'Given up hope of dying': A child protection approach to deliberate self-harm in adolescents admitted to a paediatric ward

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ABSTRACT

This paper describes an approach developed by a local authority social worker based in a paediatric department, working in close collaboration with consultant child and adolescent psychiatrists and paediatricians. The literature is informative on the significant psychosocial difficulties of young people who harm themselves deliberately, but there is little published work on the complexities of the actual multidisciplinary care given to these patients, the majority of whom are not actively suicidal by the time they are interviewed. The task is as much to intervene in the lives of young people at risk of harm or neglect as to prevent suicide.

THE CHILD PROTECTION APPROACH

Social workers ought to be good at assessing risk – after all that is their stock in trade. When it comes to assessment of young people who are self-harming or threatening to do so, however, their skills are not wanted. The call goes out for child and adolescent psychiatrists who are widely perceived – in spite of the Royal College of Psychiatrists' recommendations to the contrary (Royal College of Psychiatrists 1998) – to be the only professionals capable of carrying out this kind of assessment. In line with national advice we have developed a system of a social worker, closely supported by child and adolescent psychiatrists, carrying out all initial assessments of these young people, all of whom are first admitted from the Accident & Emergency (A&E) department to a paediatric bed. This system can only work with active and continuing collaboration between all parts of the chain – A&E, paediatrics, social work and child psychiatry.

The child protection approach to deliberate self-harm is designed first to identify all areas of risk in the context of a medical admission. These include physical, sexual or emotional abuse or neglect, low self-esteem, poor parenting or support, and difficulties at school, in friendships or within the family. In these families there will often be members, including the young person herself, with both long-standing medical histories and contact with social services. The next task is to quantify the risk and, finally, to design with the patient and the family a strategy for monitoring and containing it, and a network that everyone agrees has a good chance of providing the necessary support to the young person.

Although it is of course possible that they may appear elsewhere, very few of our patients re-present with overdoses and those that do commonly have multiple social problems. They may already be in care, which is known to be associated with psychopathology (McCann *et al.* 1996), or involved in drug abuse (Hawton *et al.* 1993; Lockhart 1998), prostitution or other high risk activities (Schonberg 1991). We work in a deprived inner city area – most of our patients come from the London boroughs of Islington and Haringey with some from Camden and Hackney. The UK Department of Employment, Transport and the Regions (DETR) 1998 Index of Local Deprivation (www.detr.gov.uk) scores our local boroughs in the following order (most deprived being the lowest number): Hackney 4, Islington 10, Haringey 13 and Camden 17. In a recent audit we saw 47 patients in one year and only one of those presented more than once. While the subsequent suicide rate amongst

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teenagers who take overdoses is between 4 and 11% (Spirito *et al.* 1989; De Moore & Robertson 1996), the only deaths we have known about in over 10 years of this work are two: one girl who misinformed doctors of the timing of her paracetamol overdose and then died of liver failure, and one boy who, following his first overdose aged 16, took a fatal overdose several years after he was discharged. Since that time the latest available Health Authority data reveal that four males and one female under 18 killed themselves in Camden and Islington between 1995 and 1999. Self-poisoning did not appear to be a factor in any of these.

An increasing number of child and adolescent mental health teams have found that non-medical professionals can carry out assessments just as reliably as psychiatrists. Yet in places where the current practice is to use doctors only, there seems to be an anxiety that if the assessment is 'wrong' the young person may kill themselves at a subsequent attempt. The fear is that the entire professional team, including social worker, paediatricians, psychiatrists, and hospital managers up to and including the chief executive, will then be blamed and publicly shamed in the media. Most of the young people we see are not actively suicidal but many are at risk of further impulsive self-harming gestures. Given the increased likelihood of repeat if the patient is simply discharged from the A&E department, the protocol is designed to reduce risk by admitting to paediatric care all young people who have harmed themselves deliberately (regardless of the severity of physical injury or overdose) or who are threatening to do so. In spite of the recommendations from the Royal College of Psychiatrists (Dorer 1998) it is significant that in a number of hospitals A&E departments do not routinely admit all adolescents who have taken overdoses.

IDENTIFYING MENTAL ILLNESS

A further anxiety non-psychiatric professionals may have about undertaking this work is the possibility that young self-harmers are mentally ill. Given that psychiatrists are trained to assess this, the logical assumption is that no one else can. Yet there is growing recognition in the field, borne out of expediency, that a well-functioning multidisciplinary team, including social workers, can share responsibility for assessments provided that each can rely on the others to 'take over' when specific expertise or knowledge is required. Although many adolescents who harm themselves may have ongoing psychiatric disorders, some transient, it is clear that the overdose is in the majority of cases provoked by a crisis in a close relationship in the context of chronic stress and poor social or emotional support. Our experience is that psychotic adolescents rarely present with self-harm. Mood disorders are commoner, and often coexist with other symptoms (Kerfoot *et al.* 1996; Flisher 1999). Depression increases the risk of suicide, though it may not happen until later in adolescence (Rao *et al.* 1993). A sense of hopelessness, more easily assessed by non-psychiatric staff, is in any case as good an indicator of suicidal risk (Kienhorst *et al.* 1991). We have learned over time to pay particular attention to an indefinable feeling of unease that may occur in the presence of a patient. This can alert us to the possibility of less obvious, yet potentially sinister, psychopathology. Given that the majority of high risk cases have histories of quite serious abuse or neglect, we should be prepared to have disturbing experiences in the presence of these patients, even if it is not yet possible to put a finger on the source of anxiety, or to make a formal psychiatric diagnosis. Whatever is being said by the young person, it is important to notice, rather than brush aside, the sense (sometimes fleeting) that something unpleasant, even perverse, is being presented at an emotional level. With training and support, other health or social services professionals are quite able to screen cases for possible mental illness during the risk assessment interview and refer on to a psychiatrist when required. Most workers will know that something is not right, for example, when presented with a hypomanic adolescent or someone suffering from auditory hallucinations, disordered thoughts, delusions, etc. Whether the young person is floridly ill or not, judgements about the risk can only be relied upon if there is continuing mutual support between professions in the team. Some have undertaken specific training but the most important learning can only take place in detailed case discussion at regular meetings, as well as consultations during the crisis itself. The literature is rather quiet on the subject of interdisciplinary learning, as it is hard to study systematically. 'Reflective practice' (Fowler & Chevannes 1998) means learning from experience shared, over and over again.

THE SELF-HARM PROTOCOL: CREATING NARRATIVE AND NETWORK

The Accident & Emergency department of our busy District General Hospital sees 68 000 patients per

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year. All young people up to the age of 18 who present after self-harming (usually overdose but sometimes cutting), or threatening to do so, are treated medically in A&E and then admitted to the paediatric ward. The paediatric staff give further medical care and take a more detailed history, which gives the young person and his or her family a second opportunity to tell the story, rather than simply reacting to events. This is a crucial part of the process: the adolescent is accepted as a patient, whatever she may feel about that. Her account of the overdose is related to a doctor who feels supported in this work by the paediatric department's commitment to multidisciplinary treatment of deliberate self-harm. There is rarely any need for a mental health (or child protection) assessment at the acute stage, since the patient is likely to be feeling ill and shocked and needs looking after away from the scene of the crisis. The social work assessment takes place within 24 hours or on Monday after a weekend admission. This protocol is as recommended by the Royal College of Psychiatrists and the purpose is fourfold:

- to provide temporary respite for the young person;
- to allow assessment to take place;
- to allow for initiation of treatment;
- to give time for networks to be mobilized.

A series of interviews takes place in varying order. The young person and their family or carers are seen together and the adolescent is seen alone, even if briefly. Parents occasionally ask to be seen separately.

> One young woman had taken an overdose and come into A&E with a friend telling a story of physical and emotional abuse by her mother. When the mother presented and heard this story she was so angry with the girl that she needed a lot of persuasion not to leave the hospital altogether. She calmed down and told a very different story of a sexual relationship with a much older man, known to be a local drug dealer, which she had just discovered and reported to the police in an attempt to protect her daughter. In this case the overdose did appear to be an attempt by the girl to 'opt out' of a situation which had gone beyond her control. Routine checks confirmed the mother's version of events. When confronted with her mother the girl was able to agree that this was the case and was, eventually, able to admit that there was real cause for her mother's anxiety. This then enabled us to work with the family on a plan to protect the girl.

The facts

We start by establishing the facts – What, When, Where, Why and How. Much information about intent can be gained from the adolescent's description of the process. Sustained intent is required to swallow large numbers of tablets, especially if they are in blister packs rather than loose in a bottle. It is useful to find out if all available tablets were taken – and if not, why not? What did they imagine would happen? Many young people imagine that death will be instantaneous and are surprised if nothing much happens immediately. Did they go to some lengths to conceal the process or did they tell someone immediately or soon afterwards? We have met a small number of young people who had taken a potentially lethal overdose of paracetamol and slept on it, only bringing themselves to medical attention the following morning when they felt sick and had given up hope of dying.

How suicidal?

Suicidal intent is a measure of the likelihood of a repetition of the suicide attempt. Concealment and planning of a self-harming event for more than 3 hours previously indicate higher levels of risk. Although used mainly with adults, the Samaritans' method of scoring suicide risk is useful: previous attempts, recent broken relationship, isolation, no hope, dependence on drugs (Vining 1995; Brent *et al.* 1999). Feelings of hopelessness and lack of energy for life correlate better than depression with higher risk, as does expressed suicidal intent (Kienhorst *et al.* 1991), particularly if this is sustained after medical treatment and some time in hospital. An inability to provide a coherent account of feelings or of the precipitating factors to a self-harming event indicate a higher risk. These two factors also correlate with a higher risk of psychiatric disorder. A history of abuse in childhood is associated with suicide risk (Grilo *et al.* 1999). Parental mental disorder and previous attempts increase the risk of repeat self-harm (see also Chitsabesan *et al.* 2003).

Why now?

The precipitating factors are usually multiple influences rather than a single linear cause. Factors most often reported by young people include abuse, family conflict or ill-health, school problems – bullying, exam stress, etc., problems with boy/girl friends and difficulties with other friendships. Very often a combination of these factors will lead to feelings of hopelessness and a desire to 'make it all go away'. Losses or separations which may not seem particularly bad from the point of view of an adult interviewer or bystander may be experienced by the young person as

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the end of everything, and the trigger for the final way out.

Wish to die

We always assume that the wish to die has been present, even if only fleetingly, at the moment of self-harm (Sutton 1986). Very few young people will disagree with this statement if presented to them, although they may also describe themselves as having been 'stupid' and 'not wanting to die' or 'only wanting some attention'. Talking about suicidal feelings can be a relief and provide a model that distressing experiences can be talked about. This is particularly useful in the aftermath of an event when parents or carers may be tearful, shocked and angry. The adolescent may be shocked after being told of the risk to which they have exposed themselves. There is often a great temptation to minimize the situation with talk of 'attention seeking behaviour' and it is important to emphasize that the patient is lucky to be alive. This opens the way for the young person to consider the feeling of overwhelming hopelessness and helplessness which is likely to have been present at the time of the event.

Not a cry for help but an attempted solution

Although every young person's story is different, the causes of a self-harming event can usually be summarized as relationship problems in a crisis which is beyond the control of the adolescent. The self-harm is then understood as an *attempted solution* to this crisis. The young person feels that all avenues of help have been exhausted or closed off due to crisis. They have given up hope, even if temporarily, of getting any help in this life and see no alternative to unbearable suffering except death (Kienhorst *et al.* 1995). They may often feel that their families or carers may be better off without them to worry about and act in an attempt to protect others from their own problems or behaviour. Families will often attempt to minimize a self-harming event by describing it as a 'cry for help'. From our experience the cry for help may take place before or after the event but is rarely the event itself. A genuine cry for help might be an overdose taken in front of another person the adolescent might reasonably expect to stop her. Sadly, we met one young woman who did just this in front of her mother who ignored the action and it was left to the girl herself to summon assistance. This was a genuine cry for help which did not achieve its objective.

The 'social state examination'

The assessment of the young person's mental state is vital but this can, in our experience, be undertaken by a social worker: 'the social state examination'. Social workers in child and adolescent mental health teams are well equipped to carry out an assessment of emotional health and functioning, and formal mental illness will not be an issue in most cases. The social worker enquires as to how the young person is functioning in the family or care system, at school and in his or her social life. Most important is the capacity of parents or other responsible caregivers to understand and protect their adolescents. They may, of course, be angry with the young person but if there is little sign of concern behind that, the young person is at greater risk of further harm, self-inflicted or not, because he or she has not been heard.

Discharge or transfer

The majority of our patients are discharged home following assessment. A child and adolescent psychiatrist will be asked to see a patient before discharge if there is concern about the young person's mental health, if they are still expressing active suicidal intent during the assessment, or if the parents or carers appear to be unable to provide a level of care which meets the child's immediate needs. Most of the young people are offered follow-up by the social worker in conjunction with a child and adolescent psychiatrist. If accepted, this takes the form of an initial consultation session, and further sessions can be discussed and planned at that time. The approach used is broadly based on family intervention (Reder *et al.* 1991; Asen 1998; Byford *et al.* 1999), while at the same time ensuring that psychiatric disorders are attended to, and careful individual interviews with the young person are carried out.

CHILD PROTECTION ISSUES

Occasionally, follow-up is refused and the social worker gives consideration as to whether there is a need for statutory action to protect the child or, alternatively, whether a family is likely to be able to deal with the adolescent and the consequences of the self-harm adequately within their own resources. A minority of our patients have to be admitted to adolescent psychiatric units, and may have to stay on the paediatric ward until a place can be found. This is only possible when there are continuing good relationships with paediatric staff, maintained by weekly multidis-

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ciplinary liaison meetings where all patients causing concern are discussed in depth.

Occasionally, a young person discloses some form of abuse as the precipitant factor and in these cases child protection procedures are used and a child protection conference is held. This may result in removal of the adolescent from the family and alternative accommodation being found. The advantage of having a local authority social worker undertaking the initial assessment is that the assessment, therapeutic and statutory roles are combined and a core assessment of the adolescent and their family undertaken using the Department of Health's (2000) *Framework for Assessment* involving paediatricians, child and adolescent psychiatrists and the other resources of a hospital children's ward.

Daisy, aged 13, was admitted to A&E at 5.30 pm having been brought in by an ambulance called by a neighbour. Daisy was having trouble at school with a group of friends and had just had news this group was going to 'get' her. Although she was a bright and popular girl this was the 'last straw' for Daisy. Taking advantage of the fact that her mother was out she took all the tablets available to her in the house. She had expected to die immediately and when this did not happen she drank some vodka, cut herself and subsequently tried to hang herself. As this too was unsuccessful she finally went to a neighbour who called an ambulance. The A&E staff administered immediate medical treatment and Daisy was referred to the junior paediatrician on call. She was admitted to the paediatric ward and seen the following morning by the social worker. A sad story unfolded: Daisy's mother had experienced a deprived childhood. As a teenager she had been involved in a road traffic accident which left her with some residual brain damage including problems with memory. She had managed to look after her two children whilst small but, as they grew, difficulties began to emerge. Daisy, entering adolescence, had begun to argue with her mother and they described words being used as weapons – Daisy being much more fluent than her mother. Mother had resorted to violence and Daisy described regular fights with her mother when they would hit and kick each other. Daisy was still suicidal at this point and a child and adolescent psychiatrist joined the social worker for further assessment. In view of Daisy's depression and difficult home circumstances, referral was made to an adolescent psychiatric unit where Daisy was admitted directly from hospital. Consideration was given to the child protection issues identified – Daisy's physical safety was ensured by her admission and her brother was interviewed to ascertain his position. He was not involved in fights with his mother at that point but one of the aims of the family work at the unit was to ensure his continuing safety as he grew up and also entered adolescence. Daisy spent just over a year in an adolescent psychiatric unit, and was discharged to the care of her maternal grandmother with whom she had a supportive relationship.

CONCLUSION

The approach outlined here works well as long as there is good liaison between all parts of the hospital system. Because junior doctors change posts every six months, Accident & Emergency and paediatric Senior House Officers need regular training on the protocol to minimize misunderstandings, the commonest of which is that a small overdose is not significant. The repetition of the narrative at each stage is regarded as therapeutic, rather than a nuisance. Social workers are confident because they have rapid access to consultant psychiatrists if need be. So far it has not been necessary to call consultant child and adolescent psychiatrists out of hours. The procedure, and the links that support it, effectively contain the anxieties that are inevitable when faced with the possibility, however remote, of death.

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