothing going on in my head”) and then the negative longer-term consequences (a panic attack and having to attend the ED) helps the YP to understand the link between their emotions and behaviour. Developing a detailed personalised trajectory enables the YP to explore where *they* feel it would be helpful to think about breaking the cycle. This contrasts with more generic advice about stopping self-harm and reflects the logic model mechanisms of change, namely building the YP’s self-awareness of their self-harm and instilling confidence in how to break the cycle. Synthesis of accounts of people who reduced or stopped self-harming reveals the importance of breaking the link between an individual’s psychological or social states and self-harm behaviour [30]. YP report being given advice that they do not feel is relevant for them [31]. Previous research has found the Therapeutic Assessment to be effective in improving engagement in subsequent follow-up care [32]. In this case, the YP attended four further sessions after the TA, indicating good engagement in the SASH intervention.

The SP case illustrates an initial focus on what the YP is like when they are well. This addition to the SP was suggested by our Young Person Advisory Group (YPAG) who we collaborated with during the SASH trial. This is consistent with a more positively framed approach, similar to the Reasons for Living approach, which focuses on positive reasons for staying alive in YP admitted to the hospital [33]. Enhanced Safety Planning is a very granular approach. YP identify *their* own personal warning signs (thoughts, emotions, and body sensations), where they typically are when these signs appear, and a range of coping strategies they can draw on in these moments. It incorporates principles of behaviour change by explicitly asking about barriers to implementing helpful behaviours and reaching out to others when things are starting to deteriorate and how to overcome these barriers.

While SP are recommended in NICE guidelines following an episode of self-harm [1], they typically provide basic information about means restriction and crisis phone numbers. Although there is little research on YP’s experiences of safety planning, adults have described safety plans as too generic and not sufficiently personalised to them [34]. Patients often report doubts about being able to use their safety plan [35]. This reflects the importance of troubleshooting barriers to using the coping strategies and thinking these through before the person is going into or in a crisis: Adah described saying positive affirmations to herself in these moments. These strategies provide new ways of thinking, which support the YP’s motivation and hope that they can break the self-harm cycle.

SFBT sessions focus on the YP’s or carer’s best hopes for the future (rather than problems) and current strengths. They generate positive emotions by visualising and describing a good day, identifying what is already working, noticing exceptions to the problem, and orienting the YP/carer to notice small signs of progress. Similar to TA and SP, SFBT elicits personalised, detailed descriptions about the YP/carer’s situation. In Case study 3, Charlotte describes wanting to get better mentally and to communicate better. Her visualisation and detailed description of a good day starts with her getting straight out of bed in the morning and being happier to go to school and socialise more with people. This would make her happier, which in turn would make her mentally better. The transcripts of the SFBT sessions show how questions elicit detailed descriptions of what will be happening in the person’s daily life when things are better [36].

SFBT has been used with people with suicidal thoughts or in a mental health crisis [37]. By focusing on the person’s strengths and resources, it helps to instil hope [37]. SF approaches have also been used in the assessment and [37,38] management of suicide risk, albeit more commonly in adults [39]. A solution-focused approach is a paradigm shift

from the usual way of working in crisis mental health care in the NHS. However, it can be embedded within NHS systems of care and in the context of self-harm and suicide risk management [40].

Supporting carers is increasingly recognised as an important part of care for YP presenting to the ED with self-harm in a mental health crisis. Recent clinical and practice reviews recommend greater attention paid to family involvement [7,18]. Meanwhile, Mughal et al. (2022), in their systematic review of the needs of individuals supporting YP, found that they also need support, especially as they negotiate new identities when handling self-harm in YP [41].

Strengths and Limitations

This paper presents five case studies based on materials and recordings of the SASH intervention sessions, which were collected as part of a process evaluation in an ongoing randomised controlled trial. The intervention was implemented in routine clinical settings in the NHS in the UK. Clinical and other outcomes (e.g., depression, anxiety, wellbeing, and school attendance) are assessed after 6 months, and the primary outcome is self-harm. The trial will also consider service use, costs to carer, and carer health-related quality of life to evaluate the costs and cost-effectiveness of the intervention.

As described by McLeod (2010) [27], this is useful for demonstrating how psychological interventions are delivered in practice and provides practitioners with real examples of working with YP presenting with self-harm. We used case materials from medical records and intervention recordings to illustrate components of the SASH intervention delivered by child and adolescent mental health practitioners. While the RCT results have not yet been published, this study offers insights into real-world treatment, providing fine-grained and practice-based evidence of how the SASH intervention was delivered to YP in crisis. This offers valuable information for clinicians on how the SASH techniques were implemented in real clinician-patient interactions. Multiple sources of data, including intervention session transcripts, bespoke intervention materials, and qualitative interviews, are used to demonstrate the delivery of the intervention in practice. The logic model provides a structured conceptual framework for interpreting potential mechanisms of change of the intervention. While we only presented five case studies, there was cultural diversity in the cases described.

Limitations relate to the availability of intervention session recordings and sampling of the cases. Intervention sessions were sampled according to availability, audio quality, and fidelity to the intervention according to the manual. Only $n = 16$ intervention sessions were recorded among 78 participants. Consent from the young person, carer, and practitioner was required, and in many cases, consent to recording was not given by one or all parties. Future studies could further encourage the recording of intervention sessions in research studies.

Only five case studies were presented, which may not capture the variation in implementation across different groups of YP and may not be representative of the broader pool of intervention sessions. Once the trial results are available, it will be important to consider the clinical and service use outcomes of the YP in the SASH intervention compared to those receiving Treatment As Usual. Given the link between ED self-harm presentations and the risk of future suicide, re-presentations to the ED will be of particular interest. In addition, data on YP engagement in the intervention, YP who dropped out, and the number of sessions attended will provide insights into the acceptability of the intervention. The SASH trial recruited YP and carers from nine EDs in London. All of the case studies were based on YP who were female (and cis gender). This reflects the overall SASH sample, which was predominantly female. None of the current case studies included YP who were

neurodivergent or gender diverse. This may limit the generalisability of the findings to a more diverse group of YP and carers.

5. Conclusions

These case studies demonstrate how YP improved their self-awareness and understanding of the link between feelings and self-harm behaviour and identified ways of breaking the self-harm cycle, along with detailed strategies for managing difficult feelings and situations at school and with friends. The carer case study demonstrates the potential to support carer mental health so they can, in turn, better support their YP's mental health. Supporting YP and carers in this way has the potential to reduce the risk of future self-harm.

Supplementary Materials: The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/healthcare14020168/s1>, Figure S1: Therapeutic Assessment: cycle of self-harm; Figure S2: enhanced safety plan template; Figure S3: solution-focused brief therapy template (first session); Figure S4: solution-focused brief therapy template (follow-up session).

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References

1. Self-Harm: Assessment, Management and Preventing Recurrence NICE Guideline. 2022. Available online: <https://www.nice.org.uk/guidance/ng225/evidence/p-skills-required-by-staff-in-specialist-settings-pdf-403069580827> (accessed on 19 December 2025).
2. Butt, S.; Randall, E.; Morris, S.; Appleby, L.; Hassiotis, A.; John, A.; McCabe, R.; McManus, S. Suicidal thoughts, suicide attempts and non-suicidal self-harm. In *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4*; NHS England: London, UK, 2025.
3. WHO. *Suicide Worldwide in 2021: Global Health Estimates*; WHO: Geneva, Switzerland, 2025.
4. Appleby, L.; Kapur, N.; Shaw, J.; Hunt, I.; Ibrahim, S.; Gianatsi, M.; Rodway, X.; Williams, A.; Tham, S.; Raphael, J. *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*; Healthcare Quality Improvement Partnership: London, UK, 2017.
5. Cadorna, G.; Vera San Juan, N.; Staples, H.; Johnson, S.; Appleton, R. Review: Systematic review and metasynthesis of qualitative literature on young people's experiences of going to A&E/emergency departments for mental health support. *Child Adolesc. Ment. Health* **2024**, *29*, 266–275. [CrossRef] [PubMed]
6. Owens, C.; Hansford, L.; Sharkey, S.; Ford, T. Needs and fears of young people presenting at accident and emergency department following an act of self-harm: Secondary analysis of qualitative data. *Br. J. Psychiatry* **2016**, *208*, 286–291. [CrossRef] [PubMed]
7. Witt, K.; Stewart, A.; Hawton, K. Practitioner Review: Treatments for young people who self-harm—Challenges and recommendations for research and clinical practice. *J. Child Psychol. Psychiatry* **2025**, *66*, 122–131. [CrossRef]
8. Ougrin, D.; Zundel, T.; Ng, A. *Self-Harm in Young People: A Therapeutic Assessment Manual*; CRC Press: Boca Raton, FL, USA, 2009.

9. English, O.; Wellings, C.; Banerjee, P.; Ougrin, D. Specialized Therapeutic Assessment-Based Recovery-Focused Treatment for Young People with Self-Harm: Pilot Study. *Front. Psychiatry* **2019**, *10*, 895. [CrossRef] [PubMed]
10. Abbott-Smith, S.; Ring, N.; Dougall, N.; Davey, J. Suicide prevention: What does the evidence show for the effectiveness of safety planning for children and young people?—A systematic scoping review. *J. Psychiatr. Ment. Health Nurs.* **2023**, *30*, 899–910. [CrossRef]
11. Kennard, B.; Mayes, T.; King, J.; Moorehead, A.; Wolfe, K.; Hughes, J.; Castillo, B.; Smith, M.; Matney, J.; Oscarson, B.; et al. The Development and Feasibility Outcomes of a Youth Suicide Prevention Intensive Outpatient Program. *J. Adolesc. Health* **2019**, *64*, 362–369. [CrossRef]
12. Lewis, P. Reaching the Tipping Point. Children and Young People's Mental Health. Mental Health Network NHS Confederation. 2021. Available online: <https://www.nhsconfed.org/publications/reaching-tipping-point> (accessed on 6 February 2023).
13. NHS Digital. Waiting Times for Children and Young People's Mental Health Services, 2023–2024. 2025. Available online: <https://digital.nhs.uk/supplementary-information/2025/waiting-times-for-children-and-young-peoples-mental-health-services-2023-24> (accessed on 19 December 2025).
14. Malla, A.; Shah, J.; Iyer, S.; Boksa, P.; Joobar, R.; Andersson, N.; Lal, S.; Fuhrer, R. Youth Mental Health Should Be a Top Priority for Health Care in Canada. *Can. J. Psychiatry* **2018**, *63*, 216–222. [CrossRef]
15. Punton, G.; Dodd, A.L.; McNeill, A. 'You're on the waiting list': An interpretive phenomenological analysis of young adults' experiences of waiting lists within mental health services in the UK. *PLoS ONE* **2022**, *17*, e0265542. [CrossRef]
16. Young Minds. Mental Health Waiting Times Harming Young People. Online Press Release. Available online: <https://www.youngminds.org.uk/about-us/media-centre/press-releases/mental-health-waiting-times-harming-young-people/> (accessed on 19 December 2025).
17. Gingerich, W.J.; Peterson, L.T. Effectiveness of Solution-Focused Brief Therapy: A Systematic Qualitative Review of Controlled Outcome Studies. *Res. Soc. Work. Pract.* **2013**, *23*, 266–283. [CrossRef]
18. Meza, J.I.; Zullo, L.; Vargas, S.M.; Ougrin, D.; Asarnow, J.R. Practitioner Review: Common elements in treatments for youth suicide attempts and self-harm—A practitioner review based on review of treatment elements associated with intervention benefits. *J. Child Psychol. Psychiatry* **2023**, *64*, 1409–1421. [CrossRef]
19. McCabe, R.; O'Keeffe, S.; Ougrin, D.; Priebe, S.; Martin, P.; Feng, Y.; Temple, R.; Long, M. Protocol of a randomised controlled trial of a novel brief psychological intervention for young people presenting to emergency departments in the UK with self-harm or suicidal ideation with recent self-harm: The SASH study (Supporting Adolescents with Self-Harm). *BMJ Open* **2025**, *15*, e101015. [CrossRef] [PubMed]
20. Stanley, B.; Brown, G.K. Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. *Cogn. Behav. Pract.* **2012**, *19*, 256–264. [CrossRef]
21. Franklin, C.; Ding, X.; Kim, J.; Zhang, A.; Hai, A.H.; Jones, K.; Nachbaur, M.; O'Connor, A. Solution-Focused Brief Therapy in Community-Based Services: A Meta-Analysis of Randomized Controlled Studies. *Res. Soc. Work. Pract.* **2024**, *34*, 265–276. [CrossRef]
22. Creswell, C.; Violato, M.; Fairbanks, H.; White, E.; Parkinson, M.; Abitabile, G.; Leidi, A.; Cooper, P.J. Clinical outcomes and cost-effectiveness of brief guided parent-delivered cognitive behavioural therapy and solution-focused brief therapy for treatment of childhood anxiety disorders: A randomised controlled trial. *Lancet Psychiatry* **2017**, *4*, 529–539. [CrossRef]
23. Franklin, C.; Sucher, K.; Kim, J.S. Solution-focused brief therapy core elements and the process of change. In *Solution-Focused Brief Therapy with Families: A Training Manual*; American Psychological Association: Washington, DC, USA, 2025; pp. 23–49. [CrossRef]
24. Franklin, C.; Guz, S.; Zhang, A.; Kim, J.; Zheng, H.; Hai, A.H.; Cho, Y.J.; Shen, L. Solution-Focused Brief Therapy for Students in Schools: A Comparative Meta-Analysis of the U.S. and Chinese Literature. *J. Soc. Social. Work. Res.* **2022**, *13*, 381–407. [CrossRef]
25. Carr, A.; Hartnett, D.; Brosnan, E.; Sharpy, J. Parents Plus Systemic, Solution-Focused Parent Training Programs: Description, Review of the Evidence Base, and Meta-Analysis. *Fam. Process* **2017**, *56*, 652–668. [CrossRef]
26. Gong, H.; Hsu, W. The Effectiveness of Solution-Focused Group Therapy in Ethnic Chinese School Settings: A Meta-Analysis. *Int. J. Group Psychother.* **2017**, *67*, 383–409. [CrossRef]
27. McLeod, J. *Case Study Research: In Counselling and Psychotherapy*; SAGE Publications Ltd.: London, UK, 2010. [CrossRef]
28. Willcox, G. The Feeling Wheel. *Trans. Anal. J.* **1982**, *12*, 274–276. [CrossRef]
29. Hawton, K.; Bergen, H.; Waters, K.; Ness, J.; Cooper, J.; Steeg, S.; Kapur, N. Epidemiology and nature of self-harm in children and adolescents: Findings from the multicentre study of self-harm in England. *Eur. Child Adolesc. Psychiatry* **2012**, *21*, 369–377. [CrossRef]
30. Brennan, C.A.; Crosby, H.; Sass, C.; Farley, K.L.; Bryant, L.D.; Rodriguez-Lopez, R.; Romeu, D.; Mitchell, E.; House, A.O.; Guthrie, E. What helps people to reduce or stop self-harm? A systematic review and meta-synthesis of first-hand accounts. *J. Public Health* **2023**, *45*, 154–161. [CrossRef]

31. Wadman, R.; Nielsen, E.; O’Raw, L.; Brown, K.; Williams, A.J.; Sayal, K.; Townsend, E. “These Things Don’t Work.” Young People’s Views on Harm Minimization Strategies as a Proxy for Self-Harm: A Mixed Methods Approach. *Arch. Suicide Res.* **2020**, *24*, 384–401. [[CrossRef](#)] [[PubMed](#)]
32. Ougrin, D.; Boege, I.; Stahl, D.; Banarsee, R.; Taylor, E. Randomised controlled trial of therapeutic assessment versus usual assessment in adolescents with self-harm: 2-year follow-up. *Arch. Dis. Child.* **2013**, *98*, 772–776. [[CrossRef](#)] [[PubMed](#)]
33. Ugueto, A.M.; O’Hagan, L.A.; Lucassen, M.F.G. Reasons Why Suicidal Adolescents Want to Live: A Corpus-Driven Language Analysis. *Psychiatr. Serv.* **2025**, *76*, 951–958. [[CrossRef](#)] [[PubMed](#)]
34. O’Keeffe, S.; Suzuki, M.; McCabe, R. An Ideal-Type Analysis of People’s Perspectives on Care Plans Received from the Emergency Department following a Self-Harm or Suicidal Crisis. *Int. J. Environ. Res. Public Health* **2023**, *20*, 6883. [[CrossRef](#)]
35. Hollenberg, E.; Shin, H.D.; Reid, N.; Stergiopoulos, V.; Lestage, L.; Nicoll, G.; Walji, A.; Zaheer, J. Context, Timing and Individualized Care: A Realist Evaluation of Safety Planning for Individuals Living with Suicide-Related Thoughts and Behaviours, Their Families and Friends and Service Providers. *J. Clin. Med.* **2025**, *14*, 4047. [[CrossRef](#)]
36. Jerome, L.; Masood, S.; Henden, J.; Bird, V.; Ougrin, D. Solution-focused approaches for treating self-injurious thoughts and behaviours: A scoping review. *BMC Psychiatry* **2024**, *24*, 646. [[CrossRef](#)]
37. Perry, N.; Goldie-McSorley, L. Suspending Disbelief—Using Solution Focused Practice with Young People in Mental Health Crisis. *J. Solut. Focus. Pract.* **2024**, *8*, 1–14. [[CrossRef](#)]
38. John, H. *Preventing Suicide: The Solution Focused Approach*; Wiley: Hoboken, NJ, USA, 2017.
39. Perry, N.; Orr, M. *Solution Focused Practice and Mental Health Crisis*; Routledge: London, UK, 2025. [[CrossRef](#)]
40. McCabe, R.; Akubat, A.; Bakou, A.E.; Long, M. ‘This magical lightbulb went off in my head’—How training NHS staff in Solution Focused Practice can change the experience of people presenting in mental health crisis. In *Solution Focused Practice and Mental Health Crisis*; Routledge: London, UK, 2025; pp. 44–54. [[CrossRef](#)]
41. Mughal, F.; Troya, M.I.; Dikomitis, L.; Tierney, S.; Corp, N.; Evans, N.; Townsend, E.; Chew-Graham, C.A. The experiences and needs of supporting individuals of young people who self-harm: A systematic review and thematic synthesis. *eClinicalMedicine* **2022**, *48*, 101437. [[CrossRef](#)]

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