NHS East of England Clinical Networks

NHS

Welcome: Learning from the Literature

Risk Factors for CYP Crisis and Brief Crisis Interventions

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11th November 2021

What Will We Cover ?

- Housekeeping
- Background
- Risk Factors: Admissions and Re-Admissions
- Brief Crisis Interventions

Action to support children & young people who need urgent & emergency mental health care

FiM and FYFV committed the NHS to *Improved Crisis Care for all ages, including places of safety*

Key functions of urgent and emergency MH care

- **Support , advice and triage** 24 hrs a day, seven days a week
- A **comprehensive assessment** available 24/7 to ensure that CYP receive the right intervention without delay
- **Intervention**, with crisis support available 24/7 and
- **Intensive Home Treatment** - across extended hours

These functions should be undertaken by professionals **trained, competent and experienced in working with CYP mental health**

CYPMH Long Term Plan Commitment

CYPMH Crisis Long Term Plan commitments

The LTP commits that: *By 2023/24: There will be 100% coverage of 24/7 age-appropriate mental health crisis care provision for CYP, via NHS 111, which combines crisis assessment, brief response and intensive home treatment functions.*

To support the LTP ambition for CYP crisis, the Mental Health Implementation Plan set out a national expansion trajectory and funding, which is increasing year on year:

Objective	2019/20	2020/21	2021/22	2022/23	2023/24
CYP crisis - % coverage of 24/7 crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions	30%	35%	57%	79%	100%

- The crisis services developed in line with the Long Term Plan ambition should be **comprehensive**, meaning they should, as a minimum, offer the functions and hours of operation below to CYP ages 0-18 years (*up to 17 years and 364 days*):
  1. Single point of access including through 111 to crisis support, advice and triage
  2. Crisis assessment within the emergency department and in community settings
  3. Crisis assessment and brief response within the emergency department and in community settings, with CYP offered brief interventions
  4. Intensive Home Treatment service aimed at CYP who might otherwise require inpatient care, or intensive support that exceeds the normal capability of a generic children and young people's mental health community team

Hours of operation:

- *Functions 1, 2 and 3 – crisis assessment and brief response must operate 24/7*
- *Function 4 – the intensive home treatment function should be available 7 days per week across locally determined extended hours*

Risk Factors:

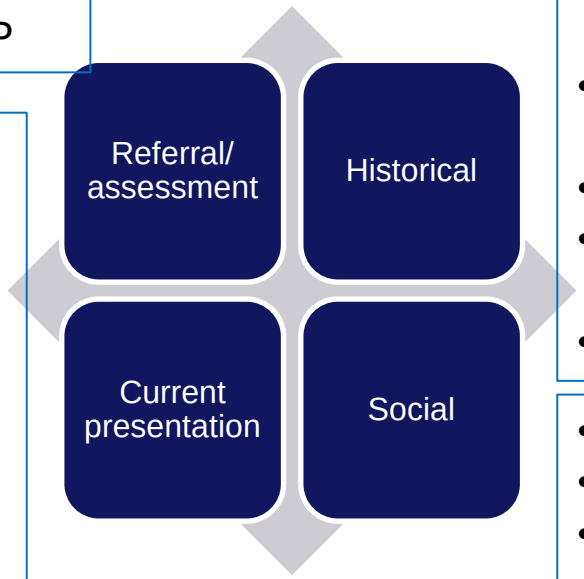
Crisis and Admissions

NHS England and NHS Improvement

Risk factors for admission

- Prior admission to hospital
- Consultations taking place at night and outside the patient's home
- Referral by psychiatric services rather than GP

- Female (66 - 78.8% of admissions have been reported as females)
- Suicidal behaviour (78.2%)
- High risk of serious self-harm
- Sleep problems (75%)
- Older age (CYP)
- Moderate or severe psychiatric symptoms
- Diagnosis of depression
- Externalising problems rather than relational problems
- Poorer global functioning
- High risk of aggression which cannot be managed at home
- Longer symptom duration (mean 2.04 years)
- Co-morbid psychiatric disorders
- Substance abuse/dependence



- Previous diagnosed mental health difficulty; major depressive disorder, situational crises and dysthymia accounted for 66% of admissions
- 26.9% reported lifetime victimisation of sexual abuse
- 22.2% reported previous physical abuse.
- 52.8% reported previous history of significant family trauma.
- History of family psychiatric disorder

- Parents separated (65.6%)
- Living with a step parent
- Bullying (60.4%)
- Not living with both parents
- BAME (19%)
- Family problems
- Covert family dynamics
- Parent-child conflict
- Interpersonal relationship difficulties

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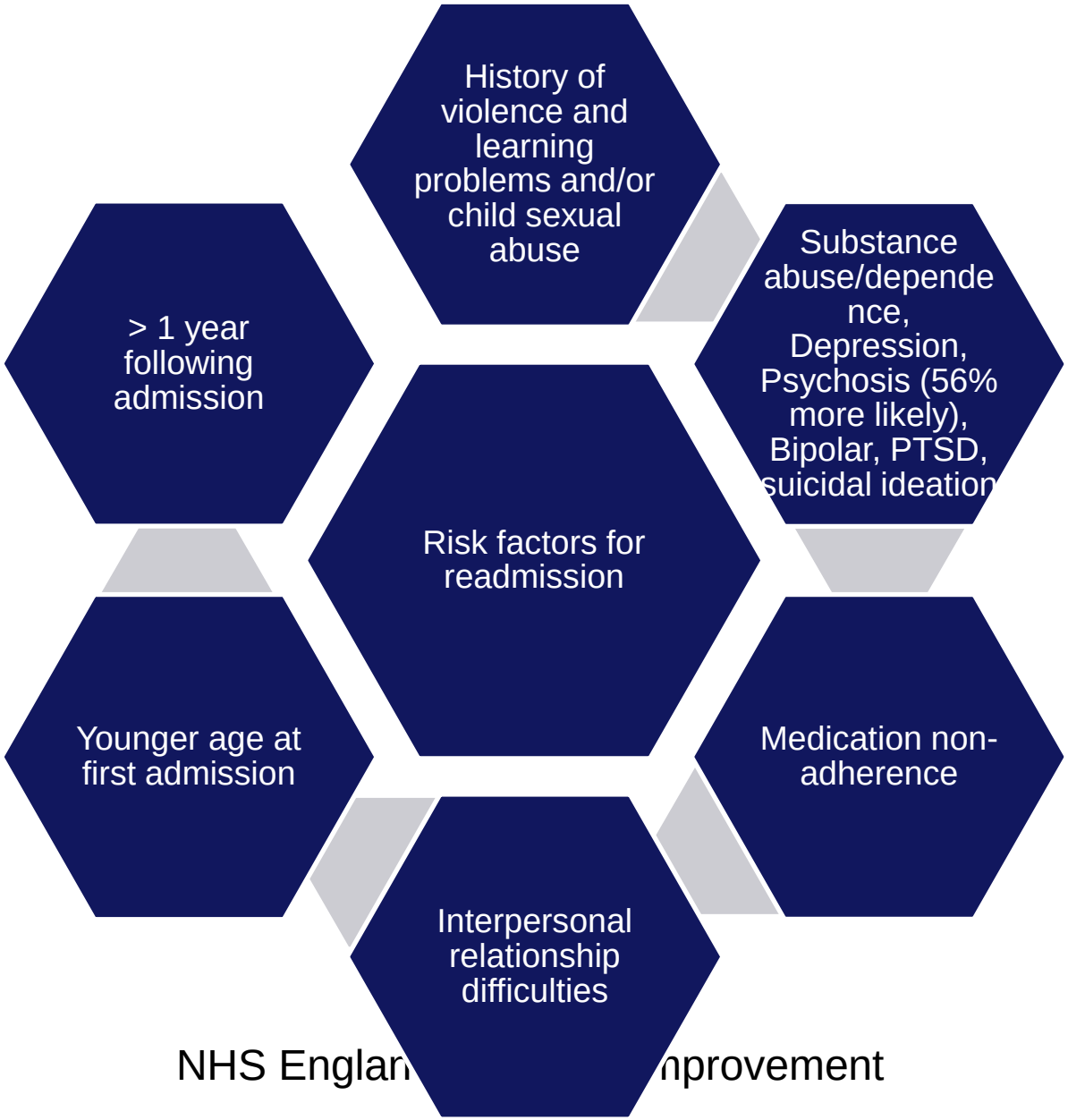
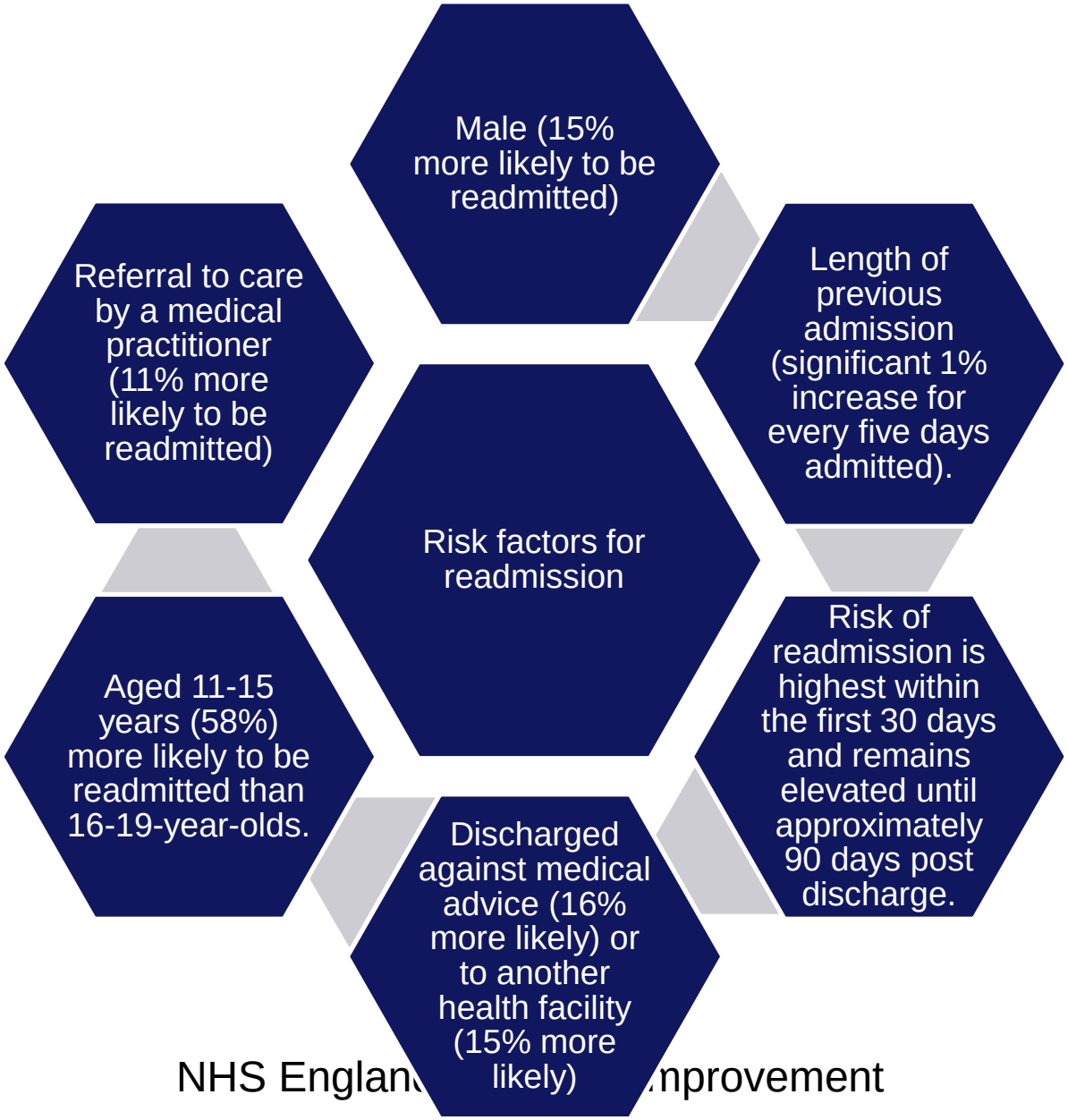

History of violence and learning problems and/or child sexual abuse
Substance abuse/dependence, Depression, Psychosis (56% more likely), Bipolar, PTSD, suicidal ideation
Medication non-adherence
Interpersonal relationship difficulties
Younger age at first admission
> 1 year following admission
Risk factors for readmission



NHS England ... Improvement

(Risk factors drawn from Barker, 2010; Boekamp, 2018; Bobier, 2005; Miller, 2020; James, 2010; Tossone et al., 2014)

Protective factors against admission/readmission

- Regular outpatient care (So et al., 2020)
- Involvement with evidence-based services is related to symptom reduction and improvement in functioning.
- Engaging both the young and families in outpatient services.
- Outpatient services may be able to stabilise the situation before admission is required.
- Relapse is more likely to be identified by parents, therefore regular contact with the family could be helpful.
- Post-discharge services during the 30-day follow-up, combining intensive and non-intensive support, led to a 75% reduction in readmission rates (James, 2010).

What does the literature tell us about Alternatives to Admissions?

Alternatives to admission (1)

- Evidence on efficacy of alternatives is inconclusive.
- Sheppard et al, (2009) **reported Intensive home treatment support was found to support children to live at home for longer**; 50% of children who had an inpatient admission were living at home 1.5 years post support compared to 72% of children who received intensive home treatment.
- **Specialist outpatient services for young people with anorexia nervosa have been found to be as effective as inpatient care** (Gowers, 2007). This is further supported by Firth (2017).
- **Youth assertive community treatment teams have been shown to effectively reduce psychiatric symptoms, improve general functioning, reduce duration and frequency of admissions**, although effect sizes vary from small to large when reviewed. (Vijverberg et al., 2017)
- **Intensive outpatient treatment should combine evidence-based treatment of the child's difficulties with attention to the parents' or families' personal and psychosocial problems**, and help to **provide parents with the skills and resources which they need to effective parenting for children with mental health difficulties and externalising behaviour**. This can be exhausting for parents, even in the absence of other family problems. (So et al, 2020)

Alternatives to admission (2)

- **Intensive community treatment is associated with shorter admissions, lower costs and greater patient satisfaction as compared to inpatient admissions**. However, few studies reviewed included CYP with severe immediate risk to self and/or others. **Multi-systemic therapy was reported to be as effective as admission for CYP in psychiatric emergencies**. (Kwok et al, 2016).
- **CAMHS intensive treatment services reduced median length of stay from 28 to 15 days** and the number of admissions increased**. Admissions of CYP to adult wards reduced by 65% and average LOS reduced from 65. to 1.9 days**. (Duffy & Skelson, 2013)

- **Intensive treatment services should actively target those CYP in socially deprived areas where higher rates of mental health difficulties are present**. They highlight the **improved efficiency and greater choice of service provision for CYP** following in introduction of intensive treatment services (Duffy & Skeldon (2013).
- **CYP who receive community-based alternatives report higher satisfaction** but **higher levels of parental burden** and a range of complex emotional reactions associated with engagement with crisis services. (Vusio et al., 2019)
- **CYP preference of being treated in community-based services rather than in hospital or clinical-based settings.** (Vusio et al., 2019)

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Brief psychological interventions for children and young people (CYP) in mental health crisis: a systematic review.

Sheryl Parke, Amber Cole, Molly Cross, Madeleine Johnson, Araminta Peters-Corbett, Bhavna Sidhpara and Dr Timothy Clarke

With thanks to Dr Brioney Gee (NSFT) and Norfolk and Suffolk NHS Foundation Trust Library Services

REVIEW RATIONALE (1):

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- Mental health disorders in CYP are a **considerable and growing health burden** (Polanczyk et al., 2015); **over half** of adolescents with a mental health diagnosis have **self-harmed or attempted suicide**, with a **leading cause of death** in CYP being death by suicide (Hawton et al., 2012; Wasserman et al., 2005).
- Research has also highlighted notable **increases** in **CYP mental health presentations** to **emergency departments** (Fitzgerald et al, 2020).
- Despite this, community-based crisis interventions are seldom explored and thus effective, evidence-based clinical interventions in this area are unclear (Hawton et al., 2015).

REVIEW RATIONALE (2):

Norfolk and Suffolk NHS Foundation Trust

- The National Health Services (NHS) **Long Term Plan** (Alderwick & Dixon, 2019) references a 24/7 mental health crisis provision for CYP which combines **crisis assessment, brief response and intensive home treatment** by 2023/24 (NHS Long Term Plan, 2019), aligning with the NHS' wider approach to **suicide prevention** within this age group (NHS England, 2016).
- Collectively, this highlights a vital need to identify alternative models for mental health crisis presentations in CYP that are ***brief*** in light of limited resource; offer **quick**, **timely** intervention at time of presentation; reduce the use of **unnecessarily restrictive measures** by supporting in the community; and are **effective and acceptable** to CYP (Orygen, 2018; Kwok, et al., 2016).

REVIEW AIMS:

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What brief psychosocial interventions are used for children and young people when they present to services in mental health crisis?

How effective are the interventions that are being used?

Who is delivering the interventions?

What do the interventions include?

METHODS:

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A **computer-based search** of the literature across **four databases** (CINAHL, MEDLINE, PsycINFO and Embase) was conducted **June 2021**.

Search terms:

- therap* OR counsel* OR "problem solving" OR "solution focussed" OR intervention* OR psychotherap* OR psychosocial
  AND
- CYP OR CFYP OR child* OR adolescent* OR youth OR "young people" OR teen*
  AND
- crisis OR crises OR suicid* OR "self harm“

Search restrictions: Publication date limit set to ‘2011 to current’ (June 2021), limited to studies in or translated to English

METHODS CONTINUED: *PRISMA* FLOW CHART

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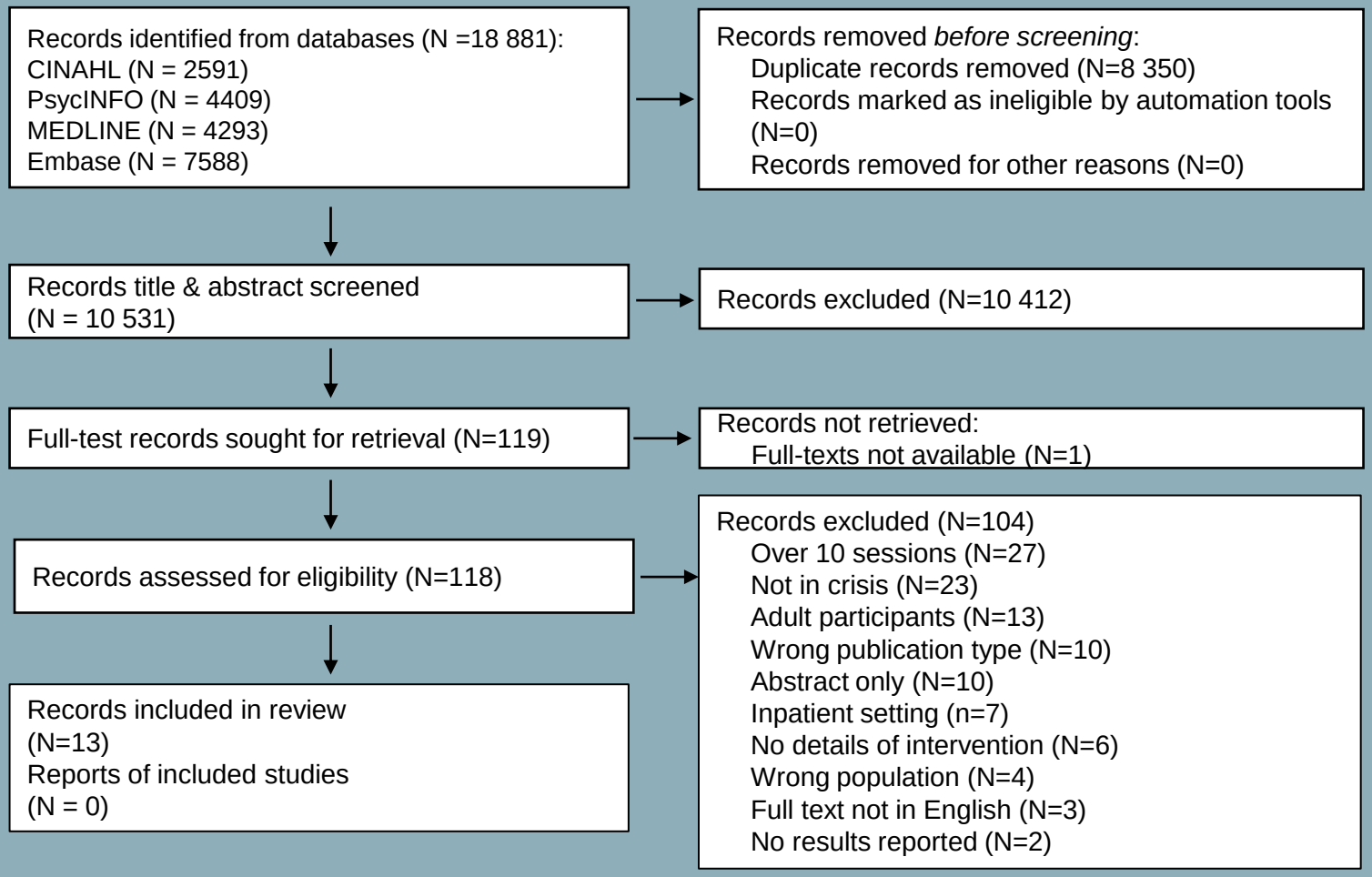

INCLUDED STUDIES:

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Studies by design:

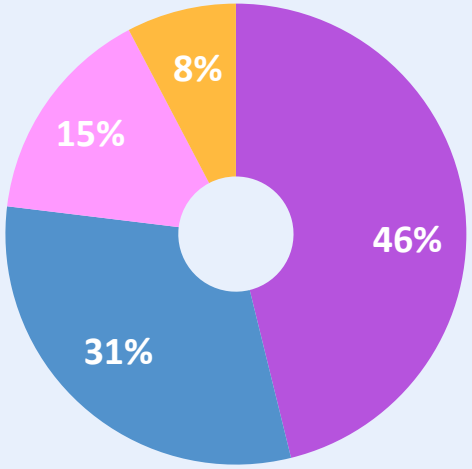
All included studies were assessed as moderate (N = 6) to high (N = 7) in quality.

Randomised Control Trials (RCTs): N = 6

Extended follow-up of included RCTs: N = 4

Pilot study: N = 2

Case study: N = 1



Study population details:

Size range: 1 to 832

Age range: 9 – 18 years

Type:

- Adolescent population including parents/ carers: 12
- Parent only: 1

MAIN FINDINGS:

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Generally, therapeutic assessments, interpersonal therapy, family-based and parent-only interventions all reported a reduction in suicidality in those receiving the intervention.

Single and multi-session family based crisis interventions (FBCI) resulted in **significantly lower hospitalisation (**Wharff et al., 2020), and a significantly lower rate of **suicidal behaviour** (Rengasamy & sparks, 2019).

The importance of **risk factors**; interventions should proactively target **younger females** and those whose **index episode** included the use of both **self-injury and self-poisoning** due to an increased likelihood of **repeat self-harm** (Cottrell et al, 2020).

Therapeutic assessment at the point of presentation increases subsequent attendance to appointments, treatment and mental health support (Ougrin et al., 2011; Zullo et al., 2020). Maintained after 2 years (Ougrin et al., 2013), but no statistical impact was recorded on presentation to the emergency department with SH (Ougrin et al., 2013).

Single-session brief family interventions immediately delivered following ED assessment were found to have the **strongest positive evidence** (Wharff et al., 2012, 2017), with longer periods of interventions reporting less positive and indifferent results between intervention and control groups, as well as a **reduced cost-effectiveness** (Cottrell et al, (2018).

FAMILY-BASED INTERVENTIONS

- Self-report measures found individuals **increased engagement of clinical supports**, **improved family relationships** and **no further suicide attempt**s after a **single-session** intervention focusing on the reasoning behind the crisis and how this can be improved (Ginnis et al, 2015).
- Of suicidal adolescents presenting to an ER, those who engaged in a **single-session** family based crisis intervention were more likely to be referred on to **intensive outpatient services, were significantly less likely to be hospitalised, and had a lower mean depression score** than those receiving treatment as usual (TAU; Wharff et al, 2012).
- Families engaging in a **90-minute** family based crisis intervention reported significantly higher levels of **family empowerment** and **satisfaction with care** which was maintained at follow-up (Wharff et al, 2017).

FAMILY-BASED INTERVENTIONS CONTINUED

- Participants receiving **up to eight sessions** of manualised family therapy sessions reported significant positive outcomes on subscales of the Strength and Difficulties Questionnaire (**overall mental health and emotional and behavioural problems**), Beck Scale for Suicidal Ideation (**intent and the severity of actual suicidal wishes and plans**) and **caregiver family functioning** (Cottrell et al, 2018).
- **Younger females** and those whose **index episode** included the use of both **self-injury** and **self-poisoning** were identified within long-term follow-ups as **more likely to repeat self-harm** (Cottrell et al, 2020).
- High risk adolescents recently discharged from an inpatient admission reported a **significantly lower rate of suicidal behaviour** and a **significantly greater confidence in their safety plan** following **up to six telephone contacts** aimed at discussing topics such as goals, safety plans, parental concerns, follow-up treatment, suicidality and reasons for living compared to a single session intervention (Rengasamy & Sparks, 2019).

THERAPEUTIC ASSESSMENT & INTERPERSONAL PSYCHOTHERAPY

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Therapeutic assessment

- Engaging in therapeutic assessment was associated with a **statistically significant increase** in the **attendance of follow-up appointments** and **engagement in treatment**, maintained at the 2-year follow-up (Ougrin et al. 2011; Ougrin et al, 2013).
- Those engaging in the therapeutic assessment were more likely to attend outpatient treatment, received combined psychotherapy and medication and have more psychotherapy visits in comparison to those receiving TAU (Zullo et al, 2020). Authors concluded the intervention **improved adolescent's mood** and **decreased suicidal thoughts**.

Interpersonal psychotherapy:

- A **significant reduction** in **suicidal ideation** was found, compared to a non-significant decrease in the TAU group, and a **significant increase** in those on the **waitlist** (Haruvi-Catalan et al, 2019) .

INTERPERSONAL PSYCHOTHERAPY CONTINUED AND PARENT ONLY

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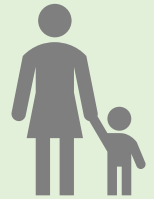
Interpersonal psychotherapy:

- **Significant reductions** in **depressive symptoms** were found between baseline and post-intervention for the **interpersonal therapy, TAU and waitlist groups** (Haruvi-Catalan et al., 2020).

Parent Only:

- **Four, two-hour psychoeducation sessions** resulted in a **reduction in adolescent's suicidality** and other **psychiatric symptoms**, both post-intervention and at the six-month follow-up as well as a **significant improvement** post-treatment on parent reports of **emotional and behavioural adjustment** (Pineda & Dadds, 2012).



Intervention Breakdown

Study breakdown

Rengasamy & Sparks; 2019 – Brief telephone based follow-up intervention

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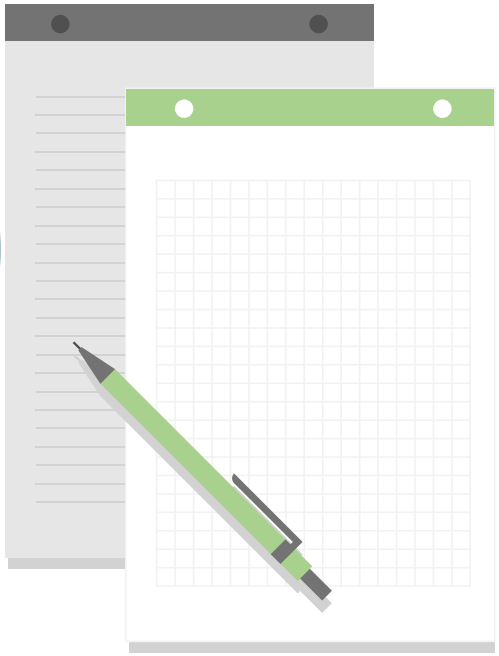
Method;

Adolescents admitted to inpatient unit following suicidal ideation/ attempt received either a MCI (six 10- to 20- minute phone contacts over a three-month period) or the SCI (one phone contact with the guardian over a three-month period)

The intervention;

Phone call with guardians; typically reviewed parental concerns of suicidality and concerns related to treatment follow-up.

The intervention with adolescents; Typically reviewed **assessment of suicidality via the C-SSRS; review of the safety plan (based on the National Suicide Prevention Lifeline's safety plan); assessment of the adolescent's confidence in the safety plan, short- and long term goals, and helpfulness of the intervention; and elicitation of reasons for living.**



Rengasamy & Sparks; 2019

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Findings

Patients in the recurrent intervention had fewer incidents of suicidal behaviour (6%) compared with patients in the SCI (17%) ; Participants in the MCI were approximately four times less likely to have suicidal behaviour compared with their peers in the SCI

No difference existed for inpatient rehospitalization rates between the MCI (15%) and SCI (19%).

Adolescents receiving the MCI reported significantly greater confidence in their safety plan at 90 days (95%vs. 74%; p=0.001), which, in turn, was associated with a lower rate of suicidal behaviour

High discharge level of care, diagnosis of major depressive disorder and young age were all predictors of suicidal behaviour, while gender, race, prior suicide attempt, prior inpatient hospitalisation, other psychiatric diagnoses, reason for admission and duration of hospitalisation were not.

A diagnosis of major depressive disorder and younger age were associated with suicidal behaviour

Study breakdown

Wharff et al; 2012 – Family Based Crisis Intervention (FBCI)

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Method;

Suicidal adolescents and parents were recruited when presenting to the ER.
Patients are discharged home only when the patient, family, attending psychiatrist, and assessing social worker agree that this is the best disposition for the adolescent.
FBCI is delivered in a single ER visit

The intervention;

The social worker holds separate meetings with the adolescent and family to assess the sequence of events and differing perceptions leading to the suicidal problem.
Attempts to create a unified perception of the problem with input from both the young person and family, improve communication, utilise CBT approaches such as relaxation, problem-solving and cognitive reframing; tackling any specific dilemmas; safety plan creation and changes to improve the young persons feelings of safety.

Wharff et al; 2012 – Family Based Crisis Intervention (FBCI)

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Findings

2012

Patients in the pilot cohort were significantly less likely to be hospitalized than were those in the comparison group (36 percent versus 55 percent).

Sixty-five percent of suicidal patients presenting during the study period were discharged home, whereas only 44.7 percent of the comparison cohort (n = 67) were discharged home.

Adolescents and their families presenting to the ER during the pilot study period were significantly more likely to receive a referral to intensive outpatient services (acute day treatment programs and intensive home-based therapies) at discharge from the ER than were their TAU counterparts in the retrospective cohort

2012 continued

Only two of the patients in the FBCI cohort were hospitalized immediately after receiving the intervention during their ER visit.

2017

Adolescents receiving FBCI were significantly more likely to be discharged home with outpatient follow-up care compared with their TAU counterparts ($P < 0.001$)

Families randomized to the FBCI condition reported significantly higher levels of family empowerment and client satisfaction with care at post-test compared with their TAU counterparts.

Study breakdown

Pineda & Dadds; 2013 - Resourceful Adolescent Parent Program (RAP-P)

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Method;

Suicidal adolescents and their parents at an outpatient psychiatric clinic.
Key outcome measures of adolescent suicidality, psychiatric disability, and family functioning were completed at pre-treatment, 3-month, and 6-month follow-up.

The intervention;

RAP-P consisted of an interactive psychoeducation program for parents of adolescents implemented over four 2-hour sessions (held once a week or once every 2 weeks).
Introductory session for parents to enhance their understanding of suicidal or self-injurious behaviour, practical strategies to help their adolescent avoid or minimize their self-injurious behaviour, and information to facilitate access to appropriate support services.
Session 1: identification of existing parental strengths and identification and management of stress to enhance calm and effective parenting
Session 2: information on normal adolescent development and strategies for promoting adolescent self-esteem and balancing independence and attachment issues
Session 3: provision of strategies to promote family harmony and to manage conflict

Pineda & Dadds; 2013 - Resourceful Adolescent Parent Program (RAP-P)

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Findings

The intervention was associated with a greater improvement in reported suicidality and mental health compared to routine care alone, and these improvements continued through to follow-up.

The treatment group showed significant improvements on family functioning from pre- to posttreatment, and the improvements continued through to follow-up; compared to no improvement in the routine care group.

The treatment group showed significantly greater improvements on mental health measures from pre- to post-treatment and through to follow-up

Engagement in the intervention was high and drop-out was minimal. with session attendance greater than 90%.

Study breakdown

Ougrin et al; 2011, 2012 & 2013 – Therapeutic Assessment

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Method;

Adolescents newly referred for psychosocial assessment who had self-harmed from either emergency department presentation or urgent GP referral.
Self-harm was defined as self-injury or self-poisoning irrespective of the underlying intent.

The intervention;

1. Standard psychosocial history and risk assessment (approximately 1 h).
2. A 10 min break to review the information gathered and to prepare for the rest of the session, followed by a 30 min intervention covering the next four steps.
3. Joint construction of a diagram (based on the cognitive analytic therapy paradigm) that consists of three elements: reciprocal roles, core pain and maladaptive procedures. 28
4. Identifying a target problem.
5. Considering and enhancing motivation for change.
6. Exploring potential ‘exits’ (ie, ways of breaking the vicious cycles identified).
7. Describing the diagram and the exits in an ‘understanding letter’. In addition to the ‘understanding letter’

Family members involved in all stages wherever possible.

Ougrin et al;

Findings

2011

Those in the TA group were significantly more likely to attend the first follow-up appointment: 29 (83%) versus 17 (49%),

Those in the TA group were more likely to attend four or more treatment sessions: 14 (40%) versus 4 (11%)

Both groups improved significantly between the initial assessment and the follow-up on the measures of general psychopathology and function; but There were no statistically significant differences in the SDQ and the CGAS scores between the groups

2012

Families randomized to the FBCI condition reported significantly higher levels of family empowerment and client satisfaction with care at post-test compared with their TAU counterparts.

2012 continued

Adolescents with suicidal self-harm were more likely than those with nonsuicidal self-harm to be young women, had a later age of onset of self-harm, and used self-poisoning more often.

Only those with nonsuicidal self-harm had an improvement on Children's Global Assessment Scale score following a brief therapeutic intervention,

2013 (2-year follow-up)

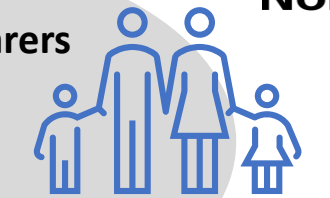
TA was associated with a statistically significant increase in treatment engagement of the adolescents presenting with self-harm over a period of 2 years.

Treatment engagement remained higher in the TA group than the AAU group.

Clinical Recommendations

The collaborative approach

- All studies focused on the importance of **engaging both the young person and families/carers throughout the intervention.**
- Promote further **de-escalation** and aid **treatment planning**.
- Understanding **different perspe**ctives on the episode of crisis allows for **one narrative** to be developed



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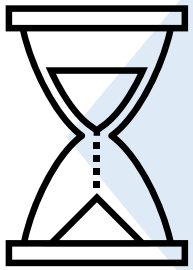
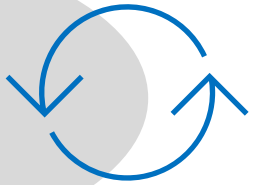
Therapeutic assessment at the point of crisis



- Increases the likelihood of further engagement with mental health support
- Potential benefits include; **no waiting time for psychological support, avoiding long-term hospitalisation, least restrictive practice, and reduced cost to health services** (Ginnis et al., 2015).
- Recorded increases in **family/carer resilience** and skills (Pineda & Dadds, 2012).

Risk factors

- Demographics and historical self-harm events can assist with identifying those more at risk for repeat self-harm (Cottrell et al., 2020).
- Findings suggest the importance of **proactively targeting these groups**.



IMPLICATIONS FOR FUTURE RESEARCH:

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To support future implementation of interventions, it is important that robust methodology is utilised, as well as the completion of an economic evaluation of the intervention.

More detailed demographic information, particularly relating to gender-identity, learning disabilities, ethnicity and religion may support researchers and clinicians to understand potential confounding variables and how interventions may need to be adapted to be as inclusive as possible.

Further research should also focus on the role and professions used in delivering interventions given the range of professionals who offer support at the point of crisis both in community and hospital settings.

Future research should specifically examine the role of family/ caregivers and related variables. For example, the various support roles of those engaged in the intervention and who else from a child or young person's support system could be involved. This would allow for a greater understanding of the effects of different situational factors and ensure interventions are as inclusive as possible.

REFERENCES

Norfolk and Suffolk NHS Foundation Trust

- Polanczyk, G.V., Salum, G.A., Sugaya, L.S., Caye, A., & Rhode, L.A. (2015). Annual research review: A meta-analysis of the worldwide prevalence of mental disorders in children and adolescents. J Child Psychol Psychiatry, 56(3), 345-65.
- Hawton, K., Saunders, K.E.A., & O'Connor, R.C. (2012). Self-harm and suicide in adolescents. Lancet, 379(9834), 2373-82.
- Wasserman, D., Cheng, Q., & Jiang, G-X. (2005). Global suicide rates among young people aged 15-19. World Psychiatry, 4(2), 114-20.
- Fitzgerald, E., Foley, D., McNamara, R., Barrett, E., Boylan, C., Butler, J., Morgan, S., & Okafor, I. (2020). Trends in Mental Health presentations to a Paediatric Emergency Department. Ir Med J, 113(2), 20.
- Hawton, K., Witt, K.G., Taylor-Salisbury, T.L., Arensman, E., Gunnell, D., Twonsend, E., van Heeringen, K., & Hazell, P. (2015). Interventions for self-harm in children and adoelscents. Cochrane Database of Systematic Reviews, Issue 12. Art. No.: CD012013.
- Alderwick, H., & Dixon, J. (2019). The NHS long term plan. BMJ, 364, 184.
- National Health Service (NHS) England. (2016, Updated 2017). The Five Year Forward View for Mental Health. [https://www.england.nhs.uk/wpcontent/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf]
- Orygen, The National Centre of Excellence in Youth Mental Health. (2018). Evidence Summary: Brief psychological interventions for young people with common mental health conditions. [https://www.orygen.org.au/Training/Resources/General-resources/Evidence-summary/Brief-psychological-interventions-for-young-people/Orygen-brief-psychological-interventions-evidence].
- Kwok, K.H.R., Yuan, S.N.V., & Ougrin, D. (2016). Review: Alternatives to inpatient care for children and adolescents with mental health disorders. Child and Adolescent Mental Health, 21(1), 3-10.
- Cottrell, D.J., Wright-Hughes, A., Collinson, M., Boston, P., Eisler, I., Fortune, S., Graham,
- E.H., Green, J, House, A.O., Kerfoot, M., Owens, D.W., Saloniki, E-C., Simic, M., Lambert, F., Rothwell, J., Tubeuf, S., & Farrin, A.J. (2018). Effectiveness of systemic family therapy versus treatment as usual for young people after self-harm: a pragmatic, phase 3, multicentre, randomised controlled trial. The Lancet, 5, 203-16. doi.org/10.1016/S2215-0366(18)30058-0
- Cottrell, D.J., Wright-Hughes, A., Collinson, M., Boston, P., Eisler, I., Fortune, S., Graham,
- E.H., Green, J., House, A.O., Kerfoot, M., Owens, D.M., Saloniki, E-C., Simic, M., Tubeuf, S., & Farrin, A.J. (2018b). A pragmatic randomised controlled trial and economic evaluation of family therapy versus treatment as usual for young people seen for after second or subsequent episodes of self-harm: the Self-Harm Intervention – Family Therapy (SHIFT) trial. Health Technology Assessment, 22 (12). DOI: 10.3310/hta22120
- Cottrell, D.J., Wright-Hughes, A., Eisler, I., Fortune, S., Green, J., House, A.O., Kerfoot, M.,
- Owens, D.W., Simic, M., McLellan, V., Tubeuf, S., & Farrin, A.J. (2020). Longer-term effectiveness of systemic family therapy compared with treatment as usual for young people after self-harm: An extended follow up of pragmatic randomised controlled trial. EClinicalMedicine, 18, 1-10. doi.org/10.1016/j.eclinm.2019.100246
- Ougrin, D., Zundel, T., Ng, A., Banarsee, R., Bottle, A., & Taylor, E. (2011). Trial of Therapeutic Assessment in London: randomised controlled trial of Therapeutic Assessment versus standard psychosocial assessment in adolescents presenting with self-harm. Arch Dis Child, 96, 148-153. doi:10.1136/adc.2010.188755
- Zullo. L., & Meza, J., Rolon-Arroyo, B., Varga, S., Venables, C., Miranda, J., & Asarnow, J.R. (2020). Enhancing Safety: Acute and Short-Term Treatment Strategies for Youths Presenting With Suicidality and Self-Harm. The Behaviour Therapist, 43(8), 300-305.
- Ginnis, K.B., White, E.M., Ross, A.M., Wharff, E.A. (2015). Family-Based Crisis Intervention in the Emergency Department: A New Model of Care. Journal of Child and Family Studies, 24, 172-179. DOI 10.1007/s10826-013-9823-1
- Wharff, E.A., Ginnis, K.M., & Ross, A.M. (2012). Family-based Crisis Intervention with Suicidal Adolescents in the Emergency Room: A Pilot Study. Social Work, 57(2), 133-143.
- Wharff, E.A., Ginnis, K.M., Ross, A.M., White, E.M., White, M.T., & Forbes, P.W. (2017). Family-Based Crisis Intervention with Suicidal Adolescents. A Randomized Clinical Trial. Paediatric Emergency Care. DOI: 10.1097/PEC.0000000000001076
- Rengasamy, M., & Sparks, G. (2019). Reduction of Postdischarge Suicidal Behavior Among Adolescents Through a Telephone-Based Intervention. Psychiatric Services, 70(7), 545-552. doi: 10.1176/appi.ps.201800421
- Ougrin, D., Boege, I., Stahl, D., Banarsee, R., & Taylor E. (2013). Randomised controlled trial of therapeutic assessment versus usual assessment in adolscents with self-harm: 2-year follow-up. Arch Dis Chil, 98, 772-776. doi:10.1136/archdischild-2012-303200
- Haruzi Catalan, L., Frenk, M.L., Spigelman, E.A., Engelberg, Y., Barzilay, S., Mufson, L., Apter, A., Milshtein, N.B., Fennig, S., & Klomek, A.B. (2020). Ultra-Brief Crisis IPT-A Based Intervention for Suicidal Children and Adolescents (IPT-A-SCI) Pilot Study Results. Frontiers in Psychiatry, 11, 1-7. doi: 10.3389/fpsyt.2020.553422
- Pineda, J., & Dadds, M.R. (2013). Family Intervention for Adolescents With Suicidal Behaviour: A Randomised Controlled Trial and Mediation Analysis. Journal of the American Academy of Child & Adolescent Psychiatry, 52(8), 851-862.

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