Managing deliberate self-harm in young people

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Contents

Background

This document provides guidance on managing young people up to the age of 16 who deliberately harm themselves. The group includes young people who have a learning disability whether or not that is related to incidents of self-harm.

The age of 16 has been chosen not as a recommendation but to recognise that most child and adolescent mental health services take school leaving age as their upper limit. The implication is that every commissioning authority and each relevant provider should exercise particular care to ensure that the responsibilities for young people aged between 16 and 18 are negotiated and clearly allocated.

This guidance is aimed at health authorities and health boards, NHS trusts, primary care groups/trusts (in England and Scotland), local health groups (in Wales), and local authorities, as well as Members of the Royal College of Psychiatrists and practitioners in other disciplines.

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Commissioning services

People who deliberately harm themselves should always be taken seriously since this presentation indicates that individuals may have acute or chronic psychiatric disorders or significant psychosocial problems. This applies in full measure to young people who are under 16 years old.

Deliberate self-harm may be a key indicator of the existence of a range of serious problems. The contributions of depression, disordered family functioning, substance misuse, and antisocial behaviour to its aetiology, as to that of completed suicide, are facts that have been well substantiated by research conducted in a number of countries. Other common risk factors that may be revealed by an episode of deliberate self-harm include poverty, social deprivation, bullying, rural isolation, and physical and sexual abuse.

Among adolescents who deliberately harm themselves, the factors that are most likely to be associated with a higher risk of later suicide include:

- male gender,
- older age,
- high suicidal intent,
- psychosis,
- depression,
- hopelessness, and
- having an unclear reason for the act of deliberate self-harm.

Deliberate self-harm may be the route by which child abuse or severe failures of child care come to light. The continuing risk of acting upon self-damaging or suicidal impulses may be a direct function of the parental and/or social care provided for a young person. Local child protection procedures should reflect this in the training of child health and social services staff and the provision of emergency support to families or alternative care for young people, when required.

Therefore, the full range of resources and interventions required by young people who harm themselves span the responsibilities of a range of agencies and sectors of care. Responsibility for resuscitation and for the initial physical and mental health care of young people after they harm themselves falls, appropriately, on the health service. None the less, a full and longer-term approach to commissioning care will require the coordinated activities of local and health authorities together with an awareness of the important role that non-statutory sector agencies can and do play. Therefore, the statutory sector authorities should ensure that the needs of young people who harm themselves are also fully included in the children's services plans that each local authority is required to prepare in consultation with the relevant health authorities.

Health authorities/boards should identify within their overall plans for child and adolescent mental health services the resources required to ensure the appropriate assessment and management of young people who deliberately harm themselves. This should be based on local assessments of need that are informed by awareness of the national position. *Suicide Prevention: The Challenge Confronted* (Williams & Morgan, 1994) includes reviews of the epidemiology and risk factors for deliberate self-harm and suicide in adolescence.

Each health authority/board should work with relevant NHS trusts to clarify the local arrangements for the care of young people of all ages with regard to their immediate and longer-term physical and mental health care needs for assessment, admission and continuing care.

Particular care should be taken to ensure that the arrangements for young people between the ages of 16 and 18 years are clear and effective. Experience shows that young people in this age range may fall into the gaps between the medical and mental health services for children and those for adults. Therefore, it is good practice for consultations with professionals from the specialist tiers of a child and adolescent mental health service to be available to practitioners who work in the services for adults where the latter are responsible for this age group.

Children and adolescents with learning disability may present complex management problems. Commissioners should ensure that expertise and services are available for children and adolescents with learning disabilities and psychiatric disorders.

After self-harm, a minority of young people require emergency psychiatric care delivered by their admission to a psychiatric in-patient unit that is resourced, staffed and set up to deal effectively with younger people. Therefore, all health authorities must anticipate the necessity of a number of admissions each year to these very specialised facilities, estimate the likely number, commission services prospectively and allocate budgets accordingly within their plans for child and adolescent mental health services. This may require consortium commissioning approaches in which several health authorities act together.

Locally, the arrangement of units that provide services may be complex. For example, in many parts of the country, the departments that contribute to providing services for young people are distributed across the statutory agencies and, within the NHS, between primary health care and a number of different provider trusts that offer secondary health care. Therefore, each health authority/board should:

- work with partner local authorities, trusts and primary care groups/teams to ensure that inter-agency boundaries do not create fault lines in service delivery;
- ensure that it has service agreements or contracts with the necessary range of provider agencies within its area of responsibility;
- ensure that the range of provider agencies has service agreements between them that enable protocols for assessing and treating young people who harm themselves to be put in place and used effectively.

As the structures outlined in the NHS White Papers of late 1997 and early 1998 are implemented, health authorities / boards will become more clearly responsible for taking the strategic lead and setting a strategic framework for commissioning child and adolescent mental health services through their health improvement programmes (in England and Scotland). Also, the design of local services should be based on national service frameworks, when they have been developed. Health authorities and boards are now required to work more closely than before with their local authorities.

Primary care groups and trusts (in England and Scotland) and local health groups (in Wales) will become responsible for more detailed commissioning and for purchasing services locally within the frameworks set by health authorities / boards.

Therefore, the importance of deliberate self-harm in young people should be recognised in the relevant national service frameworks as they are developed. Also, health authorities and boards should ensure that the significance of deliberate self-harm in young people is fully recognised in their health improvement programmes. They should include requirements on service providers to plan and negotiate adequate local services to support the activities described in this document.

Suicide Prevention: The Challenge Confronted (Williams & Morgan, 1994) contains advice to health authorities / boards in respect of deliberate self-harm. This includes a check-list that the staffs of health and local authorities may find helpful in evaluating their own plans and the quality of the services that they commission for adolescents who deliberately harm themselves. A framework for commissioning child and adolescent mental health services is provided by *Together We Stand* (NHS Health Advisory Service, 1995).

Providing and delivering services

Local protocols for managing young people who deliberately harm themselves

It is essential that all providers of health care, including NHS trusts, primary care groups/trusts and local health groups ensure that a protocol for the management of deliberate self-harm is agreed between the professional staff and managers of the following departments:

- child and adolescent mental health services,
- accident and emergency services,
- paediatrics and child health (including the community child health) services,
- general medical services,
- substance misuse services, and
- learning disability services.

These departments may not lie within a single trust or, in the case of larger generic trusts, within the same clinical directorate. Therefore, it is essential that service agreements are developed between trusts and across the relevant clinical directorates to enable a seamless service to be provided regardless of the corporate or physical boundaries of individual providers and/or their clinical directorates or departments.

It is recommended that, ideally, a consultant paediatrician and a consultant child and adolescent psychiatrist be nominated as the joint service leaders because the paediatric and mental health services are responsible for complementary aspects of the care provided for young people. Where this is achievable, they should work together to ensure that protocols, agreed by their colleagues, for assessing, caring for and treating young people who harm themselves are negotiated with and agreed between their employing trusts or directorates, where they are different. Additionally, they should have the task of resolving operational difficulties.

Admission to hospital

At the stage of acute presentation, emergency physical assessment and treatment accompanied by an initial assessment of the patient's mental state is usually undertaken in an accident and emergency department. Thereafter, admission to a paediatric, adolescent or medical ward or to a designated unit is usually desirable. Generally, this is indicated regardless of the toxicological state of the young person in order that adequate further physical and psychosocial assessments can occur and management/crisis intervention be planned and initiated.

Admissions should be to a paediatric ward unless, as far as young people at the older end of the age range (14–16 years) are concerned, a more suitable

setting, such as a designated ward for adolescents, exists or can be created. The policy and practice for arranging admissions should be agreed locally by the responsible clinical directorates of the relevant trusts.

Admitting staff should be responsible for:

- in each case, obtaining agreement for the psychiatric/mental health assessment from the parent(s) or other adult(s) with parental responsibility for the young person, and for seeking their full involvement in this process;
- alerting the staff of the child and adolescent mental health service to each young person's need for assessment and confirming that consent has been obtained.

Throughout their admissions, young people should remain in the overall care of a paediatrician unless there are particular and acknowledged reasons for their transfer to the continuing care of a psychiatrist or for their care becoming a shared responsibility. In the usual circumstances described here, the role of the staff of the mental health team during the in-patient phase will be that of providing a consultation to:

- the young person,
- the young person's family,
- the paediatric team, and, possibly,
- staff of the social services and education departments.

Thereafter, specific arrangements may be recommended and made for further assessment and treatment of the young person and their family by staff of the child and adolescent mental health service.

Assessment and treatment planning

Formulation of treatment plans requires the ability to:

- assess suicidal intention and the continuing risk of the young person acting on suicidal or self-damaging impulses;
- make a preliminary assessment of the young person's overall mental health and development, their psychosocial situation and the ability of those adults responsible for them to ensure their safety.

Deliberate self-harm may cause considerable anxiety in families and a number of agencies such as schools. Also, particular care and experience may be required in handling the issues of confidentiality that can arise. These matters should be the focus of training and supervision for the professionals who undertake the specialist psychosocial assessments.

Therefore, it is advisable that professionals who work within the specialist tiers of multi-disciplinary child and adolescent mental health services should carry out the processes of assessment and treatment planning after the

resuscitation phase. This work is demanding of skill and, in some cases, is stressful. Therefore, these staff should:

- have had training specifically orientated to work with young people and their families after deliberate self-harm;
- be skilled in risk assessment; and
- have consultation and supervision available to them.

This role is not specific to medical staff but access to psychiatric opinion and consultation is essential in certain cases. Where and when assessments are carried out by personnel who are not from the staff of a specialist child and adolescent mental health service, arrangements must be in place for consultation with the child and adolescent mental health service.

A protocol for assessing children and adolescents, and guidance on assessing risk in adolescents are included in *Suicide Prevention: The Challenge Confronted* (Williams & Morgan, 1994).

Experience and research evidence show the importance of cultural, ethnic and racial awareness and sensitivity in the assessment process. Not only may the profile of deliberate self-harm and its antecedents be different but the prominence of risk factors may differ across a range of groups. Managers and professional staff must be aware of the particular requirements for interpreters in the population that they serve.

Deliberate self-harm may be an indication of major psychiatric disorder requiring admission to a specialist in-patient treatment unit. The staffs of each relevant trust should anticipate this prospect and advise their service commissioners appropriately. In turn health authorities' commissioning arrangements for in-patient child and adolescent mental health service provision should take account of the requirement for this contingency.

Where a young person’s self-harming behaviour is an indication of and/or contingent upon mistreatment (physical, sexual or psychological abuse) or failures of care and protection, child protection procedures will need to be implemented. Securing a young person’s safety may require recourse to a statutory order and/or alternative care arrangements to be made by the relevant local authority social services department.

Roles and responsibilities of consultant child and adolescent psychiatrists

The roles and responsibilities of consultant child and adolescent psychiatrists include the following tasks:

- Advising health authorities / boards, primary care groups / trusts, local health groups, and local authorities about services for young people who deliberately harm themselves (including aftercare) that are appropriate to local need within the context of comprehensive child and adolescent mental health services.
- Working with staff of child health and accident and emergency departments and within other units that deliver services to develop, implement and monitor protocols for assessing and managing young people after deliberate self-harm. This will involve close liaison and cooperation between the medical, nursing and other relevant professional staff of child and adolescent mental health, paediatric, accident and emergency, general medical, substance misuse, and social services.
- Identifying the staffing levels and specialist training required to provide a comprehensive service for young people who harm themselves.
- Advising on and being involved in training of the staff of the paediatric, child health, accident and emergency, and social services departments in order to ensure that young people receive sufficient and appropriate immediate responses and aftercare when they present in acute distress after deliberate self-harm.
- Being available to teach, supervise and consult to non-medical and junior medical staffs who are involved in assessing and managing young people who deliberately harm themselves.
- In certain cases and circumstances, consultant child and adolescent psychiatrists should be directly involved in the clinical care of young patients.

References

NHS Health Advisory Service (1995) *Child and Adolescent Mental Health Services: Together We Stand. The Commissioning, Role and Management of Child and Adolescent Mental Health Services.* London: HMSO.

Williams, R. & Morgan, H. G. (eds) (1994) *Suicide Prevention: The Challenge Confronted. A Manual of Guidance for the Purchasers and Providers of Mental Health Care.* London: NHS Health Advisory Service.