# The College

## The Management of Parasuicide in Young People Under Sixteen

The Child and Adolescent Psychiatry Section has agreed that a view should be formulated about the management of suicidal attempts in young people under sixteen. This report of the Section's Working Party is being published with Council's approval. (Members of the Working Party: Dr M. Black (Convener), Dr J. Erulkar, Mr M. Kerfoot, Professor R. Meadow and Dr H. Baderman.) A Working Party of the Public Policy Committee, which includes representatives of other professions, is continuing discussion of this topic.

Parasuicide may be defined as an act of deliberate self-harm either by injury, ingestion or inhalation, although this does not result in death. Earlier guidelines (Ministry of Health, 1961; Central and Scottish Health Services Councils, 1968) make no mention of adolescents as a separate age group.

An earlier College memorandum on the psychiatry of adolescence (*News and Notes*, September 1976) defined it as roughly the period between 12 to 18 years of age. We consider only young people under 16 because where there is no overall local psychiatric service dealing with the age range 12–18, the adult psychiatric department is generally willing to accept responsibility for the over sixteens. Moreover, under sixteens are still legally in the charge of their parents or other adults, and this has management implications. Children under 12 have been included, however, because rarer attempts in this age group must be carefully evaluated.

It is apparent to those working within this field that young people under 16 and their families have special needs which require different professional responses to the attempt. Parasuicide usually happens within the family setting and in response to stresses contained there. This means that on discharge the patient is likely to return to parents or to other adults who are legally in charge of her and with whom she will continue to interact.* The tasks of assessment, management and discharge follow-up are, therefore, complex and demanding. Because of the lack of nationally agreed guidelines, various *ad hoc* arrangements, involving differing combinations of professionals both medical and non-medical, have developed throughout the country.

This point has been illustrated by an analysis of questionnaires on this topic recently completed by a group of child psychiatrists. (Questionnaires were returned by 47 child psychiatrists attending the annual residential conference of the Child and Adolescent Psychiatry Section of the College in 1980.) It is clear that there is considerable variation in the availability and content of services for the overdosing adolescent, together with marked differences in the assessment and management of suicidal behaviour. Some were not unexpectedly based upon geographical variation in the provision of services—e.g. urban versus rural settings. Practitioners may be helped by agreed provisional guidelines, although it is accepted that some differences in local arrangements, depending on available resources, necessarily will continue.

*We refer to the young patient as she throughout this document because there is a marked excess of girls who are parasuicidal in this age group.

### Statistics

National statistics are not available for children and adolescents under 16 who have made a parasuiride attempt.

In a recent study, however, Hawton and Goldacre (1982) examined deliberate self-poisoning among young people aged 12–20 in the Oxford Region from 1974–79. Their figures were based on the calculation that 97.5 per cent of hospital statistics for episodes coded as 'adverse effects of medicinal agents' were in fact cases of deliberate self-poisoning.

Their findings showed that admission rates rose sharply from the age of 12 years, more so for females than males, and peaked at the age of 16 years for females and 18 years for males (Table I). Admission rates varied from year to year, but increased overall between 1974 and 1979, notably among people under 16 years of age (Table II).

TABLE I

*Average annual admission rate per 10,000 people in each age-sex group*

| Age | Females | Males |
|---|---|---|
| 12 | 3.1 | 1.5 |
| 13 | 11.5 | 2.2 |
| 14 | 29.8 | 5.1 |
| 15 | 40.2 | 6.3 |
| 16 | 51.5 | 10.7 |
| 17 | 49.1 | 14.5 |
| 18 | 51.4 | 25.0 |
| 19 | 55.8 | 23.6 |
| 20 | 49.1 | 26.5 |

From a recent study by Hawton and Goldacre (1982)

### Management

A variety of professions, both in the community and in the



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**Table II**

*Number of episodes in each year by age-group and rate per 10,000 population in each age-group*

| Year | Age groups | | | | | |
|---|---|---|---|---|---|---|
| | 12–15 years | | 16–20 years | | 12–20 years | |
| | n | Rate | n | Rate | n | Rate |
| 1974 | 124 | 9.7 | 402 | 27.7 | 526 | 19.3 |
| 1975 | 138 | 10.5 | 487 | 33.2 | 625 | 22.4 |
| 1976 | 188 | 13.8 | 570 | 37.7 | 758 | 26.4 |
| 1977 | 196 | 14.1 | 647 | 40.7 | 843 | 28.3 |
| 1978 | 146 | 10.6 | 579 | 35.2 | 725 | 24.0 |
| 1979 | 181 | 13.1 | 574 | 34.1 | 755 | 24.7 |

from a recent study by Hawton and Goldacre (1982)

hospital to which the child is sent, are likely to be involved in some way or the other in management. The family doctor occupies the centre of the health network of services, and even if not directly concerned with the referral to hospital, should be kept fully informed about further developments and follow-up arrangements. It is considered that admission to hospital is desirable in most cases of parasuicide in children and adolescents.

Because of the volume of admissions in this age group it is acknowledged that this would place a great burden on available services. The problem is a complex one, however, and short-term admission may provide the opportunity for its resolution.

Toxicity must be assessed and treated, and the bed ised will depend on what is available locally. Paediatric wards will usually accept children up to the age of 14, and some are willing to accept older children, although ideally these should be admitted to an adolescent ward if this is available.

It is accepte that automatic involvement of a psychiatrist in each case may lengthen the admission time for physically fit patients. It is undesirable for such admissions to be unduly prolonged, yet if the young person leaves hospital with the reasons for the event neither understood nor dealt with, she is likely to demand further time from professional workers. This underlines the importance of having adequate child psychiatric resources available for prompt evaluation.

Delays can be lessened provided that good communication exists between the various professionals involved. There is an advantage if one or two wards can be mainly used, and the child psychiatric team† can offer regular consultation with hospital staff. Ward staff, who may be made anxious and hostile by such patients, will by degrees become familiar with the work, and will thus be more effective in their contact with the patient and her family, and through knowledge of the appropriate professional network. A hospital social worker who comes to regard this area of work as his or her specialty may be invaluable, particularly where psychiatric services are limited. Situations vary greatly. At one extreme there may be an in-patient child and adolescent psychiatric unit staffed by more than one consultant psychiatrist and with junior psychiatrists in training. At the other there may be a single-handed child and adolescent psychiatrist covering a wide geographical area on an out-patient basis, and with only a small team of social workers or other non-medical colleagues. Although the first unit is likely to be able to respond more quickly than the second, it is equally important that hospital staff know how to ask for a psychiatric opinion, so that the child psychiatric team can be alerted as soon as the young person is admitted, rather than when she is physically fit for discharge.

In those areas without a child psychiatrist the responsible hospital consultant will have to mobilize the most appropriate local resources available. These may be provided by the adult psychiatric department.

**Subsequent psychiatric assessment**

This should begin as soon as possible after the young patient is admitted to hospital, and while physical problems relating to the overdose are being diagnosed and treated. Because the involvement of the parents or guardians is essential, the hospital (ideally the designated social worker, or other person with special responsibility for overdoses) should make immediate contact, and their agreement to involvement with the child psychiatric team should be sought. At such a time of crisis, parents will usually be willing, and intervention in a tangled family situation may become briefly possible. There will be occasional situations which may require rapid intervention by the psychiatrist even in the absence of parental agreement as in any other medical emergency. Experience suggests that hospital admission provides a unique opportunity for early assessment and treatment, but once the adolescent is discharged from in-patient care motivation may diminish rapidly.

Having contacted the child psychiatric unit for assistance, the hospital will need to set up a meeting including the adolescent, her parents and the child psychiatric team. Ideally child and adolescent psychiatrists should try to be available within 48 hours. It is considered unrealistic, however, to expect a child psychiatrist, especially one who is working single-handed on an out-patient basis, and where there is no on-call rota of junior colleagues, to be immediately available for an admission late in the week. In such cases we think it is reasonable to expect the hospital to keep adolescents over the weekend in order that psychiatric evaluation can take place early the following week. In some

†*Child Psychiatric Team.* Although in some cases, the child psychiatrist may work on his own, in others and especially in out-patient child psychiatric (child guidance) clinics, a child psychiatric team may be deployed. This will commonly consist of a consultant child psychiatrist, and possibly a senior registrar or registrar, together with other non-medical members such as a social worker, or less commonly a child psychotherapist. Such teams may work in different combinations depending both on availability and on the nature of the problem. The consultant child psychiatrist retains overall responsibility for the case.



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areas, it is unrealistic to expect rapid intervention by the child psychiatrist without additional resources being made available.

**Who should do the assessment?**

Recent work from a number of different centres concerning adults admitted to hospital with self-poisoning indicates that in certain circumstances these patients can be adequately assessed by professionals other than psychiatrists (Gardner *et al*, 1978; Hawton *et al*, 1979; Catalan *et al*, 1981; Newson-Smith and Hirsch, 1979). As Black and Pond (1980) point out, however, there must always be the back-up of a full and easily available psychiatric service for immediate consultation.

In recent studies Hawton *et al* (1982a; 1982b) also report their findings on a group of self-poisoning adolescents between 13 and 18 who were assessed by a member of a multidisciplinary clinical psychiatric service.

In the present state of knowledge, however, it is considered desirable that a child psychiatric team should be directly involved with children or younger adolescents and their families, and it is recommended that evaluative studies should be conducted within our own field in order to establish whether this recommendation is necessary.

How the team is deployed is a matter for the individual psychiatrist concerned who may decide to delegate to others while retaining overall responsibility.

The form and number of meetings between adolescent, parents and child psychiatric team will vary depending both on the complexity of the problem and the style in which the team works. Some psychiatrists require at least one interview with the child on her own, followed by an interview with the parents. Others will wish to see all family members together. We would stress that it is important for both parents or those legally responsible for the child to be involved. This is important in trying to understand the problem presented and in decisions about discharge, including any likelihood of a further attempt.

In most cases the child will return home after assessment. Follow-up, which may include active treatment, should always be offered, but where there is another agency such as the Social Services Department (SSD) already involved, the family may be followed up by their own area social worker. The child psychiatric team should be available for further consultation as required and the family doctor informed of the follow-up plan.

In some circumstances the adolescent may not be able to return home because the family is too disrupted. It will then become the responsibility of the SSD to provide alternative placement, the child psychiatric team being available for continuing consultation.

Exceptionally an adolescent will need in-patient psychiatric treatment. If a unit exists locally catering for the appropriate age range the child psychiatrist will be able to arrange this. If no such unit is available, then it will be necessary to negotiate for a bed in a unit which has a regional catchment area and this may cause delay. In such circumstances it should be possible for the child psychiatrist to negotiate for a longer stay in the ward presently occupied.

**Children under 12 years**

A small proportion of young people admitted to hospital in this way will be below the age of 12 years. It is difficult to assess the size of this group, but local research in Manchester and Salford (Erulkar and Kerfoot, 1981: personal communication) indicates that among the under sixteens admitted, about 6–8 per cent of this number will be under 12.

Although there is no watershed at the age of 12, there are a number of points which deserve special emphasis with regard to this younger age group:

1. On the basis of clinical experience it seems likely that the disturbances within the families of these children will be more serious than in the families of older children.
2. The younger child may have unrealistic or inconsistent notions about death and about the harmful physical effects which may result from parasuicide. These notions will need careful exploration if the behaviour is to be satisfactorily assessed and understood.
3. It follows from this that the task of interviewing a younger child needs to be undertaken with particular skill and patience. A child's capacity to understand questions and to give verbal explanations may be quite limited, and flexibility in choice of interview method will be necessary. In addition, younger children are likely to be more dependent upon their parents and may feel more potently the influence of parental attitudes, expectations, and conduct upon themselves. Clearly this will have some influence upon their responses in interview.
4. The needs of such younger children can usually best be met by admission to a paediatric ward, rather than to some other facility.

**Summary**

1. In order to provide an adequate service a child psychiatric team should be directly involved with all parasuicidal children and their families, and the team should be strengthened to facilitate this. The team should be available for consultation with ward staff during the assessment, and more widely available to other professionals at follow-up. Evaluative studies should be undertaken to monitor the effectiveness of such arrangements.
2. In some areas, it is unrealistic to expect rapid intervention by the child psychiatrist without additional resources being made available.
3. The family doctor occupies the centre of the health network of services and should be fully informed.
4. Hospital admission is desirable in most cases of parasuicide in children and adolescents.



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5. Young people up to 14 years of age should be admitted to a paediatric ward rather than to a general surgical or medical ward. Older children should ideally be admitted to an adolescent medical ward, if this is available.
6. Hospital staff are responsible for making contact with the parents or guardian of the young person in order to seek their participation in a psychiatric assessment, and for alerting the child psychiatric team.
7. The deployment of the child psychiatric team is a matter for the individual child psychiatrist concerned. Responsibility lies primarily with the psychiatrist who may decide to delegate that responsibility to others if he so wishes.
8. The child psychiatric team may offer follow-up directly, or be available for consultation to other professionals undertaking this. Where an adolescent is unable to return home because of a disrupted family situation, it will then be the responsibility of the Social Services Department to provide an alternative placement.
9 .If an adolescent is judged to be too psychiatrically disturbed to be discharged home, then in-patient treatment may be needed in a psychiatric unit catering for the appropriate age range.

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# *Spring Quarterly Meeting, 1982*

The Spring Quarterly Meeting was held at the Holiday Inn, Liverpool and the University of Liverpool on 20 and 21 April 1982 under the Presidency of Professor Kenneth Rawnsley.

## Scientific Meetings

***Tuesday 20 April***

*The Manchester Psychotherapy Project*

The conversational model—Dr R. F. Hobson

Clarification of this model—Prof D. P. Goldberg

Teaching this model to trainees—Dr F. Margison

Evaluation of the training—Dr G. P. Maguire

*The Role of Nurses in Liaison Psychiatry*

Management of patients who have attempted suicide—Dr K. Hawton

Monitoring of progress in mastectomy patients by specialist nurses—Dr G. P. Maguire

Training community nurses and health visitors to assess psychosocial adjustment in mastectomy patients—Mrs Ann Faulkner

Screening and counselling of medical in-patients for alcohol problems—Drs G. Lloyd, J. Chick and Ms E. Crombie

Psychosomatic disorders in children—Dr Phillip Pinkerton

**Wednesday 21 April: Morning Session A**

*Psychiatric Disorder in the Elderly*

Normal effects of ageing on language—Prof Denis Bromley

The relationship of level of activity to depression in a day centre for the elderly—Ms Ann Davies

A community survey of psychiatric illness in an elderly population in London—Prof J. R. M. Copeland

Normal polycythaemia in arteriosclerotic dementia—Dr R. M. Philpott

**Morning Session B**

*General Topics*

Growth hormone responses to apomorphine: Type 1



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