04

Child and Adolescent Services for Children with Self-harm and Suicide-related Ideation

4 .1 Literature review

Self-harm, defined as intentional self-poisoning or injury of oneself irrespective of motivation or intent is a widespread behaviour among adolescents (Hawton et al 2012). A recent review of 172 adolescent community samples reported a mean lifetime prevalence of 16.9%, as well as a concerning trend of prevalence rates increasing in recent years (Gilles et al 2018). Engagement in self-harm typically begins between 12 and 13 years old, peaks around 15 and 16 years and decreases in older adolescence and adulthood (Moran et al 2012). There is evidence that adolescents and young adults who engage in non-suicidal self-injury are at increased risk of subsequent suicidal ideation, suicide attempts and death by suicide (Castellvi et al 2017). In an Irish study (Griffin et al 2018), rates of self-harm among adolescents increased over a 10-year period from 2006 to 2016, and the age of onset of self-harming was lower than previously, with the increase more pronounced among females and those aged 10 to 14 years.

Ireland had the 7th highest rate of suicide for 15-19 year-olds in the 28 European Union countries in 2014 (Eurostat Comparison Data 2015); in 2018 the rate was recorded as 15th highest (Eurostat 2018) despite the fact that rates in Ireland have not changed. In the SEYLE (Saving and Empowering Young Lives in Europe) study on European adolescents, McMahon et al (2017) gathered information on their lifestyle and mental health, and identified measures that effectively improve adolescent mental health and reduce suicidal thoughts. In Ireland, 1,112 adolescents from 17 schools in the Cork and Kerry region participated in the SEYLE study. While the majority of the Irish sample reported high levels of wellbeing and low levels of risk behaviours, 23.7% had anxiety symptoms suggestive of a possible disorder and 13.8% had depressive symptoms suggestive of disorder. Serious suicidal thoughts were reported by 7.0% of the adolescents and 3.6% reported having attempted suicide at some time in their lives. Rates of suicidal thoughts and behaviour were very similar for boys and girls.

The SEYLE trial identified one school-based intervention, Youth Aware of Mental health (YAM), which was associated with a significantly lower number of subsequent suicide attempts and suicidal ideation compared to the control intervention (Wassermann et al 2015). YAM is a brief, universal mental health awareness programme that was delivered in the classroom over a four-week period. It includes role-play sessions, interactive lectures and workshops. The programme aimed to improve the mental health literacy and coping skills of young people, to raise awareness of risk and protective factors associated with suicide, and to enhance young people's knowledge of mental health issues such as depression and anxiety. The use of YAM confirms the role of coping strategies on suicidal ideation (Kahn et al 2020).

A stated objective in the Department of Education and Skills Action Plan for Education (2017) is 'to improve services and resources to promote wellbeing in our school communities to support success in school and life' (DES 2017). The end-of-year review noted: 'The theme of wellbeing is evident in the curriculum at all levels, early years, primary and post-primary'. Successive Education Action plans have continued to promote wellness; this is further supported in *Wellbeing Policy Statement and Framework for Practice* (DES 2019). Support continues from the National Educational Psychological Services (NEPS) (DES 2010). CAMHS provides more specialist services. Ahern (2018) has shown the cost-effectiveness of introducing school-based programmes.

In 2017 the NSRF reported that self-harm was rare among 10-14-year-olds, but the incidence of self-harm increased rapidly over a short age range. The rate for female self-harm is significantly higher than the male rate among 15-19-year-olds.

Griffin et al (2018) have analysed self-harming behaviour in 10 to 25-year-olds over a 10-year period.

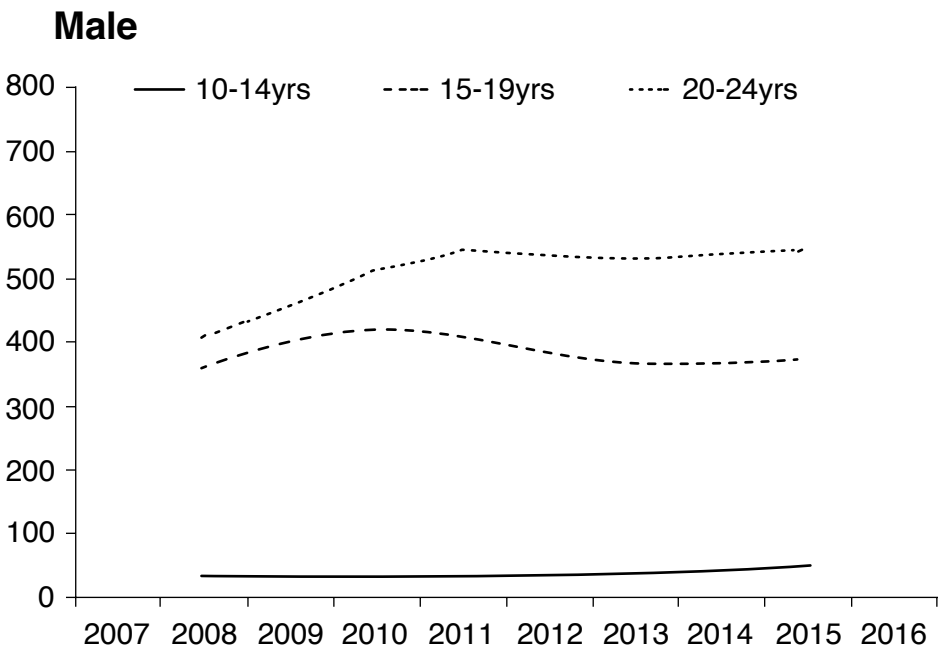

FIG. 4.1 RATE OF SELF-HARM IN IRELAND 2007–¬2016 – MALES (GRIFFIN ET AL 2018)

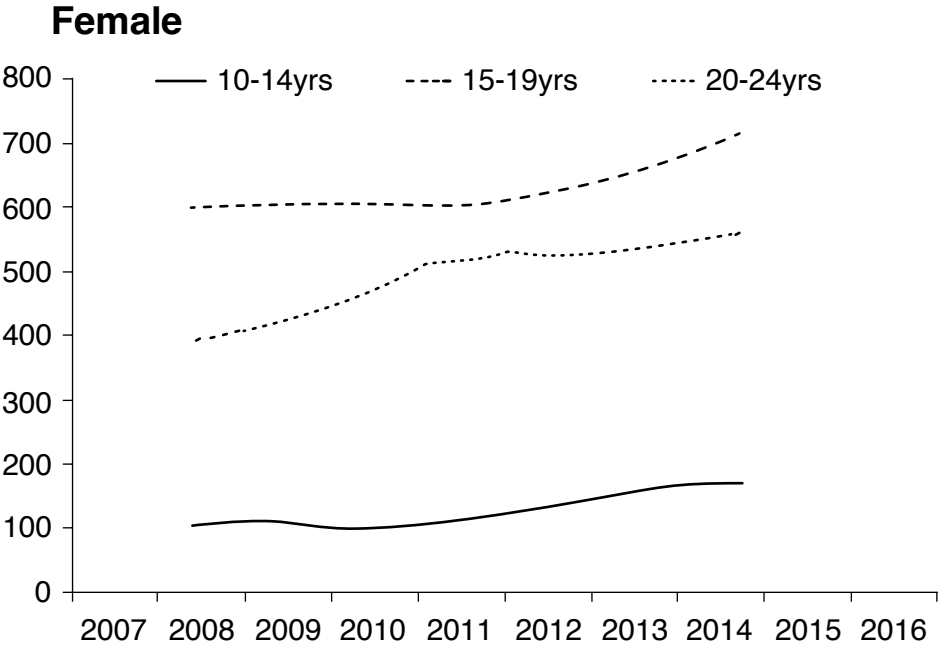

FIG. 4.2 RATE OF SELF-HARM IN IRELAND 2007–2016 – FEMALES (GRIFFIN ET AL 2018)

These numbers are rising. In 2019 in Ireland, 561 children aged 10 to 14 years presented to Irish EDs following self-harm (Griffin et al 2019a). In the same period, 2,202 young people aged from 15 to 19 presented. Presentations in Dublin accounted for 40% and 42% of presenting cases. Outside Dublin, numbers presenting to the ED in these age groups are below one per week and in some services are below one per month. Anecdotal evidence shows that schools, GPs and CAMHS are reporting an increase in minor self-harming behaviour that is not presenting to the ED. This is significant considering that Bennardi et al (2016) has shown the increased suicidal risk in children and young people who engage in self-harm behaviour.

Fitzgerald et al (2020) found a 526% increase in mental health presentations to one of the Irish paediatric EDs over a 10-year period, from 2006 to 2016. A detailed analysis of presentations in 2014 found that the most common presenting complaint was for suicidal ideation at 34.7% (n=103), followed by self-harm at 31% (N=92). Lynch et al (2017) found that, in another paediatric hospital in Dublin over a six-month period, 52% (n-44) engaged in self-harm behaviour, and that almost half of those presenting (46% n=50) were known to CAMHS services.

Presentations to hospitals of self-harm and suicidal ideation in Ireland are just the tip of the iceberg (McMahon 2014). Using coronial and Self-Harm Registry records and a community survey of adolescents, McMahon et al found that, for every boy who died by suicide, 16 presented to hospital and 146 reported self-harm in the community. For every female suicide, 162 girls presented to hospital with self-harm and 3,296 reported self-harm in the community.

Supporting children who self-harm and those with suicide-related thoughts is complex and will not be managed by general practice or the ED alone.

In the UK, the Thrive Framework (Wolpert et al 2019) provides a set of principles for creating coherent and resource-efficient communities of mental health and wellbeing support for children, young people and adults. In Ireland, the Youth Mental Health Task Force Report (DoH 2017a) provides a similar framework for Ireland.

The NICE guidelines recommend that all children or young people who have self-harmed should normally be admitted overnight to a paediatric ward and assessed by a mental health professional the following day, before discharge or further treatment and care is initiated. Alternative placements may be required, depending on the age of the child, circumstances of the child and their family, the time of presentation to services, child protection issues, and the physical and mental health of the child. This might include a child or adolescent psychiatric inpatient unit where necessary (NICE 2011). It is also recommended that training for staff who work with children who self-harm should follow the same principles as for adults who self-harm, but should also include a full assessment of the family, their social situation, and child protection issues. The need to admit all children who self-harm to a paediatric ward is no longer fully supported. A recent meta-analysis of therapeutic interventions for self-harm and suicidal ideation in adolescents indicated that currently available treatments were effective in treating self-harm and suicidal ideation, including treatment as usual in child and adolescent mental health services (Kothgassner 2020). Specific interventions such as DBT-A and family-centred therapy showed small to moderate effects compared with treatment as usual, but these differences were statistically significant and clinically important. The authors suggested using a stepped care model, with expensive and poorly available treatments targeted at young people who need them most. As with adults, Hawton et al (2015), on completing a systematic review of interventions for children and adolescents, pointed to the need for further studies.

Ougrin et al (2018) have compared the effectiveness of an intensive community-supported discharge service versus treatment as usual. They reported a reduction in repeat self-harming with intensive community support, and suggested that this may be an alternative to hospital admission.

In the UK there are examples from individual services that have used the Thrive Framework to change how they support children in crisis. These services include crisis admission avoidance services (Hope NHS Surrey and Borders Partnership Trust) and CAMHS crisis, liaison and intensive home treatment (Tees, Eske and Wear Valleys Trust).

In Ireland, a number of services are available for children, as outlined in the National Clinical Programme for Paediatric Healthcare (HSE 2020) (Figure 4.3).

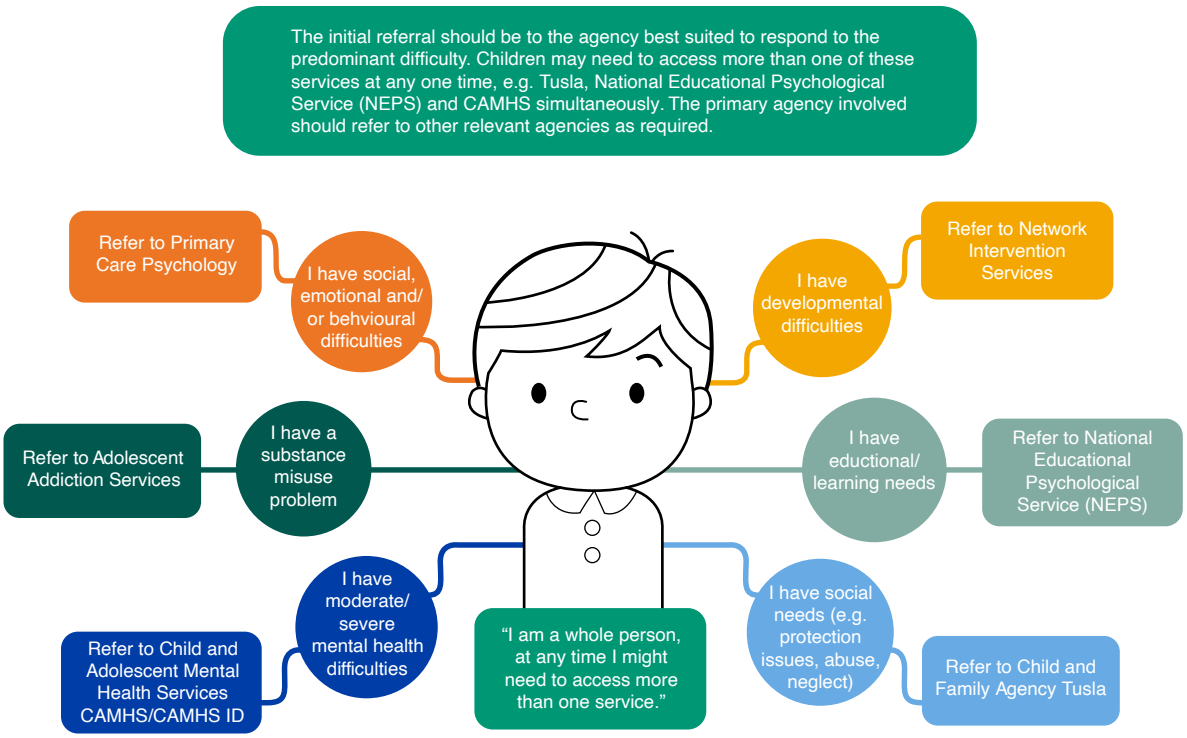

FIG. 4.3 GUIDELINES FOR GPS AND PRIMARY CARE TEAMS REFERRING CHILDREN AND ADOLESCENTS WITH SOCIAL/EMOTIONAL/BEHAVIOURAL/DEVELOPMENTAL DIFFICULTIES

Despite recommendations in *A Vision for Change* (DoHC 2006) on expanding both liaison and community child and adolescent services, in practice this has not happened. A review by Professor Fiona McNicholas noted the increasing numbers of children presenting to EDs either with suicidal ideation or following self-harm (McNicholas 2018). She put a case for increasing the child psychiatrist-led liaison teams, as recommended by *A Vision for Change*. It recommends having two child and adolescent community mental health teams (CMHT) for a 100,000 population, while one child and adolescent CMHT should also be provided in each catchment area of 300,000 to provide liaison cover. It also recommends that these liaison teams develop clear links with primary and community care services and identify and prioritise the mental health needs of children in each catchment area.

McNicholas (2018) outlined the current challenges in CAMHS services. She described CAMHS as fragmented, over-stretched and under-resourced, with staffing levels well below recommended levels. In 2019, there were 2,700 children on a waiting list, with 14% of these waiting longer than 12 months (McNicholas 2019). CAMHS understaffing is not limited to funding issues, but also to recruitment challenges in all professionals groups. McNicholas quoted national print media concerning staff burnout, consultant resignations and services being viewed as 'untenable', while clinicians reportedly perceived themselves to be placed in 'ethically compromising situations' by virtue of inadequate resources. This seems understandable given the reverse trend in overall budget funding for mental health services. The budget for mental health services has decreased from 13% of the overall health spend in 1984 to the current 6% (DoH 1984, HSE 2020a).

A Joint Committee on the Future of Mental Health Care (Oireachtas Report 2018), established in 2017, took evidence from practitioners and families regarding the state of CAMHS (Ombudsman for Children 2018). It produced a concerning report detailing inadequacies in provision of care. The essence of the report was that children were being 'abused' through neglect in the provision of adequate mental health services (Oireachtas Report 2018). Timely access to both community outpatient and in-patient CAMHS was recognised as problematic. Even for cases known to CAMHS, lack of out-of-hours services required many to attend EDs at times

of crisis 'because there was nowhere else to go'. For some, crisis presentations resulted in inappropriate admissions to adult mental health wards.

In the absence of sufficient community and specialist services, McNicholas (2018) suggested that EDs may be the most appropriate places to manage crises, noting that a rapid mental health assessment allows onward referrals to the appropriate services and interventions, maximising health gains and reducing the risk of deterioration while sitting on an inappropriate list. Assessments are often conducted on the same day, and, if admission is required, it is brief. This model may be of value in some areas, but the key issue is to ensure that all children who self-harm or who present with suicidal ideation receive a timely biopsychosocial assessment. The location of this assessment will depend on local resources.

Other child psychiatrists have noted the benefits of one professional from the CMHT visiting the child in the paediatric hospital, either on the same day or within 24 hours. The Model of Care for Paediatric Healthcare (HSE 2020b) identifies the need for timely access to liaison psychiatry and CAMHS for high-quality, safe emergency care.

Discussions with both community-based and liaison child and adolescent psychiatrists have identified a number of challenges to providing this high-quality and safe emergency care. In Dublin, ED assessments take up an increasing amount of the paediatric liaison team's time, accounting in some cases for 80% of the workload. Many presentations are already known to community CAMHS (cCAMHS). Liaison teams provide a quick response to ED presentations. In the Children's University Hospital, Temple Street, about 40% are admitted overnight. This number is higher in Crumlin and Tallaght, where there is no psychiatric liaison service after 5pm, and a limited service at weekends. Referral to next appropriate care can be a challenge; not all children require input from a cCAMHS team, and thus hospital-based teams need knowledge of all community-based services. Increasingly, GPs are referring children to EDs in order to bypass waiting lists in CAMHS, or because services in primary care do not have the training or staffing to support young people who self-harm (Lynch et al 2017).
Outside Dublin, where teams are resourced based on recommendations from *A Vision for Change*, children will be seen by cCAMHS teams within 24 hours. Where teams are poorly resourced, they do not provide advice to ED or mental health staff and cannot provide immediate CAMHS appointments. As a result children can be waiting a number of days for a mental health assessment (HSE 2017).

There is no dedicated CAMHS liaison team outside Dublin. A Consultant Liaison Child Psychiatrist has been appointed in Cork and is awaiting appointment of a team. In many services children requiring assessment in the ED wait until cCAMHS can offer assessment. Even where cCAMHS teams are well-resourced, there is a difficulty providing staff to assess emergencies in the ED, due to geographical spread. *A Vision for Change* recommended that the CAMHS teams prioritise the mental health needs of children in the catchment area; this would include the needs of children in a general hospital.

Children with mental health and intellectual disability, those with complex neurodevelopmental disorders and children in care present a number of challenges in management and require multiagency input.

4.2 Service requirements

All children who self-harm or present with suicidal ideation should have access to all four components of the Clinical Programme, as described in Chapter 1. They should receive an empathic, compassionate and validating response; they should receive a timely expert biopsychosocial assessment, including a written, collaboratively developed emergency safety plan; all efforts should be made to involve family members in both assessment and in safety planning, and the children should be followed up and linked to next appropriate care, through telephone and if required in person support.

The Model of Care (2016b) states the following in regard to children up to 18 years:

> *Timely access to Mental Health Services must be available at all times for children attending the ED with a mental health crisis. Each major ED should have defined access to assessment by Child and Adolescent Mental Health Services (CAMHS) through a simple referral procedure. This should be dedicated Liaison CAMHS*

supported by the on-call CAMHS. This service should be accessible 24/7 via a single point of contact. The service responsible for assessment of children up to the age of 18 in the ED should be explicit. Consent should be obtained for mental health assessment from the parent or guardian.

Children aged 16 and 17 years who have engaged in self-harm are assessed in an adult ED setting. Those under 16 years are assessed in paediatric ED in Dublin. Of note, the requirement for 24/7 accesses to emergency generic social work cover is of highest relevance to this age group. It is essential there should be access to social work services in all emergency departments, including out of hours and weekend cover.

The NICE guidelines recommend that all children or young people who have self-harmed should normally be admitted overnight to a paediatric ward and assessed by a mental health professional the following day before discharge or further treatment and care is initiated. Alternative placements may be required, depending on the age of the child, the circumstances of the child and their family, the time of presentation to services, child protection issues, and the physical and mental health of the child; this might include a child or adolescent psychiatric inpatient unit where necessary (NICE 2016). It is also recommended that training for staff who work with children who self-harm should follow the same principles as for adults who self-harm, but should also include a full assessment of the family, their social situation, and child protection issues (NICE 2011). Admission to a paediatric ward may not always be necessary, particularly if intensive support is available to the family (Kothgassner et al 2020).

In Dublin, where a consultant-led multidisciplinary liaison team is in place in each of the paediatric hospitals, each child will receive a response from a liaison team. Since 2018 funding has been allocated to each of the three Dublin paediatric hospitals for a CNS to deliver the clinical programme. Along with ensuring each child receives a timely, expert assessment, family are involved at assessment and safety planning. The role of the CNS is to ensure there is bridging and linkage to appropriate next care. To date, a CNS has been appointed in one of the three paediatric hospitals. Measures are in place to recruit CNSs for the other two paediatric hospitals.

Outside Dublin, CAMHS services have a responsibility to ensure each child who presents to the ED following self-harm or with suicidal ideation also receives all four components of the clinical programme.

Access to social work 24/7 is not always available. This continues to present challenges in supporting children and families out of hours.

The National Youth Mental Health Task Force (DoH 2017) recommended appointing a National Lead for Youth Mental Health and a lead for CAMHS in each CHO to coordinate the provision of services and address gaps in service provision. It also recommended the establishment of an expert group to review the services delivered from 0–25 years. The Higher Education Authority launched the National Student Mental Health and Suicide Prevention Strategy (DES 2020). These initiatives will further support the full implementation of the NCP for children.

Each CAMHS service can learn from the implementation of the Clinical Programme in Adult ED and ensure that every child presenting to the ED receives a compassionate response and a timely, expert assessment, followed by a written Emergency Care Plan, family involvement and linkage to appropriate next care. Effective links between primary and secondary care and with voluntary and HSE-funded agencies should form a central part of this learning.

The Suicide Crisis Assessment Nurse (SCAN) service that has been developed for adults will in time be appropriate for children. At present the focus should be on building CAMHS community-based teams and ensuring that each ED has the resources to provide a timely, expert assessment and support for each child who presents.

There is considerable experience in UK-based CAMHS teams of developing crisis responses for children and adolescents who self-harm. With adequate staffing, CAMHS teams in Ireland will be able to implement many of these innovations.

4.3 Summary and recommendations

- Supporting children who self-harm and those with suicide-related thoughts is complex and requires more than can be addressed through the NCPSH.
- The recommendations of the Youth Mental Health Task Force Report (2017) need to be implemented. Full staffing of community child and adolescent mental health teams is required. CAMHS teams should be encouraged to develop crisis supports for children.
- Full multidisciplinary Liaison Psychiatry services for children should be developed in line with recommendations from *A Vision for Change*.
- A CNS funded through the NCPSH should be available in each of the three Dublin paediatric hospitals, to provide liaison between the mental health staff in the ED and the community-based CAMHS teams and other community-based services.
- The Area Management Teams of the mental health services should ensure that all components of the NCP are implemented for children presenting to the ED and to CAMHS services following self-harm or with suicidal ideation.
- Training in skills for assessing and supporting children and their families, as identified in the NCPSH training schedule, should be made available to all staff working in CAMHS teams.
- The development of a National Lead and a lead for CAMHS in each CHO, as recommended in the Youth Mental Health Task Force Report (2017), would facilitate the full implementation of the NCPSH for children.
- The Higher Education Authority has developed a framework for suicide prevention for students in higher education. Staff working with children and young adults should have a working knowledge of this framework (HEA 2020).
- Development of SCAN in primary care should be considered and developed once appropriate CAMHS community and liaison psychiatry services have been established.