

Sixth, since cannabinoids have been proposed for use in psychiatric conditions, many of which are chronic, this will necessitate long-term dosing. The cannabinoid system is highly adaptive—chronic exposure to cannabinoids leads to the development of tolerance and dependence (as evidenced by downregulation of brain cannabinoid receptors), as well as withdrawal upon discontinuation. These factors will need to be accounted for when considering these compounds as long-term treatments for chronic psychiatric disorders.

In conclusion, in light of the paucity of evidence, the absence of good quality evidence for efficacy, and the known risk of cannabinoids, their use as treatments for psychiatric disorders cannot be justified at present. The process of drug development in modern medicine is to first demonstrate efficacy and safety in clinical trials before using the drug clinically. With cannabinoids, it seems that the cart (use) is before the horse (evidence).⁸ If cannabinoids are to be used in the treatment of psychiatric disorders, they should first be tested in randomised controlled trials and subjected to the same regulatory approval process as other prescription medications.

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Prevention versus intervention in school mental health

Exciting changes are taking place in schools to reinforce the important inter-relationship of education and mental health. Improving child and adolescent mental health will improve the individual's life trajectory and reap untold benefits to the socioeconomic fabric of society.¹ Mental health services are shifting away from traditional models of health care and into locations such as schools, to improve access to care and increase the availability and diversity of non-specialist mental health workers.² Finally, the conceptualisation of mental health is expanding from the focus on clinically defined disorders to a broader dimensional approach to mental health,³ approaches that are well suited the school environment.

Mental health interventions can be perceived as those that promote mental health (such as improving self-esteem), those that prevent mental illness developing (especially in children with known risk factors), and those that treat diagnosed illnesses. The school environment provides opportunities to promote resilience (eg, enhancing teacher support and positive

peer networks) and reduce exposure to risk factors (eg, bullying and academic stressors). However, it can be more difficult to define the actual scope of an intervention than in traditional settings.

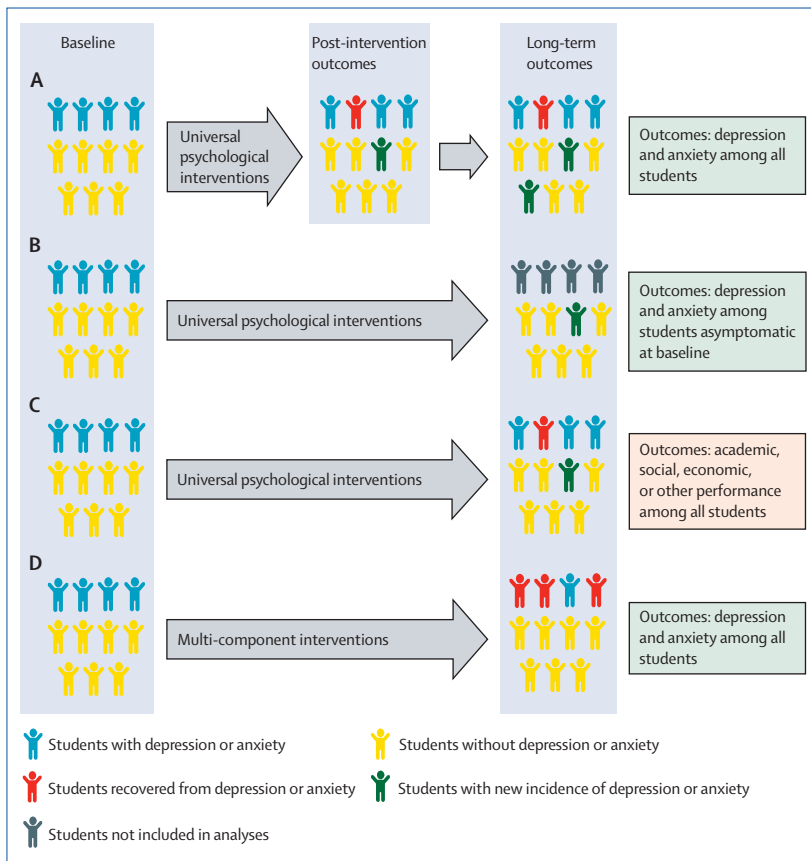
Given the potential benefit of working in schools, we raise concerns that the approach used by Deborah Caldwell and colleagues in *The Lancet Psychiatry*⁴ might lead to the potentially premature conclusion that there is little evidence to support preventive school-based initiatives.

First, the review is limited by a disconnect between the Institute of Medicine's definition of prevention and the manner in which prevention programmes are typically evaluated.⁵ This definition refers to preventions as “interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder”, and therefore, “reduce the incidence of common disorders”. Some of the studies included in the analysis provide outcomes that mix treatment of existing disorders and prevention of new incidences. Caldwell and colleagues⁴ included studies with both



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symptomatic and asymptomatic students (ie, up to 40% could have depression or anxiety at baseline) and then evaluated outcomes among this mixed group (figure A). A truly preventive analysis needs to evaluate the longer-term novel incidence among students who did not have anxiety or depression at baseline (figure B). Going forward, we recommend that universal prevention evaluations provide outcome information that distinguishes between preventive effects (ie, impact on new incidence) and treatment effects (ie, remission among individuals symptomatic at baseline).

Second, from a youth development perspective, the findings in the current meta-analysis do not report other outcomes that might be improved by the interventions. Although the mixed symptomatic and asymptomatic student sample did not show statistical improvement, there might have been population benefits to educational performance, future employment, social functioning, and risk-taking behaviours (figure C).

For example, a cognitive-behavioural therapy-based intervention for war-affected youth in Sierra Leone was beneficial for retention in school among all participants, but mental health improvement was limited to youth with more severe distress at baseline.⁶

Third, intervention approaches effective for prevention might have been excluded (figure D), such as programmes targeting bullying, mental health promotion programmes, and programmes to help students manage the consequences of a specific event (eg, parental divorce). Moreover, multi-gated interventions (with different approaches for different levels of need) are becoming the mainstay of more evolved school mental health systems.^{7,8} These interventions can have components incorporating environmental, social, and contextual factors, as well as specific cognitive and emotional interventions to treat specific disorders. Some school interventions have a great range and breadth, underlining the complexity of multi-dimensional interventions that will have components aimed at the staff, parents, whole school and specific year groups, and then for children with identified need. Excluding these programmes could misrepresent observed effects across the network.

As we herald an exciting new phase in mental health delivery, with increasing access and acceptability of interventions reaching more children with mental health difficulties, we must build the evidence base, and ensure that only interventions that have proven benefit are able to enter these somewhat unregulated new mental health environments. We must identify the right interventions for a school and ensure that they are associated with implementation support to strengthen the evidence base appropriately. This is well demonstrated by a school-based randomised controlled trial of modular evidence-based practice allowing for flexibility and individualisation, alongside family components, quality assessment, and implementation support.⁸ Rigour is needed to ensure that any statistically sensible method is also clinically meaningful. For children to thrive at school, their needs must be considered and addressed to enable a smooth journey.

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Urgent need for better care after self-harm

A presentation in the emergency department with self-harm is one of the strongest predictors of death by suicide that has been identified. There is, therefore, good reason to carefully assess people who present with self-harm in order to provide the best aftercare option. It is well known that one or two people out of 100 who present with self-harm will die within the next year. Such dire perspectives underscore the need for providing adequate support for people after self-harm.

Questionnaires and risk screens may give us an indication of who might be in the high-risk group. However, several well-researched studies have shown that these tools are poor at predicting which people we should be attentive towards. One study found that the clinician's estimate was as good as the patient's own evaluation; both of these evaluations fared just as well—or badly—as established clinical scales.¹ Similarly, a meta-analysis revealed that the accuracy of the evaluated scales was not good enough to make informed decisions regarding what type of treatment allocation should be recommended.²

In *The Lancet Psychiatry*, Galit Geulayov and colleagues³ compared the risk of suicide following hospital presentation for self-harm according to patient characteristics, method of self-harm, and variations in area-level socioeconomic deprivation, and estimated the incidence of suicide by time after hospital attendance. By following 90 614 self-harm presentations by 49 783 individuals to hospitals in five English cities,³ the authors identified 703 people who died by suicide within the subsequent 16 years. The incidence of suicide in the first 12 months following the index presentation to hospital for self-harm was 55.5 times (95% CI 49.2–62.8) higher than the incidence in the general population in England (2000–13). Relative to the general population,

the highest inflation in suicide rate after 12 months of follow-up was observed in adults aged at least 55 years. The first month after discharge, this group had a particularly high incidence of 1787.1 (1423.0–2244.4) per 100 000 person-years, which is close to 200-fold higher than in the general population. This high incidence of suicide emphasises the importance of care immediately after presentation of self-harm. Additionally, men were three times more likely than women to die by suicide after self-harm (OR 3.36 [95% CI 2.77–4.08], $p < 0.0001$). Other predictors that were linked to higher risks of suicide were having presented several times with self-harm, self-harm with a more lethal method, and use of several methods of self-harm. Counterintuitively, people who lived in the least deprived areas were more likely to die by subsequent fatal episodes of self-harm compared with people in most deprived areas. The reasons for this are unclear, but Geulayov and colleagues³ made some suggestions.

What are the options of treatment allocation in the emergency department? First, the clinician might choose to refer the patient to a psychiatric ward for admission, after a psychosocial assessment. However, this option is limited by availability of hospital beds. Second, the patient might be referred to outpatient treatment, which can be a better solution if the patient is not under immediate risk of self-harming. Few countries offer the option of referral to specialised suicide prevention clinics where the patient can engage in sessions of psychosocial therapy to address the causes that led to the self-harm and possibly develop better coping strategies for future critical situations.⁴ Some countries offer follow-up through home visits.⁵ Unfortunately, in quite a few countries patients presenting with self-harm are likely to



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