Risk assessment in Child and Adolescent Mental Health

ADMINISTRATIVE INFORMATION

For whom and in what circumstances do risk assessments change the clinical encounter for children and adolescents and what effect does this have on their mental health outcomes? (Review Protocol)

Registration

If registered, provide the name of the registry (such as PROSPERO) and registration number. To be added

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Contributions

The lead reviewer and lead author is Anna Cantrell, who manages the project, and the second reviewer is Katie Sworn. Andrew Booth is the Co-Director of the Evidence Synthesis Centre and chief methodologist for the project. Andrew Booth is the guarantor for the data. Duncan Chambers will act as a reviewer if required. Scott Weich and Elizabeth Taylor-Buck will provide subject expertise and we will also have input from the Royal College of Psychiatrists.

Amendments

Original (first) version

Support/Sources: NIHR Health Services & Delivery Research Funding Programme

Sponsor

NIHR Health Services & Delivery Research

Role of sponsor or funder
The sponsor identified the original topic through prioritisation processes and commissioned the Evidence Synthesis Centre to conduct the review. Following input into the protocol, the funder had no further input into the process or findings of the review.

Ethics
The review will not involve people participating in research either directly (e.g. interviews, questionnaires) and/or indirectly (e.g. permitting people access to data).

INTRODUCTION

Rationale
Suicide prevention is a key priority of the NHS Long Term Plan (NHS, 2019). In the most recently available figures (from 2019) a total of 5,961 deaths by suicide were registered in England and Wales (ONS, 2019). This is consistent with 2018, but is a significant increase following several years of decline, with rates of self-harm and suicide increasing amongst certain groups, e.g. young women (ONS, 2019). The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) annual report indicates that over a quarter of people who die by suicide have been in contact with mental health services within the last year (NCISS, 2021).

Predicting and managing risk is a central component of mental health care in the UK. Risk assessments are used to assess an individual's risk of harm to themselves and others and guide clinicians' predictions of future behaviour and may be used as part of a broader assessment to inform treatment planning (Royal College of Psychiatrists, 2014). In the 2011 NICE guidance on managing self-harm in over 8s risk assessment is described as "a detailed clinical

assessment that includes the evaluation of a wide range of biological, social and psychological factors that are relevant to the individual and, in the judgement of the healthcare professional conducting the assessment, relevant to future risks, including suicide and self-harm" (NICE, 2011: p30.). Risk assessment tools and scales can be part of the risk assessment and are generally checklists that can be completed by patient or health professional to give a quick and rough estimate of patient risk for example high or low risk of suicide. However, there are concerns about how risk assessments are undertaken across the UK. NICE guidance on long-term management of self-harm in over 8s recommend the following "1.3.11 Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm and 1.3.12 Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged. (NICE, 2011: p30.) The limited evidence on risk assessments is equivocal and may draw the clinical encounter towards a focus on self-harm which may have harmful effects.

Suicides in children are very rare, and predicting them is difficult. The NICE Quality Standard on depression in children and young people (NICE, 2019; NG 134) states that children and young people with suspected severe depression should be are seen by a child and adolescent mental health service (CAMHS) professional within 2 weeks of referral, or within a maximum of 24 hours if at a high risk of suicide. Prompt access to services is essential if children and young people are to receive the right treatment at the right time (NICE, 2013). Arrangements should be in place so that children and young people referred to CAMHS with suspected severe depression and a high risk of suicide are kept in a safe place and seen as an emergency, within a maximum of 24 hours, to help prevent injury or worsening of symptoms. However, CAMHS service are currently experiencing extreme pressure due to the COVID-19 pandemic.

A mental health professional called to assess a child or adolescent during a crisis situation, either in Accident and Emergency or at young person's home, needs to assess her/his suicide risk quickly. Assessment is typically conducted via an interview. Various checklists and assessment instruments have been developed to facilitate the clinical encounter and to offer a structure within which to obtain the necessary information on which to base a comprehensive assessment.

Objectives

Our initial research question is:

"Which risk assessment tools are currently in use in CAMHS services in the UK and other English-speaking high-income countries?

The review will then address the main research questions:
“For whom and in what circumstances do risk assessments change the clinical encounter for children and adolescents and what effect does this have on their mental health outcomes?”

Our aim is to address the initial research question by mapping the literature and then address the main research question by a rapid realist-informed review of published and ‘grey’ literature. The timescale for this review is three months and the purpose is to provide an overview, description and summary of the available evidence, particularly in terms of identifying when particular approaches to conducting a clinical encounter for risk assessment are most or least suitable.

Our approach will involve:
• Conducing systematic searches across the major medical, psychology and health related bibliographic databases and additional ‘grey’ literature searches.
• Descriptively mapping retrieved items meeting broad inclusion criteria plus any additional included items identified from the reference lists of review articles.
• Coding the items according to the following elements: risk assessment tools used (their features, validity), training, the clinical setting where the risk assessment tools is used, characteristics of the health professional and young people use of the tools within the clinical encounter, the short-medium term impact of the risk assessment, long term impacts.
• Coding the data according to the presence of explanations for how the risk assessment process is perceived to work (context mechanism outcome configurations or CMOCs) to inform the realist analysis
• Summarising the findings in a final literature review report.

METHODS

The review will comprise two stages. The first will involve a mapping review that allows identification of the quantity and quality of the literature on risk assessment in child and adolescent mental health services. The second involves an analytic realist logic within a realist review. A realist review is specifically designed to answers questions such as 'how?', 'why?', 'for whom?', 'in what circumstances?' and 'to what extent?' complex interventions, such as risk assessment within a clinical encounter, actually 'work'. Through a review of the literature, the review team develops an overarching programme theory which they gradually refine using data from documents identified as the review progresses. Within this programme theory, the team uses a realist logic of analysis to explore outcome patterns. In brief, mechanisms cause outcomes to occur, but the relevant mechanisms will only be activated within conducive contexts.

Eligibility criteria

To be included in the review a publication should meet all the following criteria:

Inclusion:

- English language papers
- Evidence published or produced between 2011 (date of NICE guideline) and the present day
- We will not restrict inclusion by study design (and will include relevant audits or service evaluations in addition to formal research studies)
- Studies from the UK (primary focus) and then from Australia, Canada, Ireland, New Zealand and United States (secondary focus).

Exclusion:

- Studies conducted in low or middle income country health systems; Studies conducted in non-Anglophone high income country health systems

Table 1 - Inclusion criteria

	Primary list
Date	Evidence published from 1st January 2011 onwards (year of NICE guideline)

Setting	Any setting in which structured formal child and adolescent mental health risk assessment is conducted which meets the above criteria (e.g. health or social care settings and child's own home).
Population	Child and adolescent mental health population (8 years and older to correspond with NICE guideline) and their family members and clinicians
Study type	Will not restrict by study design (will include relevant audits or service evaluations in addition to formal research studies) but these must include quantitative or qualitative research or evaluation data.
Model of care	Child and adolescent mental health and crisis care contexts
Outcomes	Include any outcomes that are reported (will classify later). Primary outcomes to include: Suicide and self-harm, Depression symptoms, Admission, Resource utilisation, Mood, Anxiety
Other	Studies from UK and reviews including studies from Australia, New Zealand, Canada, USA and Ireland) English Language papers

Table 2 - Exclusion criteria

Date	Evidence published before January 1st 2011
Setting	Interventions / services that do not typically include structured formal risk assessment. Needs assessment as a form of psychological assessment. Studies only about self-harm
Population	Adults (18 years or older) and child under 8 years
Study type	Papers that only describe interventions / services without providing any quantitative or qualitative data. Conceptual papers and projections of possible future developments.
Model of care	Other first contact that does not involve risk assessment. Unstructured or informal approaches to risk assessment
Outcome	Studies that include no process (e.g. qualitative) or outcome (e.g. quantitative) data.
Other	Studies conducted in low or middle income countries. Studies from non-Anglophone high income countries. Papers not published in English.

Information sources

A broad search to identify published and peer reviewed literature focused on how child and adolescent mental health risk assessment is delivered in the United Kingdom will be conducted, including a search for relevant grey literature. We will identify examples of current best practice, pilots and other child and adolescent mental health initiatives carried out in the UK and review their robustness, applicability and scalability.

The search strategy will include thesaurus and free-text terms and relevant synonyms for the population (child and adolescent mental health population) and intervention (risk assessment (broad terms to retrieve research on use of risk assessment, and risk assessment scale/tools; including terms for psychosocial assessment as the broad term for assessments including risk assessment components)) and will use proximity operators where appropriate. Search terms will then be combined using Boolean operators appropriately. Outcome terms will not be included in the search as outcomes information is not always included in title or abstracts meaning that including these could mean that relevant studies would potentially not be retrieved.

Once agreed with NIHR HS&DR and DHSC, the search strategy on MEDLINE will be translated for use in the other major medical and health-related bibliographic databases. The search is limited to research published in English from 2011-Current to reflect developments since the NICE guidance (2011). Methodological search filters will not be utilised to keep searching broad and ensure all relevant study types were retrieved. Where necessary geographical filters will be used; first to restrict to the United Kingdom and subsequently, to retrieve reviews.

MEDLINE (including Epub Ahead of Print & In-Process), PsycInfo, Embase, CINAHL, HMIC, Science and Social Sciences Citation Index and the Cochrane Library will be searched.

Targeted ‘grey’ literature searches will be carried out to identify reports/case studies in websites including: Mental Health Foundation www.mentalhealth.org.uk, MindEd for Families mindedforfamilies.org.uk/young-people, Royal College of Paediatrics and Child Health www.rcpch.ac.uk/, Royal College of Psychiatrists www.rcpsych.ac.uk and Young Minds www.youngminds.org.uk
Additional evidence may be identified from the reference lists and/or citation searching of included studies.

We will also utilise the expertise of colleagues working in mental health including Scott Weich and Elizabeth Taylor-Buck to identify additional documents and initiatives being carried out within a UK context to ensure that we are being as inclusive as possible.

Search strategy
See below for an example search strategy developed on Medline to be used to identify published and peer reviewed literature:

Database: Ovid MEDLINE(R) and Epub Ahead of Print, In-Process, In-Data-Review & Other Non-Indexed Citations and Daily <1946 to August 05, 2021>
Search Strategy:
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1 exp adolescent/ (2112274)
2 Child/ (1765281)
3 (adolescen* or boy? or boyfriend or boyhood or girlfriend or girlhood or child* or girl? or juvenil* or kid? or minors or minors* or paediatric* or peadiatric* or pediatric* or puber* or pubescen* or school* or teen* or underage? or under-age? or youth*).ti,ab,kf. (2230678)
4 or/1-3 (3881794)
Terms for children and young people

5 suicide/ or suicidal ideation/ or suicide, attempted/ (61339)
6 Self-Injurious Behavior/ or Self Mutilation/ (11625)
7 (suicid* or parasuicid* or auto mutilat* or automutilat* or self destruct* or selfdestruct* or self harm* or selfharm* or self immolat* or selfimmolat* or self inflict* or selfinflict* or self injur* or selfinjur* or selfmutilat* or self mutilat* or self poison* or selfpoison* or (self adj2 (cut or cuts or cutting or cutter? or burn or burns or burning or bite or bites or biting or hit or hits or hitting)) or head bang* or headbang*).ti,ab,kf,kw. (97312)
8 Crisis Intervention/ (5829)

9 cris?s.ab,ti. (72564)
10 Mental Health/ (45704)
11 Mental Disorders/ (168625)
12 mental health.ti,ab. (163919)
13 exp Mental Health Services/ (99836)
14 or/5-13 (531427)

Terms for mental health, suicide and self-harm

15 4 and 14 (153668)

Terms for children and young people and mental health, suicide and self-harm combined (population)

16 Risk Assessment/ (285662)
17 ((risk* or psychosocial) adj3 assessment*).ab,ti. (93128)
18 (((assess* or predict* or risk*) adj2 (form*1 or checklist* or check list* or index* or indices or interview* or instrument* or inventor* or item*1 or measure* or psychometric* or question* or scale* or score* or scoring or self report* or subscale* or test* or tool*)) or (comprehensive adj (assessment* or evaluation*))).ti,ab. (379219)
19 or/16-18 (686529)

Terms for risk assessment (intervention)

20 15 and 19 (10257)

Terms for children and young people and mental health, suicide and self-harm combined (population) with terms for risk assessment (intervention)

21 exp United Kingdom/ (377372)
22 (national health service$ or nhs$).ab,in,ti. (224735)
23 (english not ((published or publication$ or translat$ or written or language$ or speak$ or literature or citation$) adj5 english)).ti,ab. (41281)
24 (gb or "g.b." or britain$ or (british$ not "british columbia") or uk or "u.k." or united kingdom$ or (england$ not "new england") or northern ireland$ or northern irish$ or scotland$ or scottish$ or ((wales or "south wales") not "new south wales") or welsh$).ab,in,jw,ti. (2207322)
25 (bath or "bath's" or ((birmingham not alabama*) or ("birmingham's" not alabama*) or bradford or "bradford's" or brighton or "brighton's" or bristol or "bristol's" or carlisle* or "carlisle's" or (cambridge not (massachusetts* or boston* or harvard*)) or ("cambridge's" not (massachusetts* or boston* or harvard*))

or (canterbury not zealand*) or ("canterbury's" not zealand*) or chelmsford or "chelmsford's" or chester or "chester's" or chichester or "chichester's" or coventry or "coventry's" or derby or "derby's" or (durham not (carolina* or nc)) or ("durham's" not (carolina* or nc)) or ely or "ely's" or exeter or "exeter's" or gloucester or "gloucester's" or hereford or "hereford's" or hull or "hull's" or lancaster or "lancaster's" or leeds* or leicester or "leicester's" or (lincoln not nebraska*) or ("lincoln's" not nebraska*) or (liverpool not (new south wales* or nsw)) or ("liverpool's" not (new south wales* or nsw)) or ((london not (ontario* or ont or toronto*)) or ("london's" not (ontario* or ont or toronto*)) or manchester or "manchester's" or (newcastle not (new south wales* or nsw)) or ("newcastle's" not (new south wales* or nsw)) or norwich or "norwich's" or nottingham or "nottingham's" or oxford or "oxford's" or peterborough or "peterborough's" or plymouth or "plymouth's" or portsmouth or "portsmouth's" or preston or "preston's" or ripon or "ripon's" or salford or "salford's" or salisbury or "salisbury's" or sheffield or "sheffield's" or southampton or "southampton's" or st albans or stoke or "stoke's" or sunderland or "sunderland's" or truro or "truro's" or wakefield or "wakefield's" or wells or westminster or "westminster's" or winchester or "winchester's" or wolverhampton or "wolverhampton's" or (worcester not (massachusetts* or boston* or harvard*)) or ("worcester's" not (massachusetts* or boston* or harvard*)) or (york not ("new york*" or ny or ontario* or ont or toronto*)) or ("york's" not ("new york*" or ny or ontario* or ont or toronto*))))).ti,ab,in. (1531675)

26 (bangor or "bangor's" or cardiff or "cardiff's" or newport or "newport's" or st asaph or "st asaph's" or st davids or swansea or "swansea's").ti,ab,in. (60895)

27 (aberdeen or "aberdeen's" or dundee or "dundee's" or edinburgh or "edinburgh's" or glasgow or "glasgow's" or inverness or (perth not australia*) or ("perth's" not australia*) or stirling or "stirling's").ti,ab,in. (226335)

28 (armagh or "armagh's" or belfast or "belfast's" or lisburn or "lisburn's" or londonderry or "londonderry's" or derry or "derry's" or newry or "newry's").ti,ab,in. (28916)

29 or/21-28 (2773560)

30 (exp africa/ or exp americas/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp oceania/) not (exp great britain/ or europe/) (3057749)

31 29 not 30 (2635659)

Search filter for UK studies (Ayiku, 2017)

32 20 and 31 (1292)

Terms for children and young people and mental health, suicide and self-harm combined (population) with terms for risk assessment (intervention) and search filter for UK studies

33 limit 32 to yr="2011 -Current" (874)

Terms for children and young people and mental health, suicide and self-harm combined (population) with terms for risk assessment (intervention) and search filter for UK studies limited to studies published from 2011-Current

34 limit 33 to english language (872)

Terms for children and young people and mental health, suicide and self-harm combined (population) with terms for risk assessment (intervention) and search filter for UK studies limited to studies published from 2011-Current in English.

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Data management / data selection

Search results will be downloaded to a bibliographic management software.

Selection process

A pilot study selection exercise will involve a small sample of records (e.g. 100-200) being independently coded by the individual members of the review team. Verdicts will be compared and if the inter-rater reliability is rated as acceptable the remaining records will be distributed between the review team (AC, KS, Abo and DC (if required). If agreement levels are unacceptable then the exercise will be repeated until an acceptable rate of agreement is reached. A sample of excluded records will be reviewed to ensure that it was unlikely these have been excluded in error. Where a verdict of unsure has been recorded by one reviewer these records will be passed on to a second reviewer where agreement will be resolved by consensus. In the event of continued disagreement a third reviewer (ABo) will be asked to arbitrate on eventual inclusion.

Data collection process

Following piloting of a data extraction form, a user-friendly Google forms interface will be used to input data into a Google Sheets / Excel spreadsheet. Summary tables will be inserted within the final report and summarised data will be produced for the summary report. In accordance with most rapid reviews, duplicate data extraction will not be possible. However, data will be iteratively checked and re-checked during writing of the final report.

Data items

Data to be extracted will include:

• Year and place of study

• The tool and risk assessment method

• The population included (age group, clinical characteristics and setting)

• Study design and outcomes measured (any outcomes measured by studies relevant to patient mental health (e.g. status of condition, risks and care planning as a result of the risk assessment) will be included. NICE (2011) guidance recommends that evaluation of risk assessment covers a wide range of biological, social and psychological factors that are relevant to the patient thus, we anticipated a broad range of outcomes and we will be guided by the research.)

• Main findings

• Key messages including limitations

In addition, the data will be coded to facilitate the subsequent realist analysis. The codes will be piloted and then codes will be refined based on emerging concepts throughout the analysis period. Coded text will be selected according to its facility to address the following questions:

1. Does this section of text referring to context, mechanism or outcome?
2. How will we describe this specific CMOC (whether partial or complete)?
3. (a) How does this (full or partial) CMOC relate to the clinical encounter? (b) Are there data which support how the CMOC relates to the clinical encounter? (c) In light of this CMOC and any supporting data, does the clinical encounter need to be changed?
4. (a) Is the evidence sufficiently trustworthy and rigorous to change the CMOC? (b) Is the evidence sufficiently trustworthy and rigorous to justify changing the clinical encounter?

Quality Assessment

In line with realist-informed approaches, that privilege richness of data and relevance over rigour, preliminary quality assessment of each study will focus on generic limitations of study design only, although specific design limitations will be documented where identified.

Data synthesis

Synthesis will initially take the form of descriptive, narrative approaches – such as textual, tabular and graphical presentation. However, following a mapping process, the team will utilise a realist based approach. A realist review seeks to explore the underlying causes for observed outcomes and when these might occur by reviewing published and grey literature.

Using the analytic building blocks known as context–mechanism–outcome configurations (CMOCs) (i.e. propositions which describe what works (or happens), for whom and in what contexts and why) the team will explore these contexts (De Brún & McAuliffe, 2020). Contexts are conditions that activate or modify the behaviour of mechanisms (Ford et al, 2016). In this realist review, we are particularly interested in identifying and understanding the contexts that impact on factors that determine the outcome of the risk assessment process, whether that clinical encounter is successful or suboptimal. Realist methods offer an optimal vehicle for exploring the complex and dynamic nature of the clinical encounter.

We aim to use a realist review to explore the contexts that influence risk assessment for mental health for children and adolescents by seeking to answer the following questions:

- Which factors within the clinical encounter impact positively or negatively on risk assessment for children and adolescents within child and adolescent mental health services?
- What are the underlying mechanisms, why do they occur and how do they vary in different contexts?

This latter question will involve exploring key components and processes within risk assessment and construct programme theory statements for each stage or component – to be assessed against the identified evidence. Synthesis will follow the pathway approach used in previous realist-based reviews for primary care (Ford et al, 2016) and social care (Booth et al, 2021). All resultant CMOCs will be discussed within the research team, with patient representatives and clinical experts and fed into the iterative, cyclical process of searching, data extraction, analysis and programme theory development.

Although findings for child and adolescent mental health services in general will be privileged, the review team will seek to identify specific age differences between the two groups where these may exert an influence on the conduct or outcome of the clinical encounter. Where contextual differences relate to the setting of the risk assessment these will also be highlighted in the review findings.

Patient and public involvement (PPI)

We will involve patients and members of the public through the Sheffield Evidence Synthesis Centre PPI group. The PPI group will advise on the plain language summary and other relevant outputs and provide perspectives on relevant contextual factors and key messages for NHS staff. We will also attempt to discuss the review findings and recommendations with parents and adolescents potentially using pre-existing groups.

Review Timeline

	Week beginning				

Dates	09/08/21-30/08/21	06/09/21	13/09/21	20/09/21	27/09/21	04/10/21	11/10/21	18/10/21	25/10/21	01/11/21	08/11/21	15/11/21	22/11/21	29/11/21
Project weeks	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Core activities														
Protocol development														
Database search														
Screening														
Mapping of included studies														
Data extraction/coding														
Analysis and synthesis														

Draft report writing														
Submit draft report														
PPI														

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