Crisis - What can you do with a distressed or suicidal adolescent?

Dr Tauseef Mehdi

Consultant Child and Adolescent Psychiatrist, Berkshire CAMHS Rapid Response Service

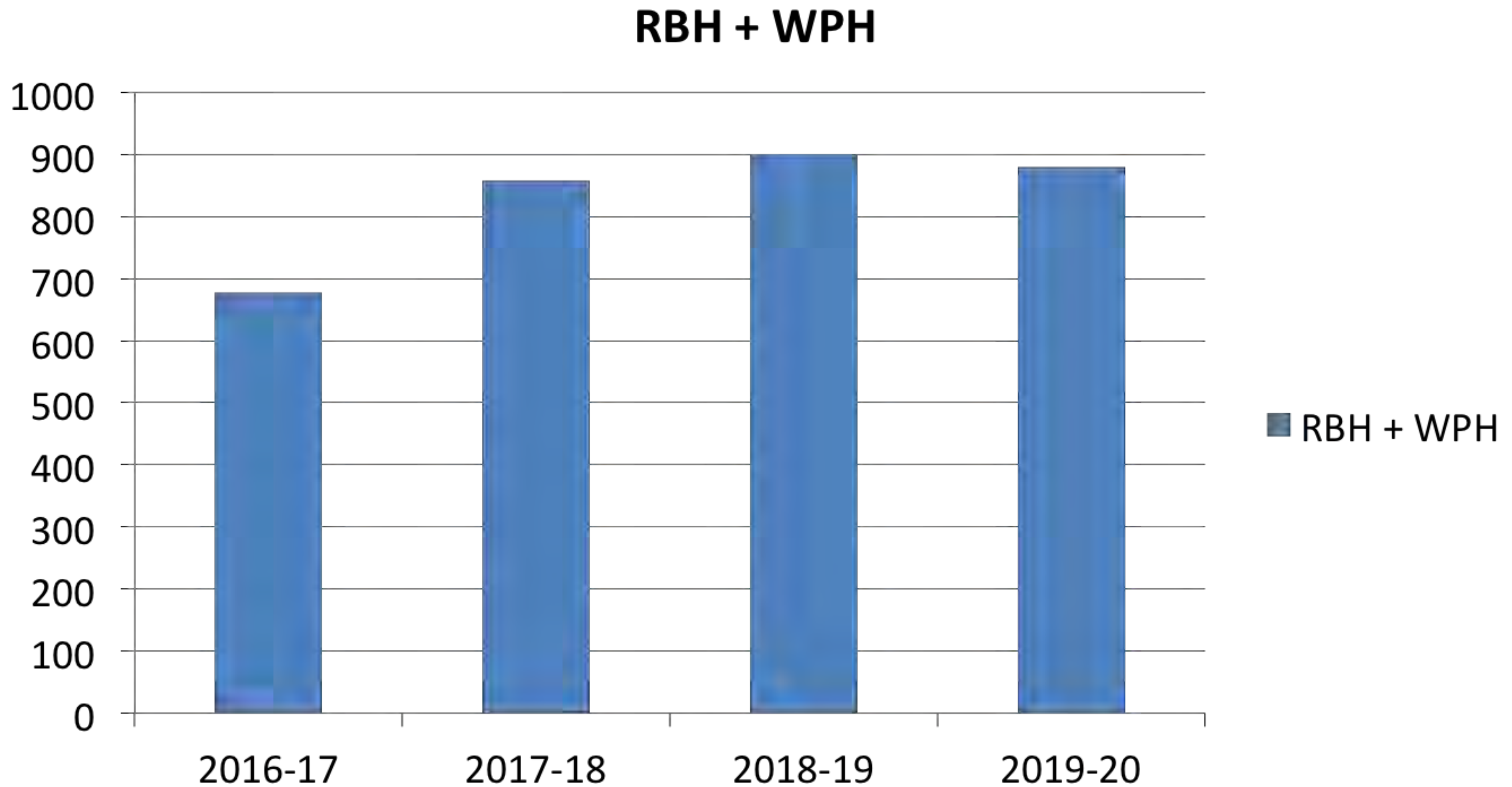
Mental Health Crisis: Contents

- **CAMHS RR service so far**
- **Brief Intervention Model**
- **Multiagency Working; example**
- Case example – how do we think about crisis?
- How can “young person’s crisis” be characterised?
- Prevalence of Self-Harm, risk factors and evidence for interventions.
- Prevalence of Suicide
- Risk Assessments – what do we actually assess?
- Assessment and Formulation
- Discussion

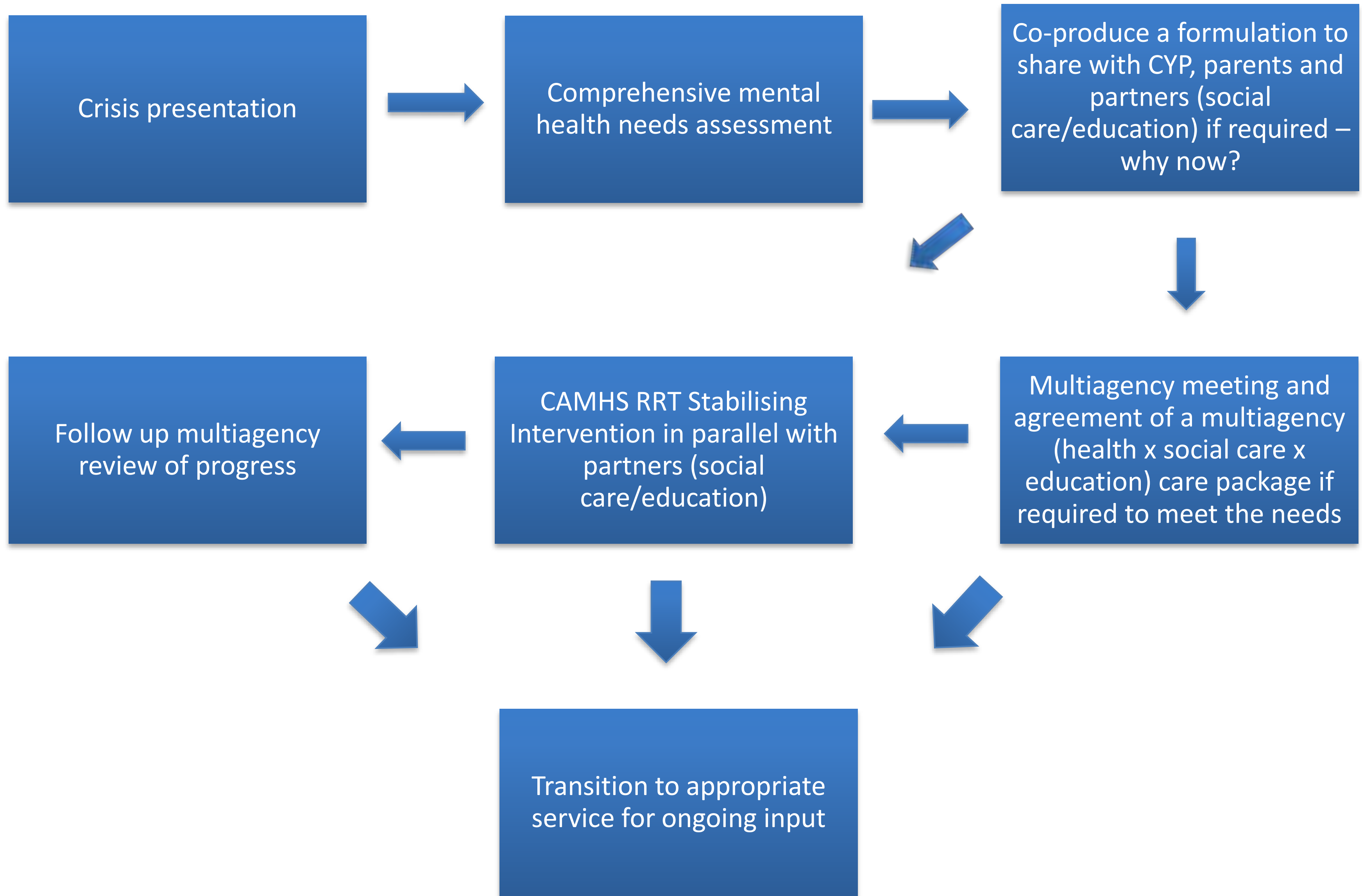
CAMHS RRT Service Aims

- Enhance quality of crisis care for CYP
- Early identification of mental health needs – comprehensive assessments not “risk” assessments.
- Early response and input to CYP’s needs in crisis – “brief stabilising intervention”
- Reduce presentation to A&Es, tier 4 admissions and delayed discharges.
- Teaching/training partner agencies.

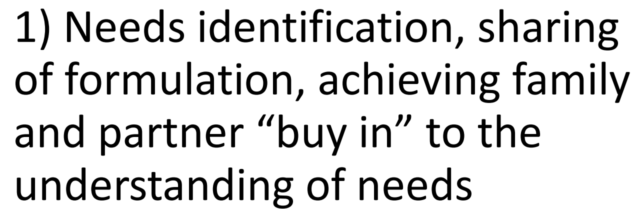
Crisis Referrals in Berkshire

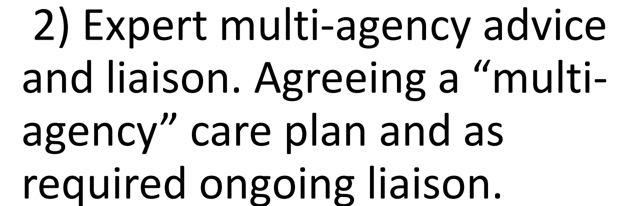


CAMHS RRT Crisis Stabilisation Pathway

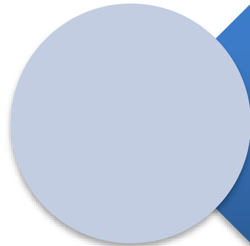


CAMHS RRT Brief Intervention

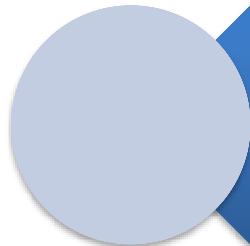




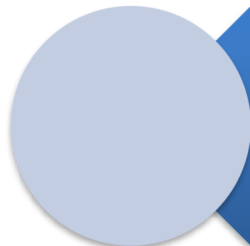
E.g. Needs Led Multiagency Care Plan



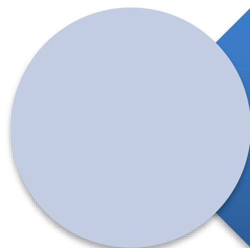
Education – Increased pastoral support at school. Movement/sensory breaks. Individualised or reduced time table. Educational Psychology assessment and educational support ?EHC plan application.



Social care – Social worker input under a child in need plan. Family group conference. Specialist behavioural and family support at home. Allocation of youth worker



CAMHS – Brief DBT Informed therapeutic intervention weekly for 4-6 weeks. Ongoing liaison and advice to school and social care. Psychotropic initiation to target mental ill health. Facilitate smooth transition for ongoing care.



Police – Request forensic opinion on needs. Psychoeducation.

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How do we think about crisis and risk; case example - Sarah

- 16 year old girl, two older high achieving brothers, both parents professionals.
- No motor, language delay; but jumpy, boisterous and fearless child.
- Private primary schooling, average/below average academic attainment, tested for dyslexia – outcome inconclusive, parental reports of longstanding social/interpersonal difficulties.
- Parents indicated early years history of emotional/behavioural outbursts

Case example - Sarah

- 1st emergent emotional difficulties in year 5/6 – stress, mood swings, anxiety, irritability
- Early 2016 – 1st CAMHS referral; disordered eating, restricting oral intake and purging, “things under control”, no further input
- Early 2017 – ongoing binge eating, purging, use of laxatives, anxiety, panic attacks, low mood, saw school counsellor but continued to worsen with emergent cutting, hair pulling. Increased irritability and worsening outbursts at home.

Case example - Sarah

- March 2017 – referred to CAMHS by School GP, assessed by Eating Disorder team and offered a care package (1-2 weekly meetings).
- May 2017, severe weight loss, purging, laxative use, excessive exercise, collapsed and admitted to Basingstoke Hospital
- June 2017 – depression diagnosed and fluoxetine initiated. Worsening risky and unpredictable behaviours (absconding from boarding school, wandering at bridges, threatening self-harm/suicide).
- Sept 17 –Feb 18; ongoing eating disorder team therapeutic support but condition deteriorating.

Case example - Sarah

- 2018 – ongoing deterioration, continued weight loss. Admitted to CAMHS Eating Disorder unit Feb – May 2018.
- May –Dec 2018 – weekly CBT, fortnightly family therapy sessions. Aripiprazole. Medical reviews. Hard to manage behaviours. Situation unchanged.
- Dec 2018; assaulted mother, arrested. Not able to return to family home, stayed in one care home in London for two months, then another in South of England for two months before returning to a foster home in Berkshire in March 2019, with a plan of family reintegration.
- June 2019, presented with OD following bf split and perceived “abandonment” from parents. Parents unable to manage her volatile behaviour at home. MHA assessment on ward – not detainable. ? Where does she go ? Secure care?.

How do we think about crisis?

- Continued deterioration 2017-2019 despite interventions – why?

June 2019; fresh re-assessment, difficulties re-formulated

Re-formulation

- March 2019 private assessment; ASD traits, diagnosed ADHD, cognitive deficits – combination of neurodevelopmental difficulties

- Escalating stress since age 10, that manifested in a variety of symptoms, and just kept on getting worse

- June 2019 – shared this formulation with parents, young person, social care and education.
- Targeted ADHD treatment
- Parallel psychological/family support for emotion dysregulation
- Prompt resolution of well being and functioning.

How do we think about crisis?

Identify first, share understanding and address unmet needs

Not offer therapy or medications

What are unmet needs

Anything that causes perpetual stress in a child

These are reversable and the 1st intervention is to work on reversal

What are unmet needs

- Any neurodevelopmental difficulty (language, learning, sensory, ADHD, ASD, DCD) that is inaddressed
- Absence of appropriate education provision
- Disruptive care-giving (any abuse/trauma)
- Threats to attachment security in LAC
- Bullying
- Substance misuse
- School refusal/poor school attendance
- Limited physical/social activity
- Untreated major mental illness

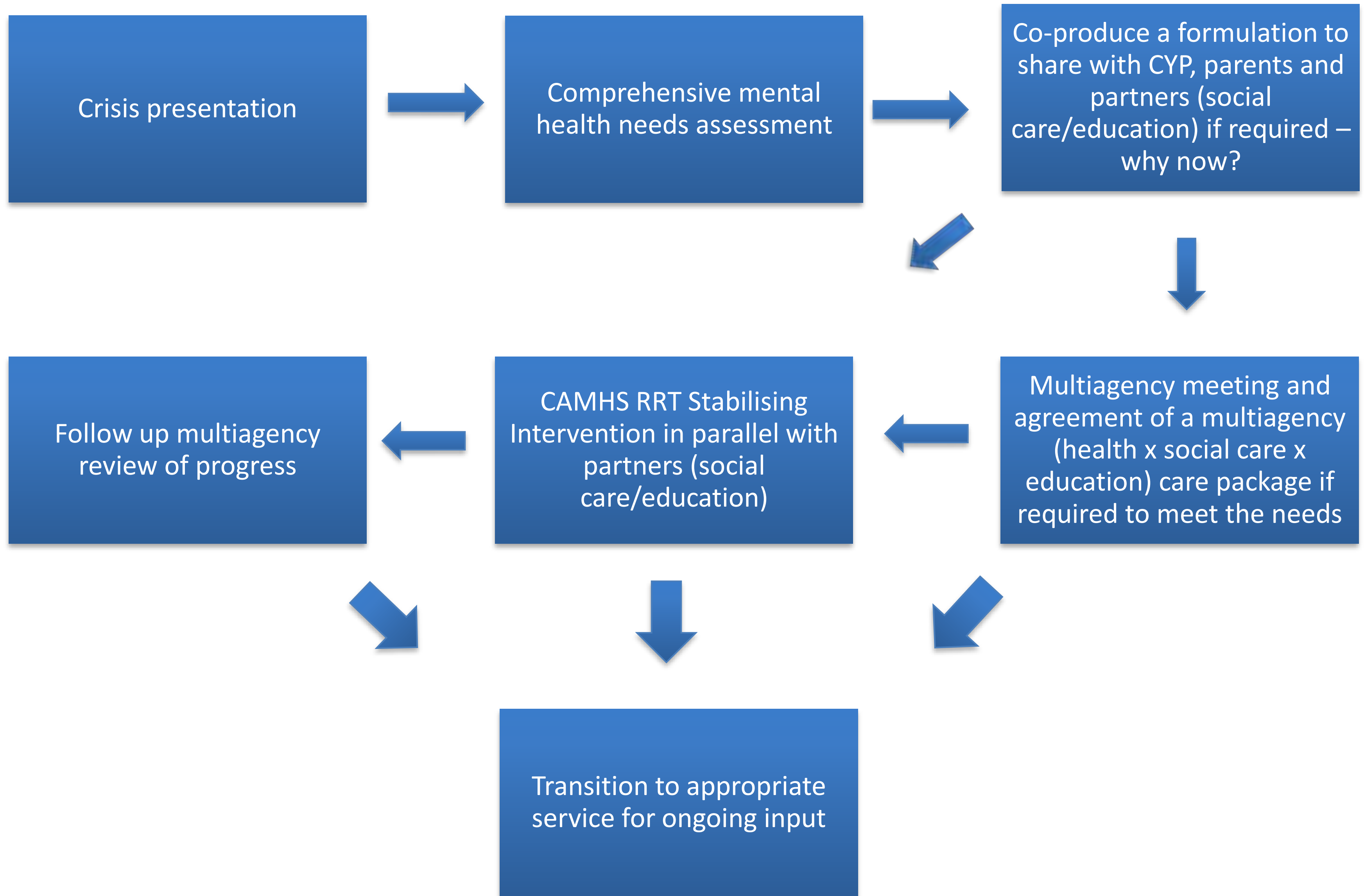
Unmet needs – Stress – Self harm

Addressing the needs = addresses the risk

Futile to work on self-harm when causes of self-harm are not addressed.

Multi-agency integrated care

CAMHS RRT Crisis Stabilisation Pathway



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Advances in the Assessment of Suicide Risk

Craig J. Bryan and M. David Rudd
Baylor University

This article reviews and integrates empirically grounded advances in the assessment of suicidality. The practices discussed are consistent with existing standards of care, practice guidelines, and applicable research. The authors differentiate between risk assessment and prediction and then emphasize the important role of time in risk assessment. We present and illustrate a continuum of suicidality for risk assessment and offer practical recommendations for clinical decision making and treatment. © 2005 Wiley Periodicals, Inc. J Clin Psychol: In Session 62: 185–200, 2006.

notion of suicide prediction is problematic, however, because predicting low base-rate phenomena such as suicide with reliability is not possible. In other words, because completed suicide occurs so infrequently, a clinician would actually be correct much more often if he or she predicted that a patient would *not* commit suicide regardless of clinical presentation. However, the legal expectation that clinicians can reliably predict their

The inability to predict suicidal behavior reliably does not mean important risk factors that place a patient at increased risk for suicide have not been identified through research. The clinician's task is not to predict suicide, but rather to recognize when a patient has entered into a heightened state of risk (risk assessment) and to respond appropriately. At its best, risk assessment both estimates the risk of suicidal behavior and explains it when used in a consistent fashion for all patients, providing a template for clinical management of any crisis, as well as short- and longer-term treatment targets.

NHS
Health Education England

Self-harm and Suicide Prevention Competence Framework

Children and young people

5.1.6. Risk assessment

When working with children and young people who have self-harmed or who experience suicidal ideation, it may seem clear that the person's current level of risk to themselves or others should be assessed. However, while there are many factors associated with risk, evidence indicates that our ability to accurately predict risk is limited.[15 16] This means that it is possible to both over-estimate and under-estimate the actual risk of suicide in a child or young person at a given moment in time. Research suggests that moving away from prediction to focusing on the needs of the person and seeing assessment as informing management rather than as a stand-alone activity.[17]

In many settings, risk classification scales and risk assessment tools are widely used when assessing risk. Using these in addition to clinical interviewing may make sense, as they can provide a helpful structure and prompt the person who is completing the assessment to ask about current feelings and motivations. However, using tools and scales in isolation from a broader discussion with the child or young person about their life as a whole can be both misleading and possibly unhelpful. As well as the evidence suggesting that risk assessment tools and scales do not have predictive value,[15 16] their use might also cause the child or

Risk assessment

Please cite this report as:

The assessment of clinical risk in mental health services. National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Manchester: University of Manchester, 2018.

The Department of Health's Best Practice in Managing Risk[6] defines risk as relating to the likelihood, imminence and severity of a negative event occurring (i.e. violence, self-harm, self-neglect). In mental health services risk assessment has traditionally focused on prediction[7-8]. Patients may be categorised into low, medium or high risk of a particular outcome. Checklists of characteristics or risk scales are sometimes used to estimate the likelihood of harm occurring. However, research suggests that categorising risk in such a way is unhelpful in guiding the treatment and management of a patient[9], and has poor predictive value[10-13]. Our previous research has

Predictive value of risk scales

9. Large M, Ryan C, Carter G, Kapur N. Can we usefully stratify patients according to suicide risk? *British Medical Journal* 2017; 359 : j4627.
10. Chan M, Bhatti H, Meader N, Stockton S, Evans J, O'Connor R, Kapur N, Kendall T. Predicting suicide following self-harm: A systematic review of risk factors and risk scales. The British Journal of Psychiatry 2016; 209(4): 277-83.
11. Quinlivan L, Cooper J, Steeg S, Davies L, Hawton K, Gunnell D, Kapur N. Scales for predicting risk following self-harm: an observational study in 32 hospitals in England. 2014 *BMJ Open* 2014; 4: e004732.
12. Quinlivan L, Cooper J, Davies L, Hawton K, Gunnell D, Kapur N (2016) Which are the most useful scales for predicting repeat self-harm? A systematic review evaluating risk scales using measures of diagnostic accuracy. *BMJ Open* 2016; 6: e00929.
13. Steeg S, Quinlivan L, Nowland R, Carroll, R, Casey D, Clements C, Cooper J, Davies L, Knipe D, Ness J, O'Connor R C, Hawton K, Gunnell D, Kapur N. Accuracy of risk scales for predicting repeat self-harm and suicide: a multicentre, population-level cohort study using routine clinical data. *BMC Psychiatry*, 2018 18, 113.

What do “suicide risk assessments” actually measure?

- “Low, moderate and high” risk of suicide “categorisation” in risk assessments
- What makes us clinically determine suicide risk is “high” or “low”? Higher?
- Can suicide be “reliably predicted”?

- Is there a suicide risk assessment tool in adolescents? And is it valid?

- If not, why not?

- What risk factors supported by empirical evidence need to be part of our risk assessments?

What do you do with a distressed/suicidal adolescent?

- Better to understand the cause of the stress underneath the self-harm
- What is the unmet need that could be causing the stress
- That will inform your referral
- Listen, acknowledge, be curious.
- Ask them to come back to see you
- Try not to think your input is NOT helpful.

- Advice on well being measures and strategies is invaluable, shows care and is an immediate mental health intervention.

- Increasing physical activity
- Increasing outdoor activity
- Self-help distraction resources (Apps/websites/telephone/webchat services)

Advice only works after a relationship is established. This may require time.

Might be better to set a goal and ask the young person to come back.

Resources

- Coping with Self-Harm booklet

- BHFT Preventing Crisis and Being Safer

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"Mental Health Crisis" – what does that mean?

- https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/dealing-with-a-mental-health-crisis-or-emergency/

Dealing with a mental health crisis or emergency

A mental health crisis often means that you no longer feel able to cope or be in control of your situation.

You may feel great emotional distress or anxiety, cannot cope with day-to-day life or work, think about suicide or self-harm, or experience hallucinations and hearing voices.

A crisis can also be the result of an underlying medical condition, such as confusion or delusions caused by an infection, overdose, illicit drugs or intoxication with alcohol. Confusion may also be associated with dementia.

“Mental Health Crisis” – what does that mean?

6. Crisis Care In Context

6.1 What is Crisis Care?

NHS England defines a 'crisis' as occurring when the level of distress and risk presented by a young person is not adequately supported or contained by the care system that is in place for them.[11] A child in crisis therefore may present an imminent threat to themselves or others via self-harm/suicide or aggression. Or they may be highly vulnerable to danger, for example via absconding, seeking help from people who may harm them, misusing drugs and alcohol and behaving in a reckless, risk taking way. Mental health crises may be triggered by deterioration in the young person, a weakening of the system around the young person or both.[11,12]

Therefore the child in crisis needs to be considered in the context of support systems around him or her. As such crisis care is not exclusively a matter for health care providers. Social care have a crucial role to play in the pathway as many presentations will be multi-factorial requiring a multi-agency, co-ordinated response. At present there is an over-reliance on the use of A&E, wards and CAMHS in relation to crisis care, even when the crisis is clearly linked to a child's psycho-social situation.

“Mental Health Crisis” – what does that mean?

1. Concordat statement: The vision

challenge for all of us. When
a person’s mental state leads
to a crisis episode, this can be
very difficult to manage, for the
person in crisis, for family and
friends, and for the services that
respond. All may have to deal with
suicidal behaviour or intention,
panic attacks or extreme anxiety,
psychotic episodes, or behaviour
that seems out of control, or
irrational and likely to endanger
the person or others.

"Mental Health Crisis" – what does that mean?

East of England Clinical Networks

EAST OF ENGLAND
MENTAL HEALTH CRISIS CARE TOOLKIT
- CHILDREN AND YOUNG PEOPLE

Summary Document

2 DEFINITIONS OF CRISIS

2.1 SAFEGUARDING AND SYSTEMIC APPROACHES

For children and young people there is often a very significant cross over and interplay between 'social care' crises and 'mental health' crises. Young people are inevitably affected by a number of different systems. A crisis for young people is rarely due to a mental health problem alone: the breakdown in significant relationships; the impact of past or current trauma and abuse or problems with money or housing are likely to present as well.

Emotional wellbeing and mental health affects all aspects of the lives of children and young people, and significantly impacts on their current outcomes and their outcomes later in life. It is therefore vital that they receive the right support as quickly as possible. The interplay between mental health and safeguarding needs can be complex but is vital to ensure that the risk of significant harm is assessed thoroughly on each and every occasion, that local safeguarding children procedures are followed, and that young people receive the right care at the right time. This toolkit adheres to the principles outlined in Working Together to Safeguard Children 2015[1] which emphasises the collective responsibility of agencies in safeguarding children and the need to provide a child centred approach to meet the needs of children and young people as effectively as possible.

The most vulnerable young people often present with complex issues and their behaviour is frequently challenging and dangerous with root causes stemming from traumatic and damaging life experiences. In a crisis, no one agency can meet needs and there is growing recognition of the value of good multi-agency, professional responses offering a child or young person centred positive outcomes.

A crisis is an acute, time-limited episode experienced as overwhelming emotional reactions to an event. What is a crisis for one person may not be so for another. What becomes a crisis may not have been a crisis before or would not be a crisis in a different setting. Crisis has been described as a system out of balance. Crises occur when balance cannot be regained, even though a person is trying very hard to correct the imbalance.

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What is a mental health crisis?

A mental health crisis is when you feel your mental health is at breaking point, and you need urgent help and support.

For example, you might have feelings or experiences that feel very painful or difficult to manage such as suicidal feelings, self-harm, panic attacks, flashbacks, hypomania or mania, or psychosis (such as paranoia or hearing voices). You might also have other experiences that aren't mentioned here.

Some people feel in crisis as part of ongoing mental health problems, or due to stressful and difficult life experiences such as abuse, bereavement, addiction, money problems or housing problems. Or there might not be a particular reason.

Terminology

Self- Harm - UK, Europe

"The term 'self-harm' is used to describe all intentional acts of selfpoisoning (e.g., overdoses) or self-injury (e.g., self-cutting), ***irrespective of degree of suicidal intent or other types of motivation.*** *Thus it includes acts intended to result in death ('attempted suicide'), those without suicidal intent (e.g., to communicate distress, to temporarily reduce unpleasant feelings), and those with mixed motivation"*

Hawton et al 2015

Non-suicidal self-injury – USA

- NSSI is most commonly described as
- **deliberate, direct destruction or alteration of body tissue**
- **without conscious suicidal intent**.
- NSSI is deemed **socially unacceptable,**
- **direct, repetitive** and leads to minor or moderate harm.

Lloyd –Richardson et al 2007

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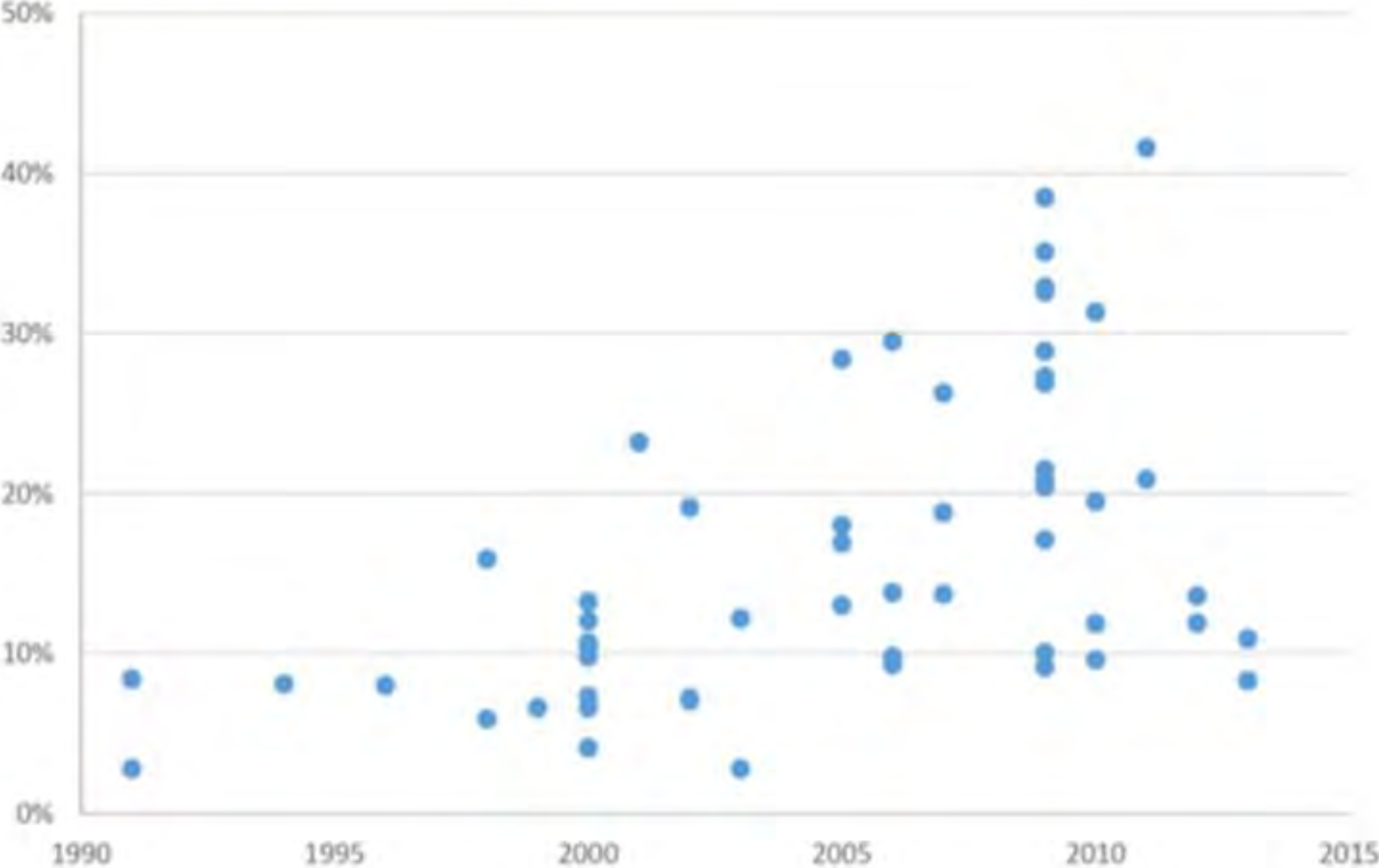
Epidemiology – Prevalence studies

	Hawton et al 2002	**Evans et al 2005**	**CASE Study 2008**	**Muehlenkamp et all 2012**
Type	School based study in England	Systematic review of 128 studies	7 country school based comparative community study	Systematic review of 52 studies from adolescents
Age group	15-16	12-20	15 +16	11-18
Number	6020	n = 513,188	30,000	Very large
Method	Self-reported anonymous questionnaire	Self-reported suicidal phenomenon	Anonymous questionnaire	Self-report single item questionnaire or multiple item questionnaires
Annual Prevalence	**6.9%**		**M:2.6%, F:8.9%**	
Lifetime Prevalence	**13.2%**	**13.2**	**M:4.3%, F:13.5%**	**Self-harm=16%** **NSSI= 18%**

Gillies et al 2018; mean starting age: 12.81 yrs

- Self-harm prevalence from community based studies 1990-2015 in 12-18y olds (n=172 datasets, 261 publications, 597,548 participants from 41 countries)
- Overall self-harm lifetime prevalence: 16.9% (4.1%-39.3%)
  - DSH: 11.4%; NSSI: 22.9%
- Past year self-harm prevalence: 13.0%
  - DSH: 9.0%; NSSI: 18.6%
- ♀>♂: RR1.72
- Most common type: cutting
- 1-2 episodes: 47%
- Most frequent reason: relief from thoughts or feelings
- Suicidal ideation: RR: 4.97, suicide attempt: RR: 9.14

Self-harm: Meta-Analysis



CASE 2008 - Method of SH

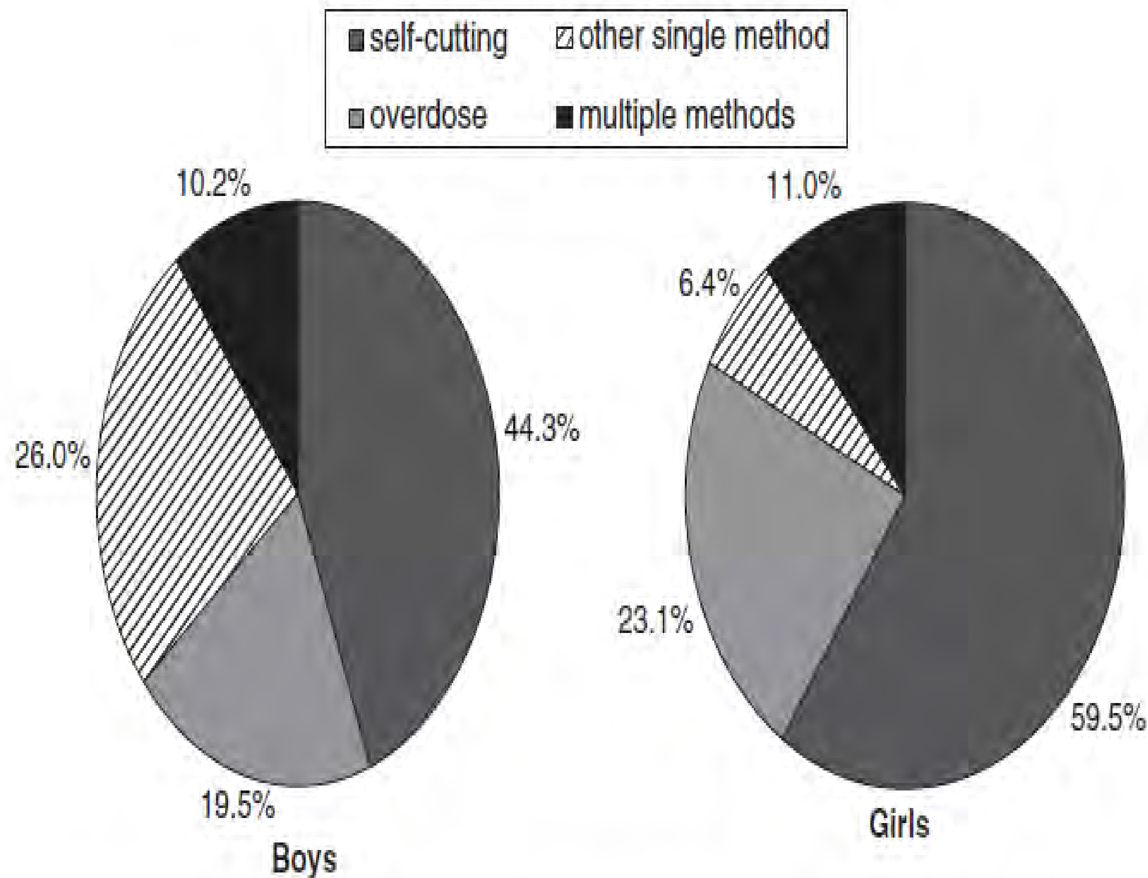


Figure 2 Methods of self-harm (based on self-harm in past year meeting study criteria), by gender, corrected for age

Epidemiology

- Presentation to hospital occurs only in 1 in 8 adolescents
- Self-cutting most common method. However, it is self-poisoning that presents to hospital.

Cully et al 2019

- Ireland: self-harm presentations to hospital ED (2010-2016): National Self-Harm Registry Ireland
- 65,690 self-harm presentations (n=46,661 individuals)

- Most common methods:
  - Intentional drug overdose: 68.3%
  - Self-cutting: 23.8%
  - Attempted hanging: 6.6%

- Self-harm is the strongest predictors of death by suicide in adolescence

Psychiatric disorders in patients presenting to hospital following self-harm: A systematic review

Keith Hawton [a,b,*], Kate Saunders [a], Anya Topiwala [d], Camilla Haw [a,c]

[a] Centre for Suicide Research, University Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX, United Kingdom
[b] Oxford Health NHS Foundation Trust, Warneford Hospital Oxford, Oxfordshire, United Kingdom
[c] St Andrews Healthcare, Northampton, United Kingdom
[d] University Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX, United Kingdom

2012; 50 studies from 24 countries; Psychiatric disorders identified in

Adult: 83.9%

Adolescents: 81.2%

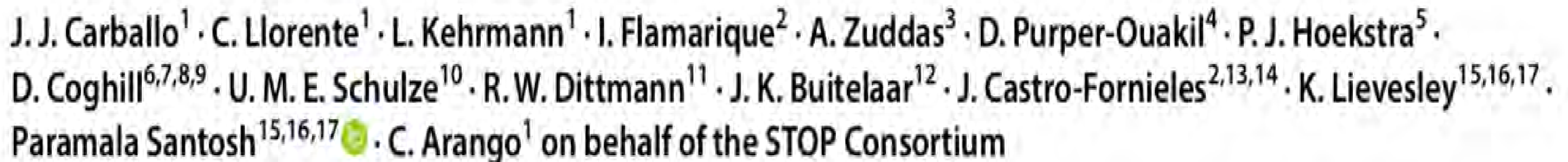
Table 3
Prevalence of psychiatric disorders in children and young people presenting with self-harm (studies using both clinical and research methods of diagnosis).

	Number of studies	%	CI	I^2 (%)
Any psychiatric disorder	9	81.2	60.9 95.5	97.0
Clinical diagnoses	2	61.4	35.2–84.5	93.0
Research diagnoses	7	86.1	62.3–98.5	97.1
Mood disorder	4	56.3	16.7–91.6	98.5
Depression	8	50.0	26.4–69.9	97.4
ADHD	3	24.0	1.2–61.7	93.3
Substance misuse	5	24.8	6.6–49.3	95.2
Anxiety disorders	4	16.6	0.9–44.1	97.8
Conduct disorder	5	9.7	1.9–21.5	85.0
Adjustment disorder	4	24.7	0.0–76.2	99.3
Eating disorder	3	8.3	5.1–12.2	0.0
Bipolar disorder	2	7.3	3.4–12.2	0.0
Psychotic disorders	6	2.4	0.9–4.3	29.5

European Child & Adolescent Psychiatry
https://doi.org/10.1007/s00787-018-01270-9

REVIEW

Psychosocial risk factors for suicidality in children and adolescents


J. J. Carballo[1] · C. Llorente[1] · L. Kehrmann[1] · I. Flamarique[2] · A. Zuddas[3] · D. Purper-Ouakil[4] · P. J. Hoekstra[5] · D. Coghill[6,7,8,9] · U. M. E. Schulze[10] · R. W. Dittmann[11] · J. K. Buitelaar[12] · J. Castro-Fornieles[2,13,14] · K. Lievesley[15,16,17] · Paramala Santosh[15,16,17] · C. Arango[1] on behalf of the STOP Consortium

Received: 19 September 2018 / Accepted: 20 December 2018
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Table 7 Studies investigating risk factors for suicidality among children and adolescents by type of self-injurious thought and/or behaviour

Variable	Suicide attempt	Suicidal behaviour	Suicidal ideation/plan	Non-suicidal self-injury	Self-injurious behaviour
Clinical variables					
Depression	[4, 8, 9, 11–14, 29, 35]	[9, 12]	[5, 9, 12–14, 35]		[12]
Previous suicide attempt	[15, 16]		[17]		
Previous suicidal ideation	[18]	[12, 18]	[18]	[18]	[12, 18]
Alcohol and substance use	[21]	[2, 4, 5, 8, 11, 13, 18–20, 22]	[5]		[23]
Eating disorders		[26]	[26]		[26]
Psychiatric disorders	[4, 8, 27]		[30]		[20]
Hospitalization	[16]				
Sleep disturbances					[20]
Adverse life events					
Family conflicts	[8, 12, 17, 18]	[12, 18]	[8, 12, 17, 18, 34]		[12, 18]
Interpersonal and legal problems	[12]	[12]	[12]		[12]
Change of residence	[42]				
Romantic break-up	[11]				
Exposure to suicidal behaviour	[11, 29]				
Bullying		[39]	[32, 41, 44]		[40]
Abuse			[45]		[43]
Sexual orientation					[43]
Academic performance			[37]		
Temperament and character					
Novelty seeking	[47]				
Impulsiveness	[4, 52]	[52]	[17]	[52]	
Neuroticism, pessimism, perfectionism, dependence			[48]		[20]
Low self esteem	[37]		[37]		[37]
External attributional style	[37]		[37]		[37]

Self-Harm; What works?

Therapeutic Interventions for Suicide Attempts and Self-Harm in Adolescents: Systematic Review and Meta-Analysis

Dennis Ougrin, MBBS, MRCPsych, PGDip(Oxon), PhD, Troy Tranah, BSc, MSc, PhD, Daniel Stahl, PhD, Paul Moran, MBBS, BSc, MSc, DLSHTM, MD, MRCPsych, Joan Rosenbaum Asarnow, PhD

J Am Acad Child Adolesc Psychiatry 2015;54(2):97–107.

Self-Harm; What works?

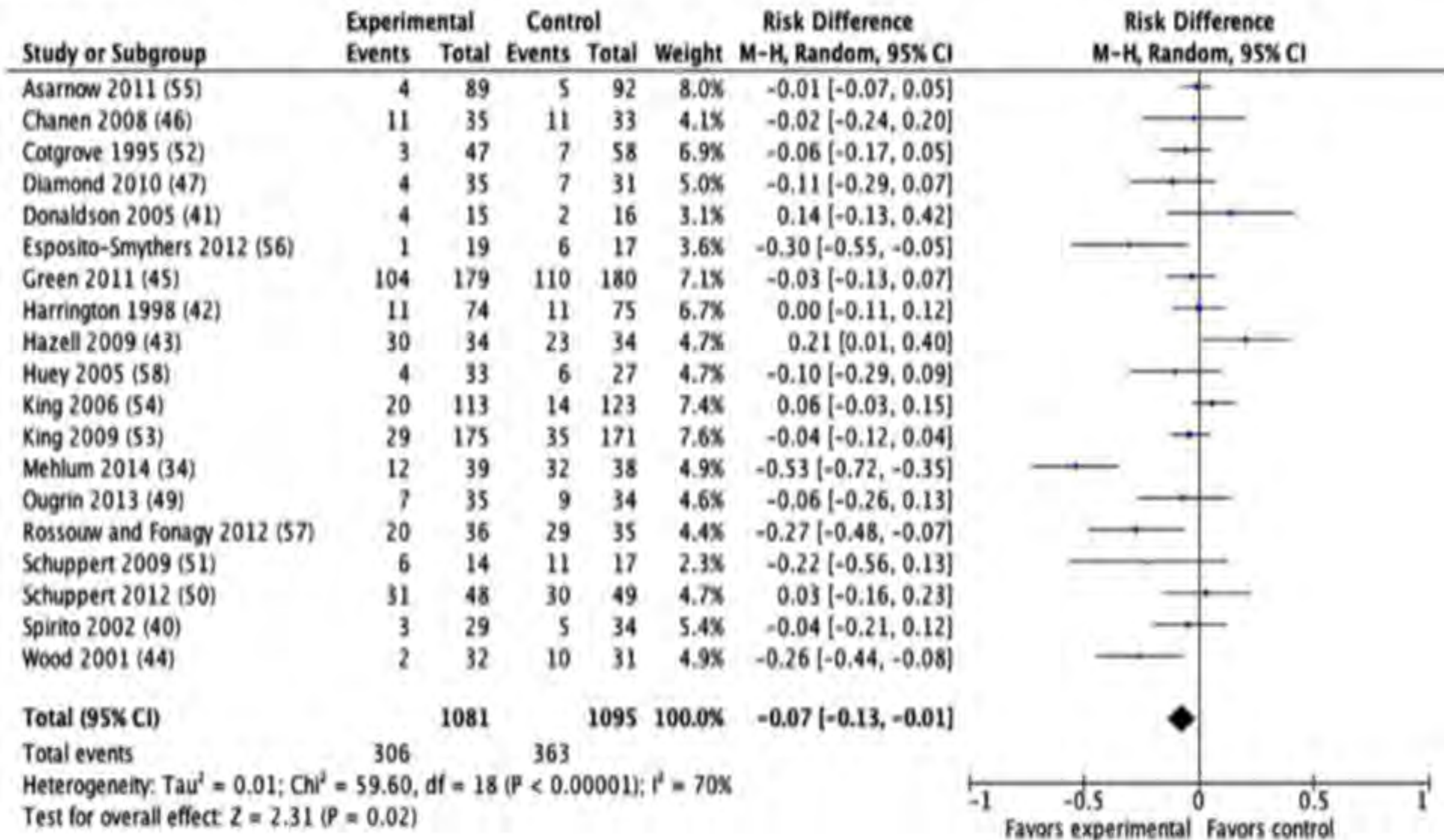

FIGURE 2 Effects of therapeutic interventions (TIs) versus treatment as usual (TAU) on self-harm in adolescents. Note: M-H = Mantel-Haenszel.

Study or Subgroup	Experimental Events	Experimental Total	Control Events	Control Total	Weight	Risk Difference M-H, Random, 95% CI
Asarnow 2011 (55)	4	89	5	92	8.0%	-0.01 [-0.07, 0.05]
Chanen 2008 (46)	11	35	11	33	4.1%	-0.02 [-0.24, 0.20]
Cotgrove 1995 (52)	3	47	7	58	6.9%	-0.06 [-0.17, 0.05]
Diamond 2010 (47)	4	35	7	31	5.0%	-0.11 [-0.29, 0.07]
Donaldson 2005 (41)	4	15	2	16	3.1%	0.14 [-0.13, 0.42]
Esposito-Smythers 2012 (56)	1	19	6	17	3.6%	-0.30 [-0.55, -0.05]
Green 2011 (45)	104	179	110	180	7.1%	-0.03 [-0.13, 0.07]
Harrington 1998 (42)	11	74	11	75	6.7%	0.00 [-0.11, 0.12]
Hazell 2009 (43)	30	34	23	34	4.7%	0.21 [0.01, 0.40]
Huey 2005 (58)	4	33	6	27	4.7%	-0.10 [-0.29, 0.09]
King 2006 (54)	20	113	14	123	7.4%	0.06 [-0.03, 0.15]
King 2009 (53)	29	175	35	171	7.6%	-0.04 [-0.12, 0.04]
Mehlum 2014 (34)	12	39	32	38	4.9%	-0.53 [-0.72, -0.35]
Ougrin 2013 (49)	7	35	9	34	4.6%	-0.06 [-0.26, 0.13]
Rossouw and Fonagy 2012 (57)	20	36	29	35	4.4%	-0.27 [-0.48, -0.07]
Schuppert 2009 (51)	6	14	11	17	2.3%	-0.22 [-0.56, 0.13]
Schuppert 2012 (50)	31	48	30	49	4.7%	0.03 [-0.16, 0.23]
Spirito 2002 (40)	3	29	5	34	5.4%	-0.04 [-0.21, 0.12]
Wood 2001 (44)	2	32	10	31	4.9%	-0.26 [-0.44, -0.08]
Total (95% CI)		**1081**		**1095**	**100.0%**	**-0.07 [-0.13, -0.01]**
Total events	306		363			

Heterogeneity: $Tau^2 = 0.01$; $Chi^2 = 59.60$, $df = 18$ ($P < 0.00001$); $I^2 = 70\%$

Test for overall effect: $Z = 2.31$ ($P = 0.02$)

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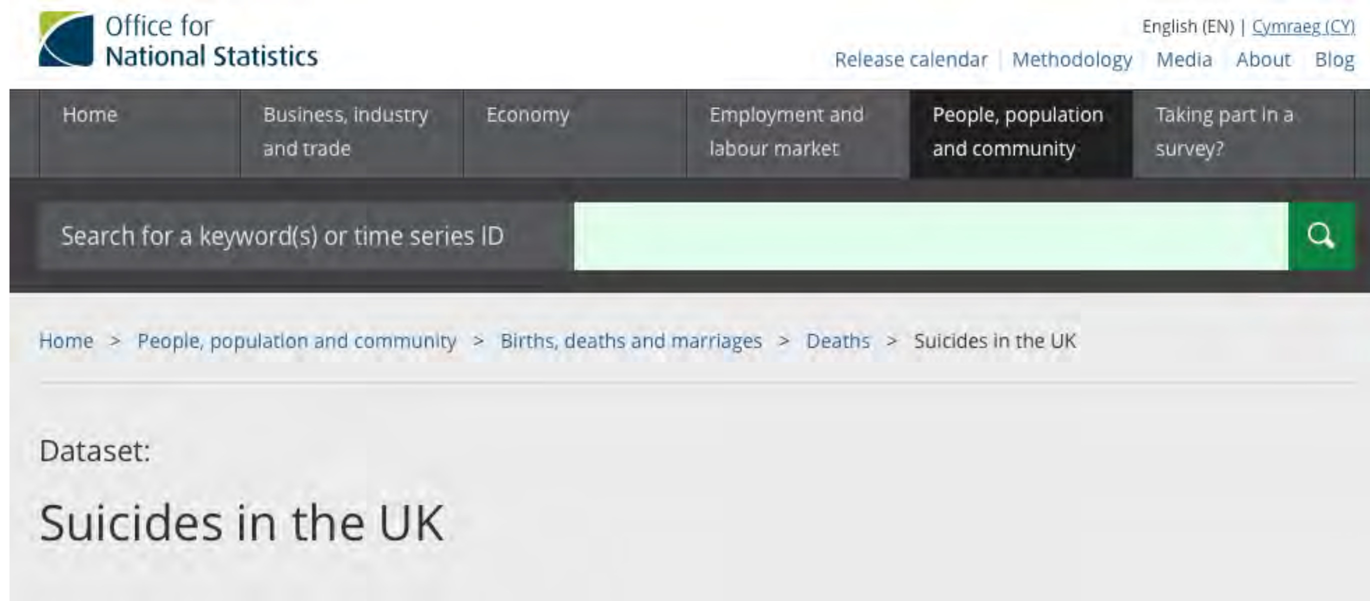
- **Prevalence of Suicide**
- Assessment and Formulation
- Discussion

Suicide - How big is the problem?

- **Completed suicide in children and young people?**



- UK definition of suicide; this includes all deaths from intentional self-harm for persons aged 10 years and over, and deaths where the intent was undetermined for those aged 15 years and over. Deaths from an event of undetermined event of undetermined intent in 10-14 year olds are not included.
- **Suicide rates are measured per 100,000 population.**

Figure 1: Age-standardised suicide rates by sex, for the UK, registered between 1981 and 2017

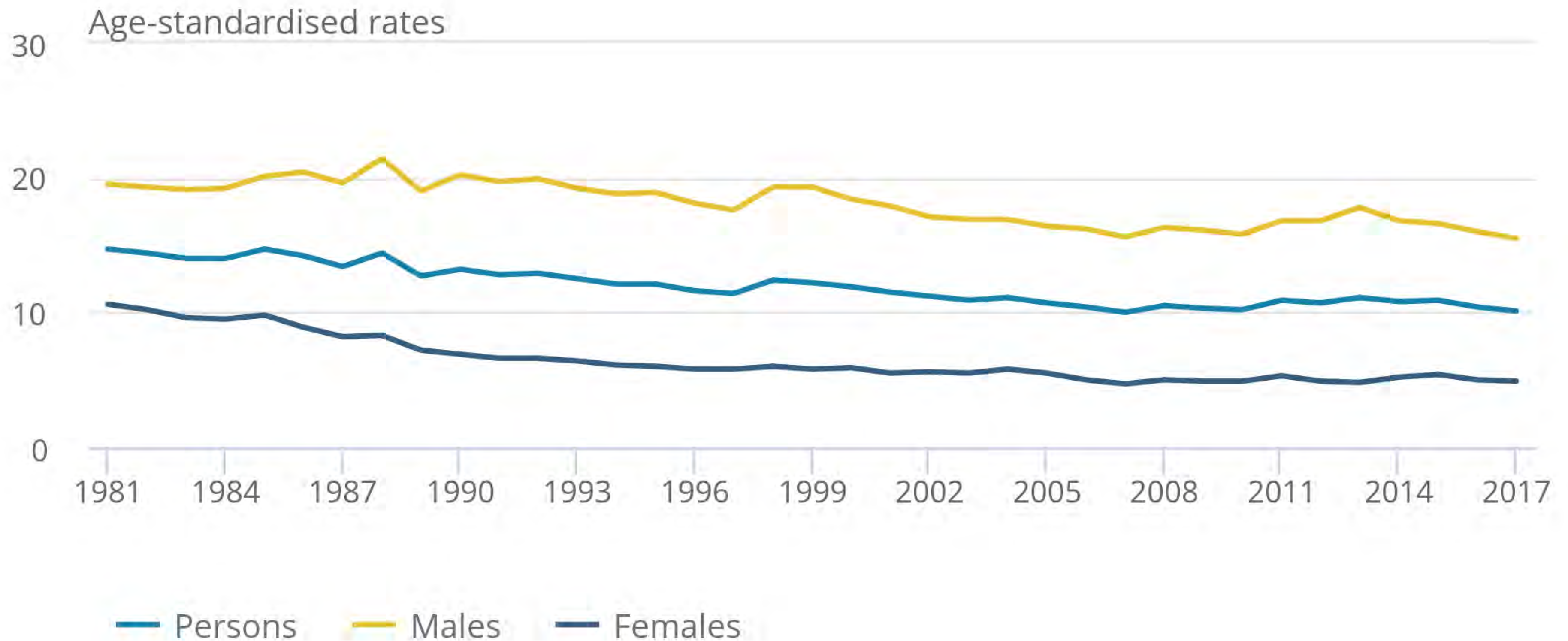
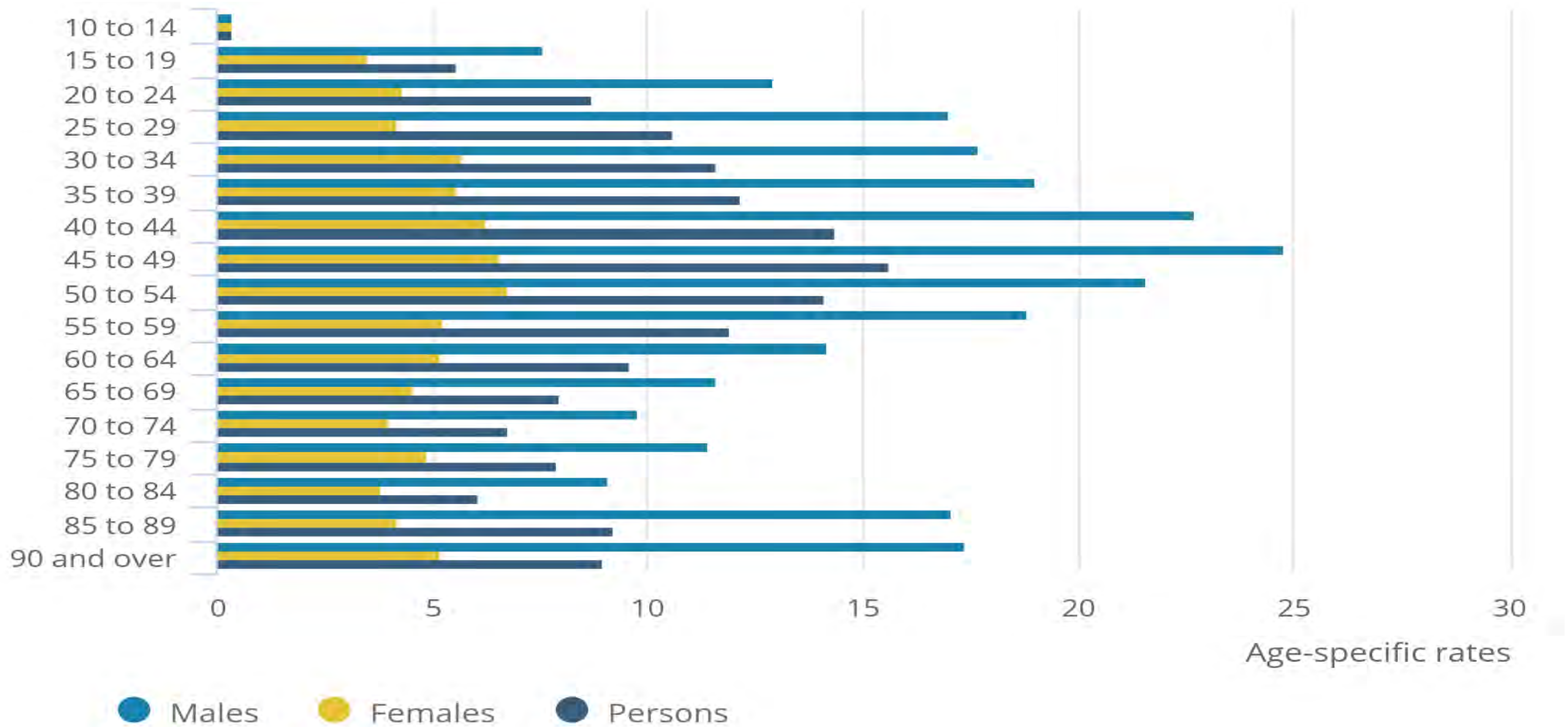


Figure 5: Age-specific suicide rates by sex and five-year age groups, UK, registered in 2017



Suicide in CYP

- UK suicide rates in 10-29 age appear to be steady
- Suicide rate in

10-14 year olds = 0.4/100,000

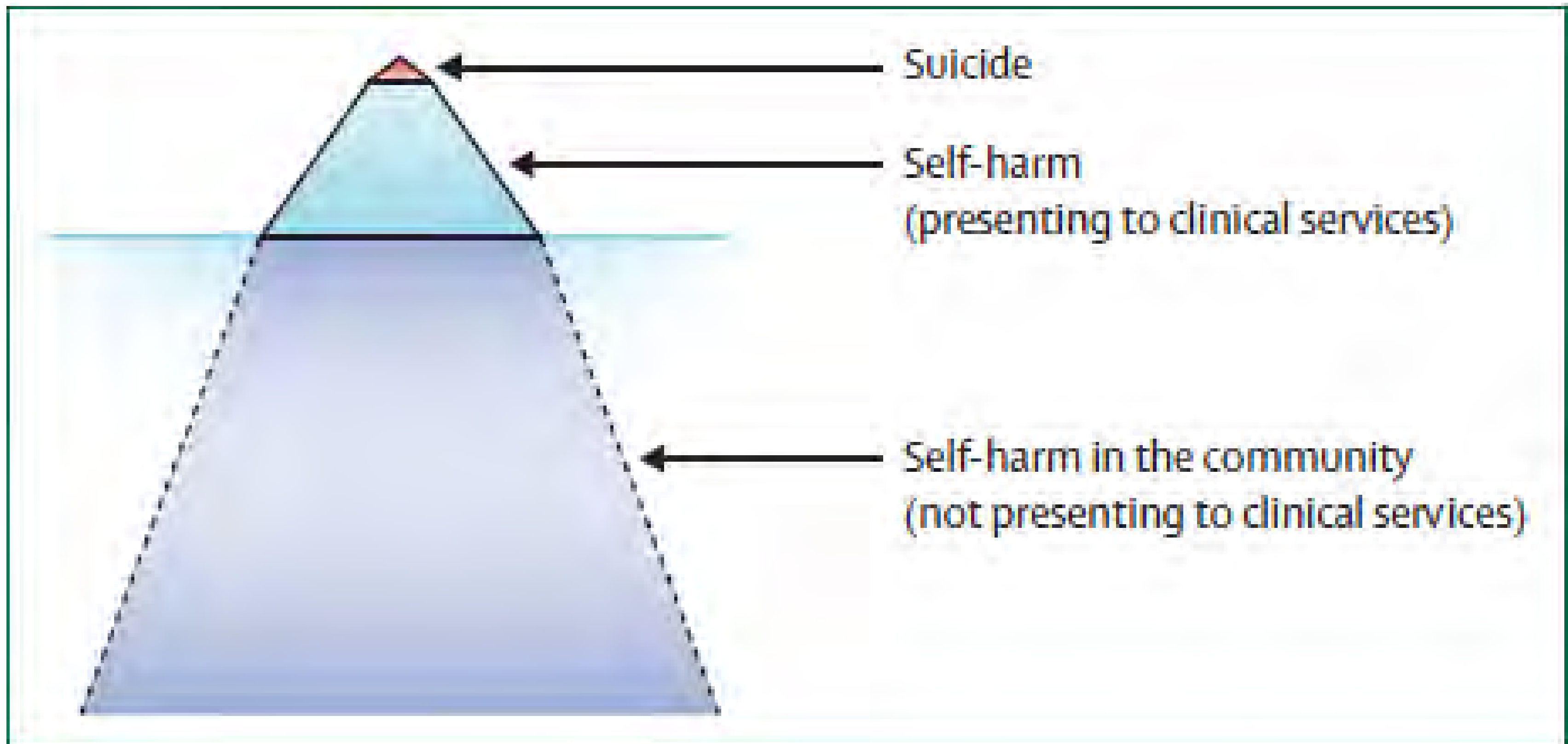
15-19 year olds = **5.6/100,000 (0.0056%)**

Population of 15-19 in Berkshire - 53,900 (2018 - ONS)

Population of 10-14 in Berkshire - 60,200 (2018 - ONS)

Suicide

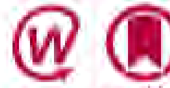
- Suicide < attempted suicide < SH < suicidal ideation



Self-Harm vs Completed Suicide

	Self-Harm	Suicide
Sex predominance	Female>male	Male>female
UK annual prevalence in "adolescents"	6.9%	0.0056%
Method (UK)	Cutting	Hanging (both sexes; M>F, all age) Followed by poisoning F>M, all age In <20s, most 2nd common method is jumping off heights
Risk measurement	Possible	?

e in children and young people in England: ecutive case series



ay, Su-Gwan Tham, Saied Ibrahim, Pauline Turnbull, Kirsten Windfuhr, Jenny Shaw, Nav Kapur, Louis Appleby

y

There is concern about the mental health of children and young people and a possible rise in suicidal n this group. We have done a comprehensive national multi-agency study of suicide in under 20s in England. o establish how frequently suicide is preceded by child-specific and young person-specific suicide risk vell as all-age factors, and to identify contact with health-care and social-care services and justice agencies.

his study is a descriptive examination of suicide in a national consecutive sample of children and young nger than 20 years who died by suicide in England between Jan 1, 2014, and April 30, 2015. We obtained pulation mortality data from the Office for National Statistics (ONS). We collected information about considered to be relevant to suicide (eg, abuse, bullying, bereavement, academic pressures, self-harm, l health) from a range of investigations and inquiries, including coroner inquest hearings, child death ns, criminal justice system reports, and the National Health Service, including data on people in contact l health services in the 12 months before their death.

5 suicides in people younger than 20 years were notified to us during the study period, of which we were in report data about antecedents for 130 (90%). The number of suicides rose sharply during the late teens ths by suicide in people aged 18–19 years compared with 66 in people younger than 18 years. 102 (70%) in males. 92 (63%) deaths were by hanging. Various antecedents were reported among the individuals for ad report data, including academic (especially exam) pressures (35 [27%] individuals), bullying (28 [22%]), nt (36 [28%]), suicide in family or friends (17 [13%]), physical health conditions (47 [36%]), family problems social isolation or withdrawal (33 [25%]), child abuse or neglect (20 [15%]), excessive drinking (34 [26%]), rug use (38 [29%]). Suicide-related internet use was recorded in 30 (23%) cases. In the week before death dividuals had self-harmed and 35 (27%) had expressed suicidal ideas. 56 (43%) individuals had no known

Lancet Psychia
3: 751–59
Published Onli
May 25, 2016
http://dx.doi.o
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See Comment

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CAMHS Crisis assessment

- Assessment of why now and causative factors
- Psychiatric disorders/Neurodevelopmental disorder and assessment of mental state
- Safeguarding and social assessment
- Assessment of risk
- Ensuring immediate safety plan and crisis management – then further CAMHS input
- Ensuring effective follow up arrangements if discharged - “therapeutic assessment” enhances follow up engagement.

Hospitalisation

- No evidence this prevents further SH attempts or dying by suicide (Gould 2003, Kings 2006)
- No rigorous RCTs show psychiatric inpatient admissions reduce self-harm
- In fact, some adolescents may increase their self-harm behaviour once placed in an inpatient unit (Huey 2004)!

Information for young people/ carers

- Young Minds '*Feeling suicidal*' '*Worried about Self Harm*' leaflets –easy to read, reassuring, contains references to other useful sources of help www.youngminds.org.uk
- Young Minds also run parent helpline

- National self harm network www.nshn.co.uk

  '*Supports individuals who self harm to decrease emotional distress and to increase quality of life, empowering and enabling them to seek further support and alternatives to self harm.'*

- www.youthaccess.org.uk database of local organisations that offer counselling
- www.selfharm.co.uk