Deliberate self-poisoning by teenagers

Sebastian Kraemer

Suicidal self-poisoning is a medical emergency but it is also a psychiatric one. Yet before a psychiatrist can be engaged it is often necessary for a physician or paediatrician to set the scene. Young people who have just taken a massive risk with their lives are in a turmoil of rage, fear, grief and shame. Though some will be keen to talk, others may be harder to reach. 'The fact that young people who have self-harmed arrive at A&E feeling like 'rubbish' may predispose them to perceive staff attitudes and behaviours as hostile and punitive, even when staff do not intend them as such.'[1] An attentive and careful medical assessment conveys that the problem is taken seriously by the hospital, for which patients will often in time be grateful.

Whether or not a mental health practitioner will be seeing the patient soon after admission, I argue that a medical assessment is therapeutic in its own right. You should enquire about the dosage and timing of overdose, and about the motive and the context. This practice both enriches medical clinical skills and also fosters a spirit of collaboration between mental and physical medicine, a benefit to patients who experience it.

MAKING SENSE OF THE STORY: 'HERE TO HELP'

The most important first step is to acknowledge the distress that the young person is in, and to say that you are here to help. This indicates that you do not view what the young person and you are doing together as a waste of time. On the contrary, you can say that it is a unique opportunity to try to make sense of the crisis. Despite a steep rise in such admissions, my impression over the years is that the predicaments in which these patients find themselves are no less severe than in the past, and some are considerably more complex.

'What did you take, when, and how much?' are essential medical questions, to be followed by an enquiry into what provoked the event. This is often an acute experience of loss or betrayal, from which the only relief is some kind of exit. The young person may have felt liberated, even triumphant, at the time but is by now more likely to be feeling ashamed or humiliated. It is not upsetting or dangerous to ask patients if they intended to die. Many will say that they did, but only for a moment while taking the overdose. 'Did you leave a note?' 'What did you wish would happen?' Then, depending on the answers, 'do you still want to die?' 'How long have you been thinking about dying?' The most worrying signs of suicidal risk are social isolation, self-hatred, pervasive hostility and hopelessness about the future.[2]

If the young person is alone, you should encourage him or her to tell you who is in their family and how you can reach them. If the response is that the family must not know of this overdose, you can leave that to one side for the moment. However, it will be necessary sooner or later to have details of legal guardians, school or college attended, any social or community worker, close friends, other physical or mental health problems and, especially useful, contacts for any individuals who are perceived by the young person to be helpful allies.

BRINGING THE OTHER PLAYERS IN

If a parent or guardian is present then they will want to tell their side of the story. In this kind of crisis, it is helpful to take a polite but directorial role, inviting one person to speak at a time so that you can make some sense of the story. You are demonstrating professional curiosity—without judgement or taking sides—about a sequence of events. If quite a few names are mentioned it is a good idea to make, and to show you are making, a map or genogram of key individuals.[3] Start with members of the young person's household, then any other significant figures who may not be living there, such as stepsiblings, one or other parent and their parents, and finally non-family members of the network. From this exploration you may uncover concurrent or impending crises in the family, such as parental separation or illness, or a grandparental death. A key question to ask of the young person is 'who do you wish could have been here to help you before this happened?' followed by 'How would it be if that person were here now?'

MEDICAL ADMISSION

If medical and mental healthcare are properly integrated it is best practice to admit any patient who has taken an overdose to a paediatric or adolescent ward, even if the level of poisoning does not require medical treatment. This gives the patient time to recover from the shock of a life-threatening moment, and allows the family and professional network around the young person to be contacted and consulted over the next few hours or days, while the crisis is still 'live' and more amenable to mental health intervention. This exploration requires advanced mental health skills and should be conducted in a therapeutic rather than inquisitorial manner. A proper assessment must include key family members, whoever they are.[4] By its impact on health services, suicidal overdose becomes a public act and close relatives will have strong views—not always sympathetic—on the causes and consequences of the crisis; and legal guardians have a right to be consulted. Without their contribution the patient risks being returned to the situation from which he or she may have been trying to find refuge. Often through tears of remorse or forgiveness some mutual understanding is possible, encouraging further clinical help for patient and family. It is rarely ethically justifiable or clinically acceptable to exclude parents or guardians from the proceedings. 'Effective treatment of self-harm in young people without family involvement seems just as unlikely as effective treatment of anxiety without exposure.'[5] From such explorations it will become clear that a small minority of young people should not return home. Social workers who can join the assessment help to make these decisions more robust.

Admission to a medical ward is likely to be resisted by medical and nursing staff unless they have good working relationships with mental health colleagues who will attend soon to share care of the patient. Even with some mental health training, ward staff rarely feel confident managing this kind of risk alone, in case a further attempt at self-harm is made. Yet with the assurance that they are not expected to provide skilled mental healthcare, doctors and nurses can use their own considerable clinical experience to befriend young people in crisis. When patients feel that their presence in hospital is not defined simply by a desperate and alarming act, an expression of interest in their lives becomes therapeutic.

Most appreciated by patients is conspicuous evidence of 'the spirit of collaboration'; that before a mental health assessment takes place, ward staff have had a detailed discussion with the mental health colleague about the story so far, and their impressions of the young person's predicament. "No

Correspondence to Dr Sebastian Kraemer, Tavistock and Portman NHS Foundation Trust, London, UK; kraemer@doctors.org.uk

21st century health system should require parents and children to go from place to place or even worse to go to multiple appointments to tell the same story." (Spoken by Ian Kennedy QC at the launch of his report: *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs*. London: Department of Health, 2010.) Between them, medical and psychiatric specialists can decide what further treatment is required, and where that should be. Even for initially high-risk patients, a short stay on the ward with daily mental health input can reduce the need for admission to a specialist psychiatric bed, with follow-up by community services instead.

Integration of physical and mental health is ethical best practice that minimises dangerous 'breakdowns in communication'. The fact that it is so frequently not the case is a collective abdication of the rights of young people.[6]

Funding None declared.

Competing interests None declared.

Provenance and peer review Commissioned; externally peer reviewed.

To cite Kraemer S. *Arch Dis Child* 2019;**104**:728–729.

Received 19 March 2018
Revised 10 June 2018
Accepted 17 June 2018
Published Online First 11 July 2018

Arch Dis Child 2019;**104**:728–729.

doi:10.1136/archdischild-2018-314742

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