

# CAMHS: Focus on Self-Harm, Suicidal Ideation in Adolescents

Nov 8<sup>th</sup> 2018



# Introductions

Mel Clarke, Clinical Nurse Specialist, CAMHS Emergency Care Service (CECS)

Dr. Gili Orbach, Clinical Psychologist, Professional Lead in Access and Tier 2 CAMHS Teams

Dr. Sarah Curran, Child & Adolescent Psychiatrist, CECS & Wandsworth Tier 3 CAMHS





# OVERVIEW of our Presentation

- CAMHS Structure and Referral Process (Recap)
- Wandsworth CAMHS Access Pathways
  - Depression & Anxiety
  - Self-harm
- Suicide and non-fatal self-harm in adolescents
- Scenario for Groupwork and Discussion



Respectful



Open



Collaborative



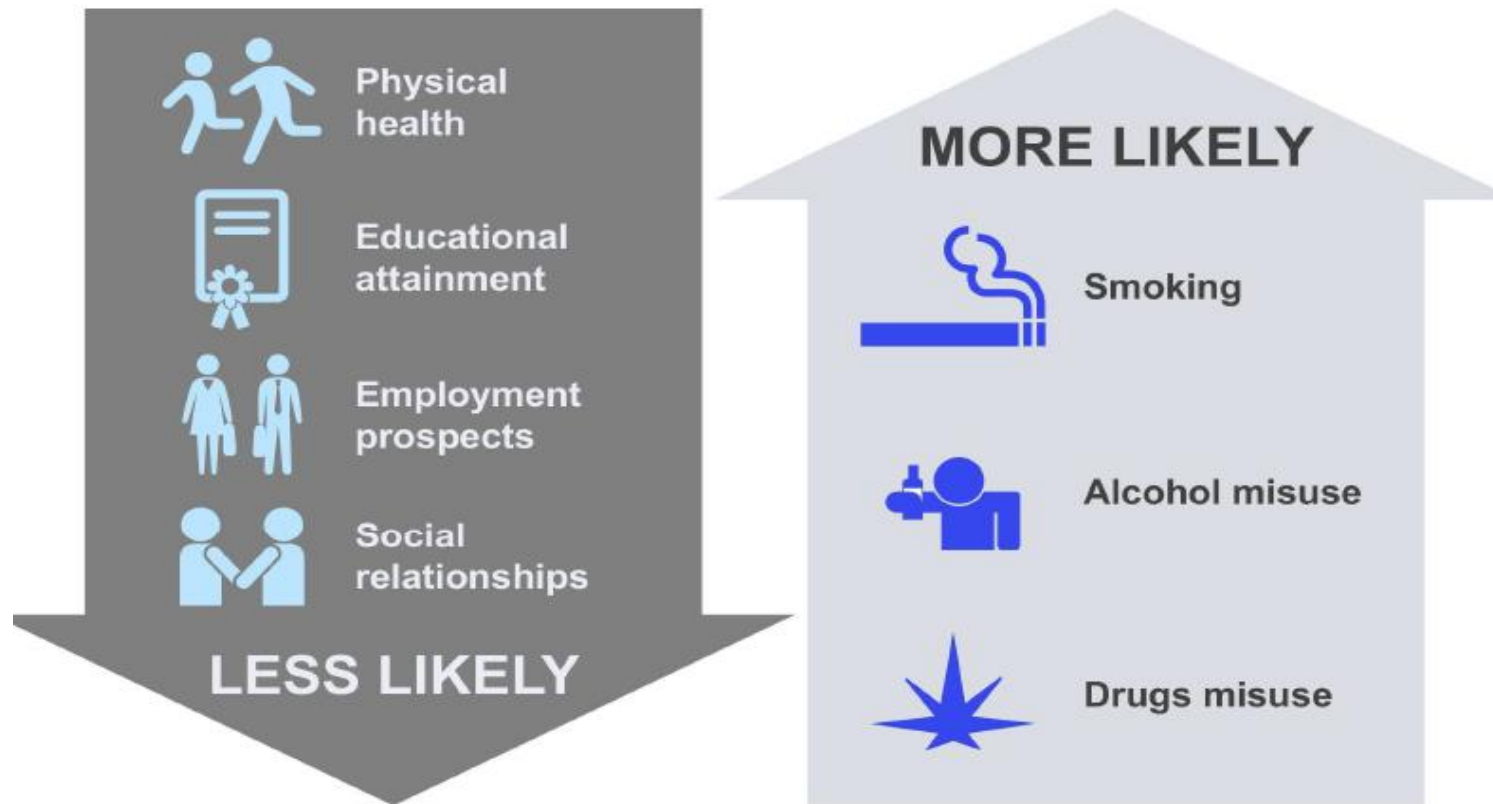
Compassionate



Consistent



# Mental health illnesses are a leading cause of health-related disabilities in CYP and can have adverse and long-lasting effects





# The mental health of children and young people in London

- ~10% clinically significant mental illness
- ~25% of children who need treatment receive it
- **Anxiety Disorders: 2.2% of 5-10 year olds; 4.4% of 11-16 year olds**
- **Depression: 0.2% of 5-10 year olds; 1.4% of 11-16 year olds**
- **Oppositional Defiant Disorder and other Conduct Disorders: 5.8%**
- ADHD: 1.7 %
- ASD ~1%
- Schizophrenia rare in childhood, increasing from 14 years onwards (1.6-1.9 per 100,000 child population)

PHE Dec 2016



Respectful



Open



Collaborative



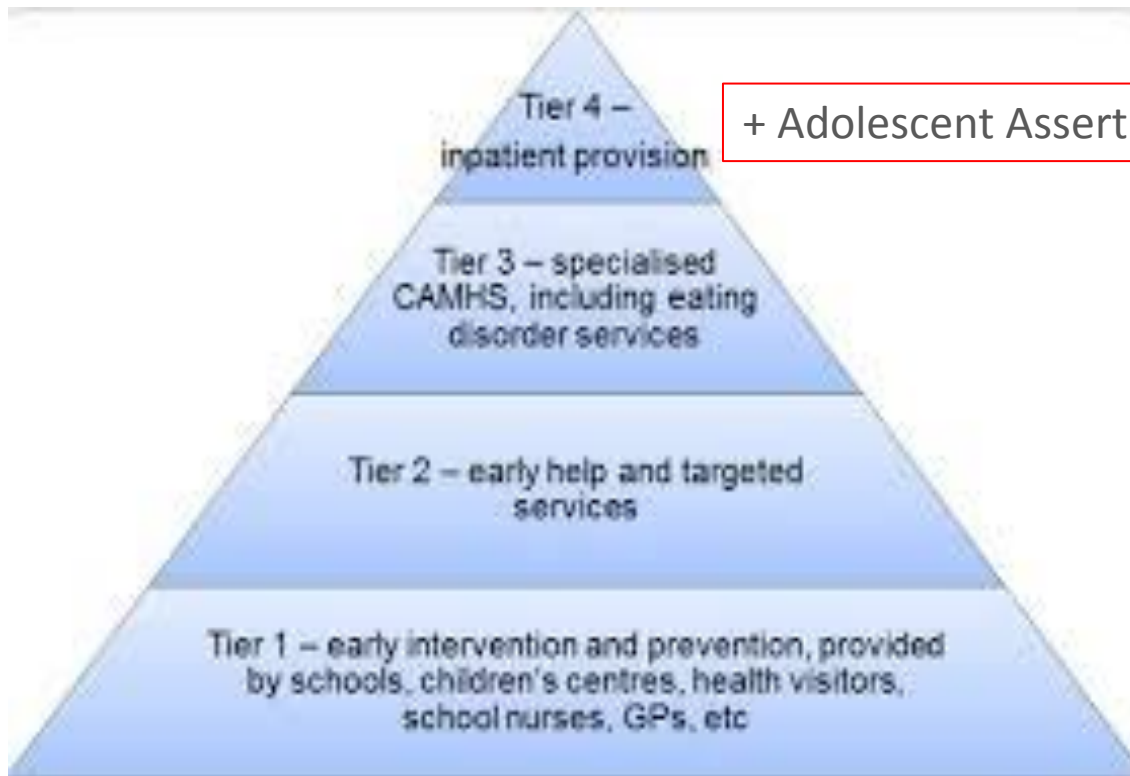
Compassionate



Consistent



# CAMHS Structure and Referral Process (Recap)



+ Adolescent Assertive Outreach Team



Respectful



Open



Collaborative



Compassionate



Consistent

# CAMHS

- CAMHS see children and young people with mental health difficulties
- Age group – less than 18 years . 16 -17 age group young persons can self-refer
- **Tier 2 CAMHS**, for example
  - Youth Offending Team
  - Looked after Children's / Edge of Care
  - Under 5s
  - PRU (pupil referral unit)
  - School CAMHS
- **CAMHS Emergency Care Service (CECS)** – emergency A&E assessments for MH crisis
- **Tier 3 CAMHS**
  - Generic
  - Dedicated Services
    - Neurodevelopmental Assessment
    - Eating Disorders
    - Intellectual Disability
- **Tier 4 CAMHS**
  - Adolescent Assertive Outreach Team
  - Psychiatric Inpatient units



Respectful



Open



Collaborative



Compassionate



Consistent

# Referral Process CAMHS

| Types of Referrals | Service                             | What it entails?   |
|--------------------|-------------------------------------|--|
| New Referrals      | ACCESS Child & Youth Mental Health  | <p>Triage within <b>1 working day</b> of receipt from the referral</p> <p><b>Urgent:</b> (low numbers/minority of presentations))</p> <ul style="list-style-type: none"> <li>• Significant concerns - risk- <b>duty call within 24h</b></li> <li>• Safety advice leaflets sent to parents re: managing risk/ self-harm (see handouts)</li> </ul> <p><b>Routine:</b></p> <ul style="list-style-type: none"> <li>• Assessed within <b>2 weeks</b></li> <li>• Signposted to appropriate service (NHS, LA, voluntary)</li> <li>• Offered treatment within total of 18 weeks if referred to Tier 3 CAMHS</li> </ul> |
| Emergency /Crisis  | CAMHS Emergency Care Service (CECS) | <ul style="list-style-type: none"> <li>• Assessed within <b>24 hours</b></li> <li>• Emergency referral – YP is unable to be kept safe at home and is in need of immediate CAMHS response</li> </ul>  |



Respectful



Open



Collaborative




Compassionate



Consistent



# Wandsworth ACCESS Child & Youth Mental Health

- 
- ACCESS is the single point of access for all referrals for Wandsworth CAMHS
  - Received referrals are Triage'd within 1 working day
  - Possible outcomes from triage
    - Duty call
    - Telephone assessment
    - Face-to face assessment
    - Family consultancy (brief solution-focused family intervention)
    - Request for screening forms (e.g. for ASD/ ADHD assessments)
    - Other (e.g. signpost to other service such as developmental Paeds)
  - If there are concerns about possible high risk at Triage (e.g. suicidal thoughts) or severe mental health are indicated in the referral letter, a telephone call is made to the family the same day to discuss risk and risk management and to plan the next steps if necessary (e.g. advise immediate A&E attendance or referral passed to tier 3)



Respectful



Open



Collaborative



Compassionate



Consistent



# Wandsworth CAMHS ACCESS Pathways

- Depression & Anxiety
- Self-harm



Respectful



Open



Collaborative




Compassionate



Consistent

# CAMHS Emergency Care Service (CECS)



Provide emergency CAMHS assessments to young people (and families) presenting with a **mental health crisis** in St George's, St Helier, Kingston and West Middlesex hospital A&E depts and paediatric wards. NURSE LED TEAM.

Significant self harm, cutting, overdose, ingestion of bleach.

Suicidal thoughts with a plan or intent to end life. Suicide attempt.

Psychosis or deteriorating mental state

❌ young people who present with challenging behaviour where there is not an acute mental health concern

❌ drug and alcohol presentations where there is no mental health concern

Offer to see young person and parent separately if they wish.

If a young person's difficulties are not a MH crisis we may give advice over the phone or ask for A&E to make referral to CAMHS Single Point of Access.



Respectful



Open



Collaborative



Compassionate



Consistent

# CAMHS Emergency Care Service (CECS)



Comprehensive psychosocial assessment

- focusing on what has led up to the current crisis. How help was sought.
- family situation, friendships, partner
- stress and how they manage/cope with this
- school, exams, coping with workload, friendships
- Mental state assessment
- Risk Assessment and how to manage/ameliorate these risks

Thinking with the young person and the family about a safety plan.

What can young person do to keep themselves safe? What does parent/carer need to do? What to do if there is another crisis? Who to call...

Liaison with schools, social care and other services working with the family



Respectful



Open



Collaborative



Compassionate



Consistent

# Tier 3 CAMHS/Dedicated Services

## Tier 3 CAMHS:

- The core business of Tier 3 CAMHS is the specialist assessment and treatment of **complex mental health difficulties and associated risks** in young people under the age of 18
- Treatment
  - Therapy include evidence based psychological interventions e.g. CBT, Family Therapy
  - Pharmacological treatment and shared care
- Urgent queries with regards to cases open to the Tier 3 team can be discussed with a duty clinician at the Tier 3 service if required Monday- Friday 9am-5pm

## Dedicated CAMHS:

- LD with MH, NDT, ED receive referrals from single point of Access – signposted for dedicated assessment and interventions
- Include of ED, NDT and LD



Respectful



Open



Collaborative



Compassionate



Consistent



# Suicide, non-fatal self-harm in adolescents



Respectful



Open



Collaborative



Compassionate

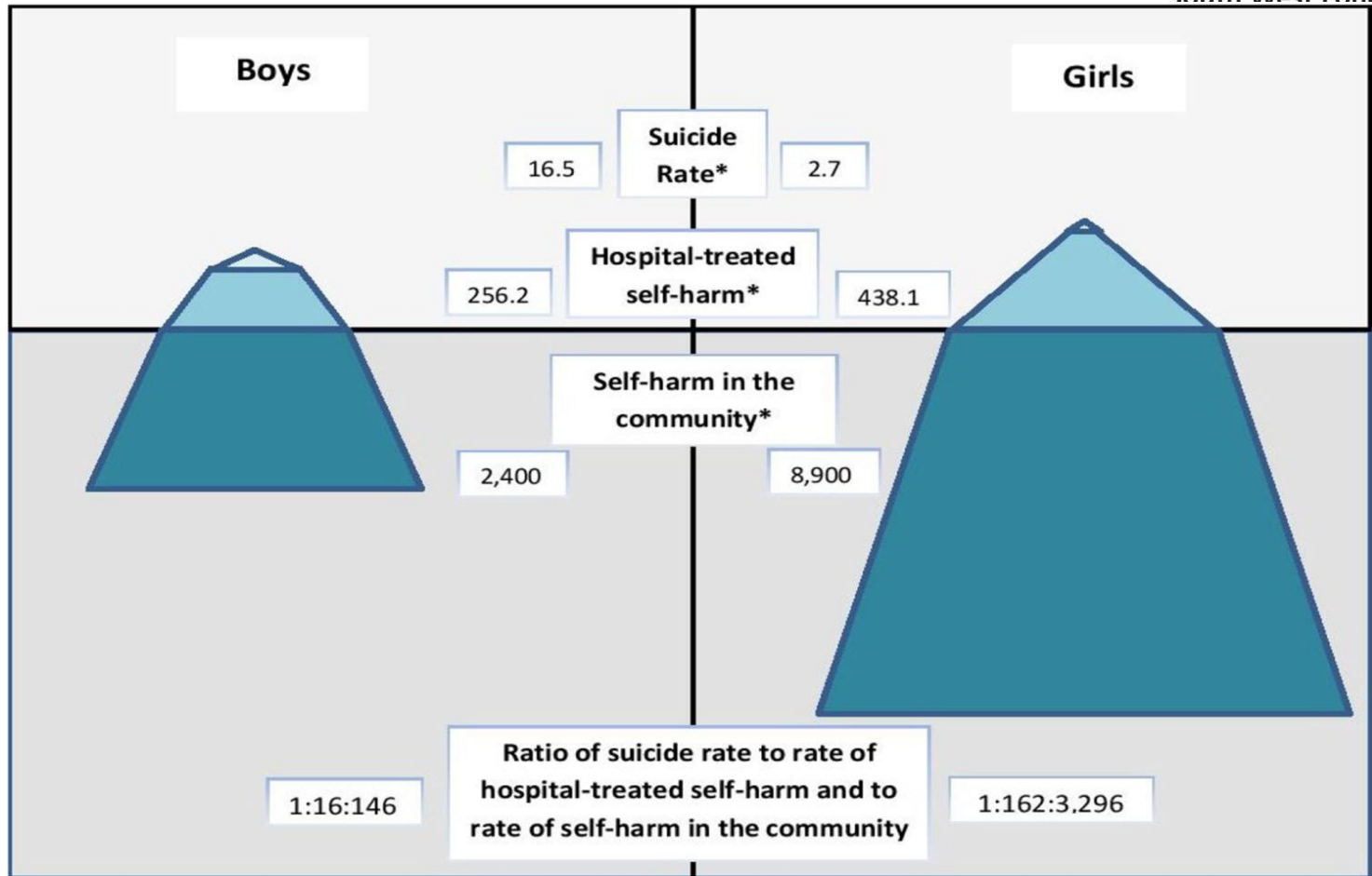


Consistent



## Suicide, non-fatal self-harm in adolescents

- Non-fatal self-harm is a common reason for hospital presentation
- Non-fatal self-harm also occurs frequently in the community without coming to clinical attention
- Suicide is a leading cause of death in adolescents and is often preceded by self-harm



\*Annual incidence rates per 100,000

Note: Differences between incidences of fatal and non-fatal self-harm is particularly marked females

McMahon et al 2018



Respectful



Open



Collaborative



Compassionate



Consistent





# Suicide

2011-2013 (National Statistics):

- 171 adolescents died by suicide in England
- Incidence per 100,000 ~1.5
- **70% male**
- 78% 15-17 years



Respectful



Open



Collaborative



Compassionate



Consistent



# Hospital Presentations of Non-Fatal Self-Harm

## 2011-2013: Multi-Centre Study Self-harm: 5 hospitals

- 1320 adolescents presented to the study hospitals following non-fatal self-harm
- **78% female**
- 74% aged 15–17 years

Geulayov et al, Lancet Psychiatry 2018



Respectful



Open



Collaborative



Compassionate



Consistent



# Community-Occurring Non-Fatal Self-Harm

## Schools Survey 2015

- 322 (6%) of 5506 adolescents surveyed reported self-harm in the past year in the community
- 78% female
- 51% aged 15–17 years

Geulayov et al, Lancet Psychiatry 2018



## Suicide:Hospital:Community

- **12–14 year olds**
  - Boys- 1:109:3067
  - Girls- 1: 1255: 21995
  
- **15–17 year olds**
  - Boys- 1:120:838
  - Girls- 1:919: 6406

Geulayov et al, Lancet Psychiatry 2018



Respectful



Open



Collaborative



Compassionate



Consistent



## Type of harm

- **Suicide:** Hanging or asphyxiation was the most common method (73% of 171)
- **Self-harm presenting to hospital:** Self-poisoning was the main reason (71% of 1195)
- **Community self-harm:** Self-cutting was the main method (89% of 322)

Geulayov et al, Lancet Psychiatry 2018

## Accuracy of risk scales for predicting repeat self-harm and suicide

- Manchester Self-Harm Rule (MSHR), ReACT Self-Harm Rule (ReACT), SAD PERSONS Scale (SPS) and Modified SAD PERSONS Scale (MSPS) in an unselected sample of patients attending hospital following self-harm
- 4000 episodes of self-harm presenting to Emergency Departments (ED) between **2010 and 2012** were obtained from four established monitoring systems in England
- Episodes were assigned a risk category for each scale and followed up for 6 months
- Scales failed to accurately predict repeat self-harm and suicide
- **\*\*\*The findings support existing clinical guidance not to use risk classification scales alone to determine treatment or predict future risk**

Steeg, BMC Psychiatry 2018



Respectful



Open



Collaborative



Compassionate



Consistent



# Suicide risk assessment

- 1. Assessment of the (dynamic) components of suicide:**
  - Ideation
  - Intent
  - Plan
  - Lethality of the method
  - Current psychiatric disorder (e.g moderate/severe depression, psychosis)
- 2. Evaluation of circumstances of suicide attempt (peer/family argument, life event, substance misuse etc?) (dynamic)**
- 3. Evaluation of suicide risk factors (static) e.g.**
  - History of past suicide attempts or self-harm
  - Family history of suicide/knowledge of peer suicide
- 4. Identification of targets for intervention e.g.**
  - Protective factors/family support/can a risk management plan be agreed?





# Scenario

Emily is a 14 year old girl brought to GP surgery by mother on Thursday evening.

Mother noted cuts on her arms from the previous night. Emily has become increasingly irritable and argumentative over the past 6 months and last night said she no longer wanted to live. Mother is frantic and seems angry and critical of Emily. She wants Emily admitted to a psychiatric ward. Emily is silent and difficult to engage.



# Case scenario – issues for consideration

- What are your worries with regards to Emily?
- How would you know if she had a mental health disorder e.g. clinical depression or if the problems are related to current stresses (e.g. family, friends, school)
- Should Emily be seen alone? Why?
- How will you assess the risk and decide if she should be seen urgently by CAMHS emergency team tonight or wait for discussion with Access tomorrow?
- Are there any safeguarding issues?
- What is your plan?
- If you decide to send Emily home, what advice would you give mum and Emily?



Respectful



Open



Collaborative



Compassionate



Consistent

# Contact Details

## Wandsworth CAMHS ACCESS

Springfield University Hospital

Building 1, Entrance 1, Harewood House

61, Glenburnie Road

London

SW17 7DJ

**Telephone:** 020 3513 6631

**Email:** [ssg-tr.wandsworthCAMHSreferral@nhs.net](mailto:ssg-tr.wandsworthCAMHSreferral@nhs.net)

**Opening hours** - Monday to Friday 9:00am-5:00pm



Respectful



Open



Collaborative



Compassionate



Consistent



# Thank you

## Questions/Discussion



# Mental Health of Children and Young People in Great Britain 2004

TABLE 1  
Prevalence of mental disorders by age and sex, 2004

All children  
Great Britain

| Type of disorder                                 | 5- to 10-year-olds |       |      | 11- to 16-year-olds |       |      | All children |       |      |
|--|--------------------|-------|------|---------------------|-------|------|--------------|-------|------|
|  | Boys               | Girls | All  | Boys                | Girls | All  | Boys         | Girls | All  |
| <i>Percentage of children with each disorder</i> |                    |       |      |                     |       |      |              |       |      |
| Emotional disorders                              | 2.2                | 2.5   | 2.4  | 4.0                 | 6.1   | 5.0  | 3.1          | 4.3   | 3.7  |
| Conduct disorders                                | 6.9                | 2.8   | 4.9  | 8.1                 | 5.1   | 6.6  | 7.5          | 3.9   | 5.8  |
| Hyperkinetic disorders                           | 2.7                | 0.4   | 1.6  | 2.4                 | 0.4   | 1.4  | 2.6          | 0.4   | 1.5  |
| Less common disorders                            | 2.2                | 0.4   | 1.3  | 1.6                 | 1.1   | 1.4  | 1.9          | 0.8   | 1.3  |
| Any disorder                                     | 10.2               | 5.1   | 7.7  | 12.6                | 10.3  | 11.5 | 11.4         | 7.8   | 9.6  |
| Base (weighted)                                  | 2010               | 1916  | 3926 | 2101                | 1950  | 4051 | 4111         | 3866  | 7977 |