

Young people and self-harm; pathways in care

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Contents

	Page no.
List of tables and figures.....	3
Acknowledgements.....	4
Executive summary	5
1. Introduction	7
2. Methodology.....	7
2.1 Eligibility and recruitment	7
2.2 Data collection.....	8
2.3 Locality.....	8
3. Results.....	9
3.1 Description of the sample	9
3.2 Locality of residence	10
3.3 Socio-demographic characteristics.....	10
4. Presentation of deliberate self-harm.....	12
4.1 Index episode.....	12
4.2 General hospital management.....	13
5. Referral patterns.....	15
5.1 Lifetime referrals.....	15
5.2 Lifetime episodes of care	16
5.3 Contact	17
5.4 Outcomes	17
6. General practice	18
7. Conclusions and recommendations	20
References.....	23
Appendices	24
Appendix A Standard data collection tools.....	24
Appendix B Drug listings.....	27
Appendix C General practice appointments listings	28

Tables and figures

Table 3.1	Age and sex characteristics
Figure 3.1	Locality with average UPA score
Table 3.2	Primary carer
Table 3.3	Living situation
Table 3.4	Family situation
Table 3.5	Sexual harm
Table 3.6	Child protection
Table 3.7	Educational circumstances
Table 3.8	Suicidal behaviours
Figure 4.1	Flowchart - general hospital management and post-discharge care plan
Table 5.1	Location of case notes
Table 5.2	Lifetime referrals
Table 5.3	Lifetime multiple referrals
Table 5.4	Lifetime episodes of care
Table 5.5	Referrals
Table 5.6	Episodes of care
Table 5.7	Contact: Pre-index \leq 12 months
Table 5.8	Contact: Post-index \leq 12 months
Table 5.9	Outcomes
Table 6.1	General practice audit process
Table 6.2	GP appointments pre and post index

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Executive summary

This report sets out the key findings and recommendations of the Young People and Self-Harm Project, a multi-agency retrospective case study of an identified group of young people (< 16 years) who presented to the accident and emergency department following deliberate self-harm. The aim of the study was to provide an in-depth psychosocial profile of the group and to describe the pathways into and through care. Deliberate self-harm was defined as a non-fatal act in which an individual deliberately causes self-injury or ingests a substance more than the therapeutic dose.

Self-harm/suicidal behaviour is rare in younger children but the incidence increases dramatically from age 14 years. Despite the considerable public health problem of self-harm, little is known about the problem of self-harm in younger people. Although there are recommendations to the contrary, there is evidence that younger people are being discharged from the accident and emergency department without an appropriate specialist assessment.

The main aims of the research were to:-

- provide an in-depth psychosocial profile of an identified group of young people seen in the accident and emergency department following deliberate self-harm;
- identify and describe the pathways into and through care;
- identify service developments to improve outcomes for this vulnerable group.

The core elements of the research project were:-

- audit of presentations at the accident and emergency department by young people following self-harm over a 12 month period;
- a 12 month follow-up period at accident and emergency department to identify repeat admissions;
- a retrospective case note review of case notes for those identified from the Accident and emergency department of case notes held by Social Services (SSD), Child and Family Consultation Services (CFCS), Educational Psychology, The Listening Zone and General Practice (GP).

The main findings were:-

- sixty individuals (n=60) identified who met the selection criteria
- 87% female, 23% male; ratio 6.5:1
- age range 9-17 years; modal age 14 years
- 8% readmitted to A&E following self-harm within 12 months of index episode
- 35% recorded as having a history of self-harm
- 18% recorded as having 3 or more episodes of self-harm
- 28% recorded as living in lone parent households (n=54)
- 30% recorded as living under adverse conditions
- 13% recorded as having experienced an alleged sexual assault and/or sexual abuse
- Child Protection investigations undertaken in 15% of cases
- 12% of individuals excluded
- 18% of individuals had a statement of need issued
- 48% of individuals recorded as experiencing school/education related problems

- 90% of individuals presented following an overdose (the index episode)
- paracetamol was ingested in 61% of all overdoses

- 70% of individuals received a psychiatric assessment
- 67% of individuals were referred to CFCS/SSD following the index episode
- 30% did not receive a referral for specialist follow-up

It is recommended that action be taken to:-

- improve access to specialist assessment and follow-up care
- develop a case management strategy to facilitate co-ordination of services and improve access for those who self-harm and their families
- the development of an 'early years' initiative(s) to assist and support families in need to mitigate the negative impact on children's subsequent development

Pathways in Care 2000 – proposed project developments

- Multi-agency working party to develop a framework for assessment of young people seen in A&E following deliberate self-harm
- Shared access electronic register of young people who self-harm

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1. Introduction

Nationally and internationally, self-harm is recognised as a major public health problem.^{1,2,3} Interventions following deliberate self-harm focus primarily on those aged over 15 years, despite the considerable problem of deliberate self-harm (DSH) in younger persons and the opportunities that exist for intervention.² Of those aged over 15 years, up to 40% of the largest age group (16 to 24 years) have previously self-harmed, indicating a potential overlap in DSH between young adults and younger persons.

The epidemiology of suicide has identified deliberate self-harm as a inter-related phenomenon.⁴ While suicide in younger people is rare, rates start increasing sharply from the age of 14 years.⁵ Recently, suicide rates have been shown to have fallen for all age groups, except that for younger men aged 15 to 24 years which appears to be rising.⁶ It is this age group for both sexes that is the most predominant amongst presentations for self-harm, accounting for 30% of all presentations.

There is evidence to indicate that, contrary to recommendations, younger persons are being discharged from the Accident and emergency department without an appropriate assessment.^{7,8} Thus, a major concern is the standard of assessment and care provided to this vulnerable group.^{9,10}

Given the local and national concerns about the service provided to younger persons who self-harm, it was decided to investigate the frequency, the response to, and the pathways in care of young persons presenting to the accident and emergency department following deliberate self-harm.

This paper sets out the key findings and recommendations of the Young People and Self-Harm Project, a multi-agency retrospective case note review (n=60) undertaken to identify the pathways into and through care for an identified group of young people.

This work builds on a previously undertaken audit of self-harm presentations conducted at the two Accident and emergency departments serving the geographical area administered by Barking and Havering Health Authority (BHHA). The project is being funded by BHHA. The research work is being carried out by the Department of Primary Care, the Royal Free and University College London Medical School on behalf of BHHA.

2. Methodology

2.1 *Eligibility and recruitment*

All young persons up to age 16 years (and those aged 16 to 18 years who were in full-time secondary education) who presented to either Oldchurch or King George General Hospitals accident and emergency departments following deliberate self-harm were eligible. Subjects were identified from each department's admission records. This activity was carried out on a daily basis at both hospitals between 1 July 1996 and 30 June 1997. Follow-up at the accident and emergency departments was completed by July 1998.

From April 1999 to March 2000, a retrospective case note review was conducted on the group of patients previously identified. The participating services in the review included the Children and Families Consultation Services (CFCS), Social Services Departments (SSD), and Educational Psychology Services (EP) in both the London boroughs coterminous with the health authority and individuals' general practitioners. The Listening Zone, a counselling service serving the Barking locale, also participated. Each service's admission records were cross-matched with the list of subjects to identify where case notes existed. General practitioners were contacted directly about individuals in their practice.

Following Kreitman,¹¹ deliberate self-harm was defined as 'a non-fatal act in which an individual deliberately causes self-injury or ingests a substance in excess of the therapeutic dose'. The original audit in accident and emergency was conducted as part of a wider audit of self-harm.¹² Amongst adults, overdose (intentional or otherwise) is a common sequel of recreational and problematic drug or alcohol use. As dedicated services for adults with drug and alcohol problems are well established locally, such presentations were excluded. In order to allow comparisons between the different age groups, such presentations were also excluded from the younger group. It is recognised that this will have resulted in an under-estimation of the incidence of self-harm generally, but especially amongst younger persons. It is also recognised that drug and alcohol use and abuse by younger people needs to be differentiated from that in adults and that comparable specialist services in this area do not exist for younger persons.

2.2 Data collection

Two standardised data collection tools were designed and completed for each identified case by the researchers (Appendix A). The first, for use in A&E, recorded personal details and history, social and demographic data, details of the presentation as well as details of the post-discharge care plan. The main source for this information was the accident and emergency records. Data was also collected from the medical case notes for those admitted to a ward from accident and emergency. This process was repeated in all instances of subsequent readmission during the twelve months follow-up period in A&E after the index episode.

The second data collection tool was designed for use in the review and was completed in respect of all individuals where case notes were accessed.* For individuals with case notes in more than one service then a corresponding number of these second forms were completed.

The case notes accessed were reviewed in their entirety. In addition to recording socio-demographic data, details were also recorded of the number of referrals, discrete episodes, presenting problems, diagnostic categories, type and frequency of contact, treatments/work undertaken and the outcomes of such treatments/work.

2.3 Locality

Postal codes were used to identify an individual's locality of residence. This facilitated the examination of rates of self-harm in the different localities and the

* Case notes (n=46) refers to files identified at Child & Family Consultation Services, Social Services and Educational Psychology Services and which were reviewed in this study.

correlation of these with the average Jarman scores, as a measure of social deprivation, for each locality. The Jarman or underprivileged area score is a social deprivation index based on a combination of several socio-economic indicators. The national average is indicated by a score of zero with positive scores indicating increasing levels of socio-economic deprivation.¹³ Localities are defined areas within the health authority's boundaries; the social and demographic characteristics of which are used to plan services at a local level. Localities are also grouped into two larger areas coterminous with the local authority boundaries. Thus, the London Borough of Barking & Dagenham (LBBD) administers localities 5, 6 and 7. The London Borough of Havering (LBH) administers the remaining localities.

The population figures used to calculate the DSH rates were derived from the London Research Centre's projected figures for 1997 which are given in four year age bands, e.g. 10 to 14 years and 15 to 19 years. Hence, the age range adopted was 10 to 19 years as this range most closely fitted the age of those identified in this study. In order to approximate realistic rates, the total number of individuals aged 10 to 19 years identified over the period surveyed was an aggregate figure compiled from this study and from a second study focusing on 'adults'. This provided information about all individuals over 16 years regardless of whether they were in full-time education. In all other respects the same eligibility criteria applied in both studies.

3. Results

3.1 *Description of the sample*

Sixty young people who satisfied the inclusion criteria were identified and all (100%) were included in the analysis. Of these, 52 individuals (87%) were identified at Oldchurch Hospital, the main provider of general hospital services to the population served by BHHA, and eight at King George Hospital. Their ages ranged from nine to 17 years (Table 1). Five young people, all female, were subsequently recorded as having re-presented at accident and emergency following self-harm within the twelve-month period since the index episode for which they were originally identified for inclusion in this study. One girl had four subsequent admissions.

Table 1 Age and sex characteristics (n=60)

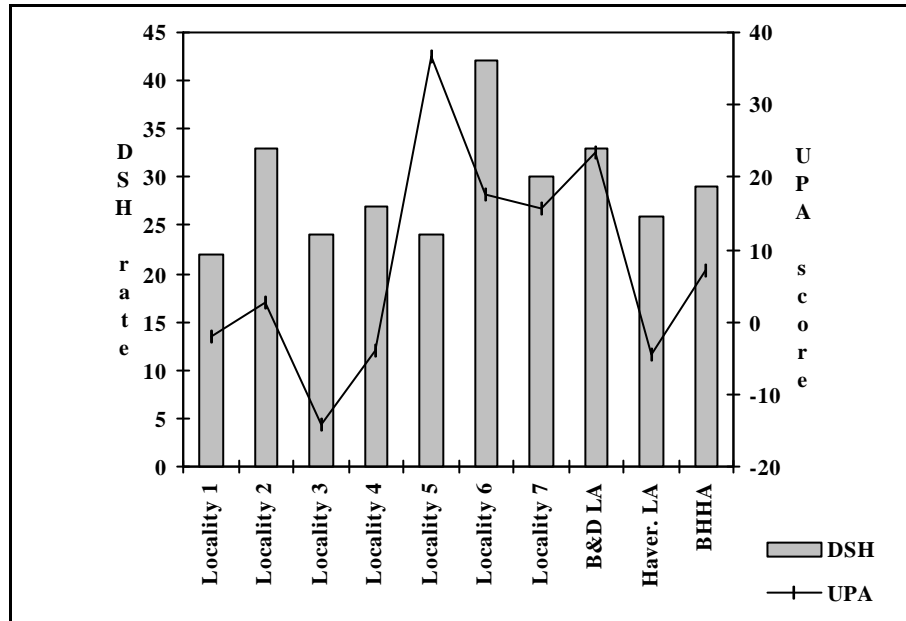
Age	Female	Male
9		1
12	1	
13	10	
14	18	2
15	14	3
16	8	2
17	1	
Total	52	8

The mean age was 14.4 years while the median and modal age was 14 years (standard deviation 1.3). The identified group was predominately female: almost 87% - a ratio of 6.5:1 female to male.

3.2 Locality of residence

Twenty-three young people were resident in LBBB and 37 in LBH. Figure 1 displays the respective rates by locality overlaid with the average Jarman (UPA) score for each locality.

Figure 1 Locality with average UPA Score. DSH rate per 100 000 age standardised (n=116)



In the study group the highest rates observed are in locality 6 in LBBB and locality 2 in LBH. Locality 2 has the highest suicide rate in Havering, higher levels of psychiatric morbidity and the highest accident rate for those 15 to 24 year olds in BHHA. Locality 6 has above average suicide and parasuicide rates.

However, the suicide rates in both localities are lower than locality 5 which has the highest average underprivileged area score as well as the highest levels of young adults (15 to 24 years).¹⁴ It is possible that the self-harm rate identified here for locality 5 is an under-estimate as some cases of self-harm may have attended Newham General Hospital, which borders this area. Overall, higher rates were detected in LBBB.

3.3 Socio-demographic characteristics

Tables 2 to 8 below display a range of important socio-demographic characteristics.

Table 2 Primary Carer

	n
Mother	16
Father	2
Both parents	37
Grandparents	1
Foster parents	1
Primary carer not known	3
Total	60

Both parents were given as the primary carer in the largest proportion of cases (37 or 65% of cases where circumstances were known). For 16 individuals (28%), the mother was given as the primary carer.

Table 3 Living situation

	n
Lone parent	15
Birth parents	28
Parent and step-parent	8
Grandparents	1
Foster parents	1
Hostel	1
Living situation not known	6
Total	60

The living situation for the majority of individuals reflected that inferred by who the primary carer was with 28 individuals recorded as living with their birth parents, 8 with a parent and step-parent and 15 with a lone parent.

Table 4 Family situation

	n
Parent/child relationship conflicted and/or abusive	10
Parental relationship conflicted and/or abusive	6
Domestic violence	5
Parental ill-health	8
Total	19*

*The column figures exceed the total as a number of individuals featured in more than one category.

Nineteen young people experienced adverse or stressful conditions at home ranging from chronic family ill health through to witnessing domestic violence. The majority of problems identified at home centred on discordant or dysfunctional relationships.

Table 5 Sexual harm

	n
Incest	2
Sexual assault	6
Total (individuals)	8

Six young people were recorded as having suffered an alleged sexual assault. In two additional cases, the young person was the victim of alleged sexual abuse by a member of the family.

Table 6 Child protection

	n
CP Concerns	9
CP Register	3
Total (individuals)	9

Child protection concerns were actively raised in nine cases, three of which were subsequently registered on the Child Protection Register. Two of the nine cases were accommodated by the relevant social services department. A total of six young people from the study group were accommodated by social services.

Table 7 Education circumstances

	n
Statement	11
Excluded	7
Truant	3
Refusal	2
Learning difficulties	5
Bullied	10
Other school problems	14
Total (individuals)	29*

*The column figures exceed the total as a number of individuals featured in more than one category

A number of educational problems were recorded ranging from difficulties with a particular teacher through to permanent exclusion. Overall, twenty-nine individuals (48%) were described as experiencing problems at school.

Table 8 Suicidal behaviours

	n
All previous self-harm	21
Readmission to A&E within 12 months post index	5
All post index self-harm	15
Parent suicide	3
Total (individuals)	27*

*The column figures exceed the total as a number of individuals featured in more than one category

A history of self-harm, i.e. incidents occurring before the index episode, for which the individual was entered into the study, was recorded in 21 cases (35%). Five individuals were readmitted to A&E following further self-harm in the 12 months after the index episode. At the time of writing, i.e. between 48 and 36 months after the index episode, fifteen individuals (25%) were recorded as having further episode(s) of self-harm. Eleven young people (18%) had episodes of self-harm before and after the index episode. In three cases, a parent was known to have committed suicide.

4. Presentation of deliberate self-harm

4.1 Index episode

Of the 60 young people in this study, 54 (90%) presented having taken an overdose. All of these, except one case, involved an overdose of medication. The number of overdoses includes one person who had also cut herself. Paracetamol was the most common agent ingested and was taken by 33 individuals (61% of all overdoses). There were a further five cases of self-laceration (8% of all presentations). One

individual (2%) had been taken to A&E by his parent following a number of incidents including running into traffic and trying to strangle himself. Alcohol was recorded as being recently ingested in relation to the self-harm presentation in nine cases. There was no record of illicit drugs having been taken

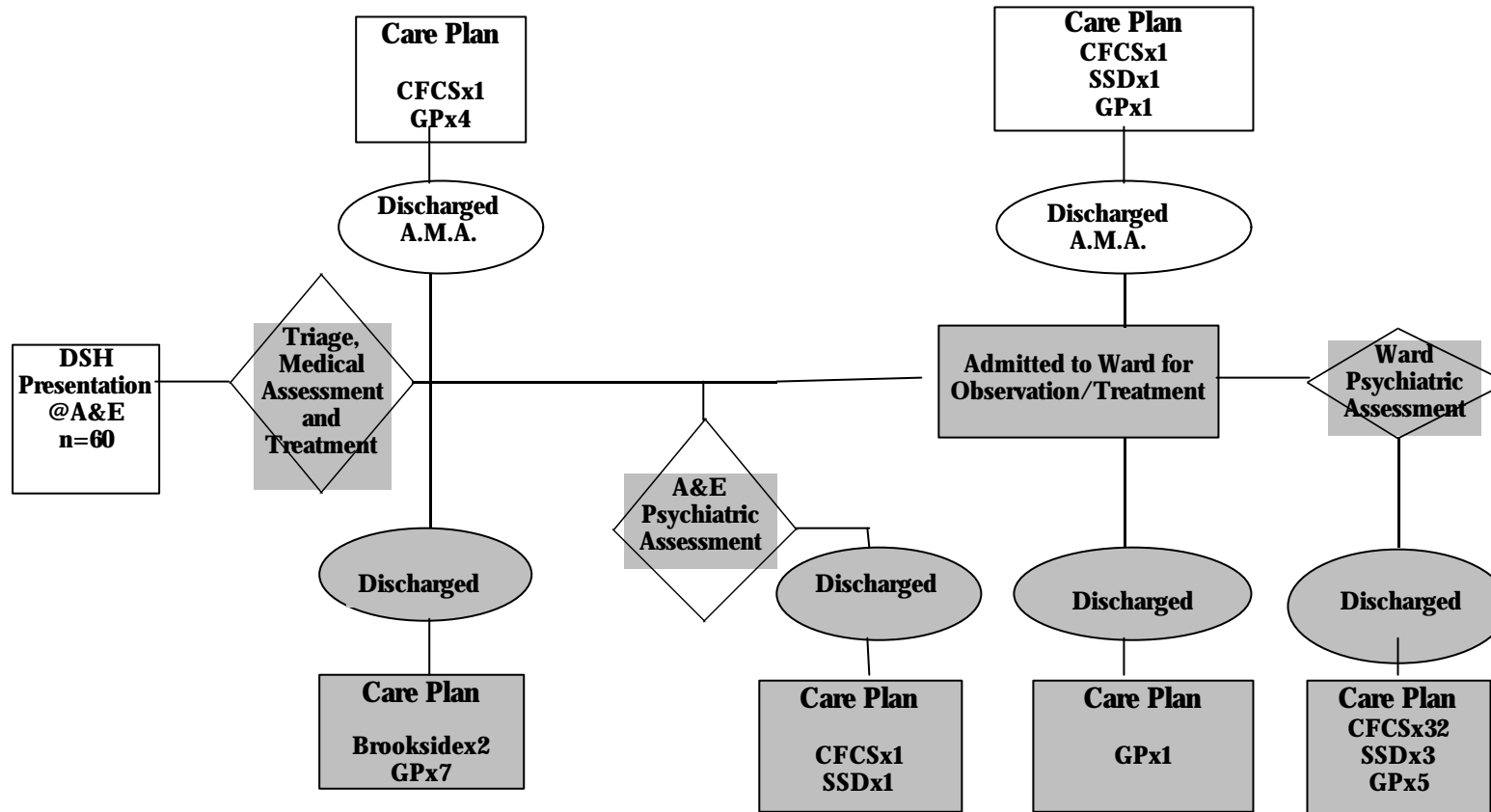
4.2 General hospital management

The general hospital management of all patients in the study group is presented schematically in Figure 2.

Forty-four young people (73%) were subsequently admitted to a medical ward for further observation and/or treatment. Forty-three individuals (72%) received a psychiatric assessment. The majority (n=40) received a psychiatric assessment after being admitted to a ward. Of those cases where the time of arrival and departure was known (n=59), 44 individuals (75%) stayed less than 24 hours in hospital. Ten individuals (17%) stayed between 24 and 48 hours. The remaining five individuals remained in hospital for between four and seven days.

Details of the post-discharge care plans were recorded in all cases (100%). Forty-two young people (70%) received a secondary referral to either the local SSD or the local CFCS. (This includes two individuals who were already in the care of Brookside Adolescent Unit and who returned to the Unit). The greater proportion of secondary referrals (35 or 58%) was to the CFCS. A considerable proportion (18 or 30%) was discharged with no apparent specialised follow-up care. This group was considered as having been, in effect, 'referred' back to their general practitioner.

Figure 2 General hospital management and post-discharge care plan



Key:
 A&E - Accident & Emergency Department
 DSH - Deliberate Self-harm
 A.M.A. - Against Medical Advice
 CFCS - Child & Family Consultation Service
 SSD - Social Services Department

Summary Points:
 Discharged A.M.A. n=8
 Admitted to Ward n=44
 Psychiatric Assessment n=43
 Secondary Referral n= 42

5. Referral patterns

5.1 *Lifetime referrals*

Of the 60 individuals in the original study group, case notes were located for 46 individuals (77% of the study group) across the participating secondary services, i.e. the two SSDs, both CFCSs, both EPs and The Listening Zone. (The results from the audit of general practice records are reported separately – see section 6). Table 9 displays the location of identified case notes and the number of case notes by the participating service in each local authority.

Table 9 Location of case notes

Service	LBBD	LBH	Total
Children and families (CFCS)	18	26	44
Social services (SSD)	11	8	19
Educational psychology (EP)	3	3	6
The Listening Zone (TLZ)	1	-	1
All services	33	37	70

Table 10 Lifetime referrals

Service	Individuals referred	Number of times referred
Children and families	44	68
Social services	19	93
Educational psychology	6	8
The Listening Zone	1	1
All services	46*	170

*The first column figures exceed the total as a number of individuals had referrals to more than one service.

Forty-six individuals were referred on 170 different occasions to one or more services. Almost all referred individuals (44 or 96%) were referred at some point to the CFCS. However, the 19 individuals referred to SSD (41% of all those referred) accounted for 55% of recorded referral activity. It is evident from Tables 9 and 10 that a large proportion of individuals had referrals to more than one service and this is examined next.

Table 11 Lifetime multiple referrals

Service	Individuals referred	Number of times referred
Children and families only	24	31
Social services only	1	1
CFCS and SSD	14	99
CFCS and EP	2	9
CFCS, SSD and EP	4	29
The Listening Zone only	1	1
All services	46	170

The CFCS was the single most common referral destination, with 24 young people being referred on 31 occasions. Fourteen individuals (30% of those referred) were referred to both CFCS and SSD at some point. A small number of individuals (4 or 9%) were referred to three different services over time, i.e. CFCS, SSD and EP.

5.2 *Lifetime episodes of care*

Quantifying referrals received by a service gives only a partial impression of activity. In order to provide a more comprehensive picture of activity it is necessary to differentiate discrete episodes of care from the mass of referrals (Table 12).

Table 12 Lifetime episodes of care

Service	Individuals Referred	Number of Episodes
Children and families	44	62
Social services	19	60
Educational psychology	6	7
The Listening Zone	1	1
All services	46*	130

*The first column figures exceed the total as a number of individuals had referrals to more than one service.

Overall, 76% of referrals resulted in a discrete episode of care. Although the SSD exhibited the biggest difference between initial referrals and subsequent episodes of care (-35%), it can be seen from Table 12 that referrals to the SSD still account for over half of all discrete episodes of care.

A particular focus of the project was the activity occurring in the 12 months immediately before and after the index episode of self-harm, i.e. that for which the individual was entered into the study (Tables 13 and 14).

Table 13 Referrals

Service	Pre-index \leq 12 months		Post-index \leq 12 months	
	Individuals Referred	Referrals	Individuals Referred	Referrals
Children and families	11	11	33	37
Social services	7	22	13	24
The Listening Zone	-	-	1	1
All services	17*	33	39*	62

*The column figures exceed the totals as a number of individuals had referrals to multiple services.

Seventeen individuals (28% of the study group) had 33 referrals in the 12 months preceding the index episode (one individual was referred to both the SSD and the CFCS). In the twelve months following the index episode, 39 individuals (65%) had 62 referrals (eight individuals were referred to both the SSD and the CFCS). In the period following the index episode, thirty individuals, half the study group, were referred as a result of the index episode.

Table 14 Episodes of care

Service	Pre-index \leq 12 months		Post-index \leq 12 months	
	Individuals Referred	Episodes	Individuals Referred	Episodes
Children and families	10	10	33	36
Social services	6	7	11	13
Educational psychology	-	-	-	-
The Listening Zone	-	-	1	1
All services	16	17	38*	50

*The column figures exceed the total as a number of individuals had referrals to multiple services.

With respect to completed episodes of care, sixteen individuals had 17 discrete episodes of care in the 12 months preceding the index episode. Following the index episode, 38 individuals had 50 completed episodes of care. All 30 referrals that were a response to the index episode of DSH progressed to completed episodes of care.

5.3 **Contact**

The case note study afforded the opportunity to describe and quantify the types of contacts the different services had with individuals and their families (Tables 15 and 16). Three categories are described: telephone conversations, communications by letter and face-to-face meetings with individuals and/or their families. The contacts quantified here are in respect of those referrals originating in the 12 months before the index or the 12 months after.

Table 15 Contact: pre-index \leq 12 months

Type of Contact	SSD		CFCS	
	Individuals	Contacts	Individuals	Contacts
Telephone calls	5	50	4	4
Letters	5	34	7	26
Face-to-face	6	29	8	30
Totals	7*	113	11*	60

*The column figures exceed the totals as a number of individuals had multiple contacts.

In the 12 months preceding the index episode, the seven individuals with referrals originating from then had 113 contacts with the SSD. During the same period, the 11 individuals referred to the CFCS had 60 contacts. One individual referred during this period was in contact with both services.

Table 16 Contact: Post-index \leq 12 months

Type of Contact	SSD		CFCS	
	Individuals	Contacts	Individuals	Contacts
Telephone calls	10	79	15	33
Letters	8	29	25	70
Face-to-face	11	109	29	101
Totals	13*	217	33*	204

*The column figures exceed the totals as a number of individuals had multiple contacts.

Following the index episode, 13 individuals with a referral beginning in this period had 217 contacts with the SSD. The 33 young people referred to the CFCS had 251 contacts with the CFCS. Eight individuals had contact with both agencies during this period.

5.4 **Outcomes**

To complete the examination of referral patterns, the outcomes of those referrals are considered next (Table 17). Outcomes were classified according to one of five categories:

- **no further action** – when the service concerned deemed that further intervention was not appropriate for whatever reason
- **withdrew** – when the individual (or her/his family) withdrew from the service

- **did not attend** – when the individual was sent an appointment(s) but never attended the service (excluding the initial hospital-based assessments carried out by the CFCS in respect of the index episode)
- **active** - the case was still active at the time.
- **not known** – when the outcome could not be determined for whatever reason.

Table 17 Outcomes

Outcomes	Pre-index ≤ 12 months		Post-index ≤ 12 months		
	SSD	CFCS	SSD	CFCS	TZ
No further action	4	4	10	12	
Withdrawn		4		12	1
Did not attend		2		8	
Active	3		3		
Not known		1		1	
Total (individuals)	7	11	13	33	1

Although some individuals had multiple referrals in a given period, only the outcome for the last referral in that period is noted here. Of seventeen individuals referred in the 12 months preceding the index episode, eight referrals were recorded as no further action, four individuals withdrew from the service, three cases were still active, two did not attend and the outcome was not known in one case. Following the index episode, of 38 individuals referred, 22 were recorded as no further action, 13 withdrew, eight did not attend, three were still active and in one case the outcome remained not known.

6. General practice

The general practices were identified from hospital or health authority records. Unlike the other agencies/services where gaining access to field requires negotiation with one or two senior managers, accessing the general practice field entails liaising with each individual practice. Following an initial letter to all identified practices outlining the project protocols and requesting access to an individual(s) records, a follow-up phone call was made to the surgery to negotiate access to the records. In some cases this sufficed but for the remainder, a second letter was required as were additional copies of the letter in the mail-shots, numerous telephone calls and faxes. Table 18 summarises the process.

Table 18 General practice audit process

	n
No. of files audited	33 (55%)
Moved/No trace	19 (32%)
GP declined/timed out	8 (13%)
Letters/Faxes	104
Telephone calls	250

A total of 33 general practice medical records (55% of the study group) were audited. In nineteen cases, the individual had changed address and either we were unable to trace their new local address or they had moved out of district. Eight GPs declined to allow access to the records for a variety of reasons. A few GPs felt that

the individual concerned should give their permission for their medical records to be accessed.

As with case files located in other services/agencies, of particular interest was the level of activity or contact in the 12 months pre and post the index episode of self-harm. Table 19 displays details of the appointments between the individual patients and their GP.

Table 19 GP Appointments pre and post index

	Pre-index \leq 12 months		Post-index \leq 12 months	
	GP Appointments	Individuals (n)	GP Appointments	Individuals (n)
	1	6	1	7
	2	7	2	6
	3	3	3	4
	4	5	4	4
	5	1	5	4
	6	2	7	2
	7	3	9	1
Totals	87	27	90	28

In the 12 months before the index episode, 27 individuals had 87 appointments. The number of appointments ranged from 1 to 7, the mean number of appointments was 3 and the median number 3.2 (standard deviation 2.3). Post the index episode, a similar pattern is evident. Twenty-eight individuals had 90 appointments. A similar range is observed, 1 to 9, and the mean and median were both 3 (standard deviation 2.1).

For 24 individuals, it was possible to determine the dates of their last appointment before the index episode. The mean time lapse between the last appointment and the index episode was 16 weeks and the median time lapse was 14 weeks (standard deviation 9.2). The range was 1 to 30 weeks. In 25 cases, it was possible to determine the dates of their first appointment following the index episode. The mean time lapse between the index episode and the first GP appointment was 14.2 weeks and the median was nine weeks (standard deviation 12.6). The range was 1 to 47 weeks.

In 27 of the 33 cases (81%) for whom GP records were audited, notification of the index episode from the admitting hospital was filed in the general practice medical records. Twenty-five of the 33 individuals had received a psychiatric assessment following the index episode and details of this were filed in the medical records in 19 cases (76%).

The subject matter of the consultation, i.e. the reasons for or outcomes of an appointment, were collected in 26 cases in respect of appointments in the twelve months before the index episode and in 28 cases following the index episode. The main reason for not collecting this data was the illegibility of the GPs' handwriting. In two cases, there was insufficient time provided at the surgery to detail specific appointments.

Four individuals had appointments before the index episode, where aspects of their mental health state were recorded by the general practitioner. Twelve individuals

had appointments following the index episode where aspects of their mental health state featured. However, there was no recorded evidence of a mental state examination per se.

The most common single subject recorded in respect of consulting a general practitioner in the 12 months before the index episode was abdominal pain (nine occasions/four cases), followed by ear problems (seven occasions/five cases) and infections (five occasions/four cases). In the 12 months after the index episode, the most common single subject recorded was 'did not attend' (eight occasions/seven cases), followed by pregnancy testing/results (seven occasions/three cases) and eye problems (six occasions/five cases). A full listing of appointments in both alphabetical order and descending frequency is given in Appendix C.

7. Conclusions and recommendations

This report sets out the key findings and recommendations of the Young People and Self-Harm Project, a multi-agency retrospective case study of an identified group of young people who presented to the accident and emergency department following deliberate self-harm. The aim of the study was to provide an in-depth psychosocial profile of the group and to describe the pathways into and through care.

7.1 Main findings

- Overall DSH rate 29 per 100 000 (ages 10-19)
- Highest rates found in Localities 2 and 7
- Female to male ratio 6.5:1
- age range 9 to 17 years; modal age 14 years

Conclusions and recommendations

The age and gender characteristics of the study group reflect that reported nationally.² From the age of 14 years, the incidence of self-harming behaviour increases dramatically in the general population.⁵

7.2 Domestic situation

- Both parents recorded as the primary carer(s) in 65% of cases
- 28% recorded as living in lone parent household
- 32% recorded as living under stressful conditions

Conclusions and recommendations

Of all dependent children in the UK, approximately 82% live with two parents and 19% live with a lone parent (Source: OPCS GHS 21).⁵ It would appear that in the study group, a greater proportion live in a lone parent family than do so in the general population.

7.3 Self-harm and suicide

- 35% have a recorded incidence of self-harm prior to the index episode
- 25% have a recorded incidence of self-harm following the index
- 18% have a recorded history of self-harm pre- and post- the index episode
- 5% have lost a parent through suicide

Conclusions and recommendations

- A history of self-harm is generally poorly recorded
- A number of individuals (18%) have extensive self-harming behaviour consistent with a maladaptive behaviour pattern rather than a singular maladaptive response to a crisis which may require a more specialised treatment response

7.4 Child protection issues

- 13% of individuals were reported as having experienced a sexual assault and/or abuse.
- Child protection actions were commenced in 15% of cases.

7.5 Education circumstances

- A statement of need was issued for 18% of individuals
- 12% of individuals were excluded
- 48% of cases experienced school/education-related problems

7.6 Index episode

- The prevalence of paracetamol poisoning is a continuing cause for concern
- 70% of individuals received a specialist psychiatric assessment
- 70% received a referral to CFCS/SSD
- 30% did not receive a referral for specialised follow-up

Conclusions and recommendations

The single most powerful determinant of who received a secondary referral and who was effectively referred back to their General Practitioner appears to be receipt of a psychiatric assessment ($x^2 = 28.7$, $p < 0.001$). In turn, receipt of a psychiatric assessment was, not surprisingly, highly dependent on whether or not an individual was discharged against medical advice ($x^2 = 13.3$, $p < 0.01$).

There is scope to improve access to a specialised assessment. Given the limitations of current psychiatric provision this will require that other appropriately trained staff undertake specialist assessments

7.7 General practice

- 33 out of 60 (55%) general practice medical records were audited
- 27 individuals had 87 appointments in the 12 months before the index episode
- 28 individuals had 90 appointments in the 12 months following the index episode
- 5 individuals had appointments before the index episode where mental health factors were featured
- 11 individuals had appointments following the index episode where mental health factors were featured

Conclusions and recommendations

- Potentially important public health findings could have been produced by an efficient collaboration with general practitioners
- Low level of recording of mental health state factors
- General practitioners need to be informed about DSH and mental health needs recognised elsewhere, within the context of many years of seeing young people and their families (median 14 years' history for these children)

7.8 Pathways in care

- Referral patterns indicate a considerable overlap between health, welfare and educational issues
- Approximately one third of individuals did not attend or withdrew from CFCS/SSD, as measured for referrals originating prior to the index episode
- Over half did not attend or withdrew, as measured for referrals originating post the index episode

Conclusions and recommendations

- The interplay of health, welfare and educational issues needs to be addressed in planning services for this group
- Given the proportions not attending or withdrawing, consideration needs to be given to developing more accessible and flexible responses
- Complex problems require complex solutions – no single initiative is likely to be sufficient
- Specialist case manager(s) could provide both assessment and oversee secondary referrals maintaining contact with clients, their families and services
- The need for flexible family support is indicated with foci to include parenting skills and conflict resolution as well as more traditional therapeutic interventions

7.9 Project developments – Pathways in Care 2000

The findings from the Pathways in Care Project have led to a number of new initiatives.

- (i) A multi-agency working party has been formed to formulate revised protocols governing the assessment and management of younger people admitted to the accident and emergency department following deliberate self-harm. The implementation of the new framework for assessment will be evaluated and also its impact on a sample of young people presenting to accident and emergency following self-harm.
- (ii) An electronic register of young people who self-harm (ERSHA), is also under development. The ERSHA project will pilot a shared-access computerised register. The aims are to facilitate joint working between health and social services, to improve the quality and effectiveness of assessment and care services to this group of vulnerable young people.

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Appendix A

Young People and Self-Harm: Accident & Emergency Department Audit

Record No	Sub-group	Week No	Date
¹ Identifier:		² A & E Number:	
		District / Other Number:	
		³ Date of Arrival {mm/dd/yy}:	
⁵ Last Name:		¹⁰ Title:	
⁶ First Name:		¹¹ Age:	
		¹⁴ G.P.'s Name: DR	
⁷ Address:		¹² D.o.B. {mm/dd/yy}:	
⁸ Tel. No.:		¹³ Sex: 1.Female [] 2.Male []	
⁹ Postcode:		¹⁶ Religion: Code []	
		¹⁷ Ethnic: Code []	
¹⁸ Social, e.g. 'homeless', 'in care of Social Services'. {Where applicable, give number of children}: Code []		¹⁹ Employment: 1. Employed [] 2. Unemployed [] 3. Home Care [] 4. Student [] 5. Retired/Pensioner [] 6. Other [] 99. Not Known []	
		²⁰ Civil Status: 1. Married/Co-Hab. [] 2. Separated [] 3. Divorced [] 4. Widowed [] 5. Single [] 99. Not Known []	
²¹ Mode of Arrival: 1. Ambulance [] 2. Private Transport [] 3. Public Transport [] 4. Other {please specify} []: 99. Not Known []		²³ If transferred, Date: Where:	
²² Presentation {e.g., Overdose - x20 Paracetamol Tablets taken with alcohol}: A&E Cat. No. Code []			
²⁴ Alcohol: 1. Yes [] 2. No [] 99. Not Known []		²⁸ Suicidal Intent determined: 1. Yes [] 2. No [] 99. Not Known []	
²⁵ Illicit Drugs: 1. Yes [] 2. No [] 99. Not known []		²⁹ Considered Suicidal: 1. Yes [] 2. No [] 99. Not Known []	
²⁶ Known Alcohol Problems: 1. Yes [] 2. No [] 99. Not Known []			
²⁷ Known Drug Problems: 1. Yes [] 2. No [] 99. Not Known []			
³⁰ Previous Self-Harm: 1. Yes-Undetermined Time [] 2. Yes-Less than 1 year [] 3. Yes-More than 1 year [] 4. No [] 5. Other [] 99. Not Known [] Details: Code []			
³¹ Mental State Exam: 1. Yes [] 2. No [] 99. Not Known [] Details: Code []			
³² Medical History: 1. Yes [] 2. No [] 99. Not Known [] Details: Code []			
³³ Psychiatric Assessment: 1. Yes [] 2. No [] 99. Not Known [] Details: Code []			
³⁴ Admitted to {give name of ward/unit}: <u>Include Any Remarks</u> 1. A&E Observation [] 2. Medical Ward []..... 3. Surgical Ward []..... 4: Other (specify) [].....		³⁸ Careplan: 1. OP Adult Psychiatry [] 2. OP Crisis Team [] 3. Child & Family Services [] 4. In-patient Psychiatric Hospital [] 5. Community Psychiatric Nurse [] 6. General Practitioner [] 7. Police [] 8. Self-discharge [] 9. Social Services [] 10. Other (specify) [] 99. Not Known []	
³⁵ Date of Discharge from General Hospital: { ³⁶ Time - if discharged from A&E (24 Hours): }			
³⁷ Length of Stay in General Hospital:			

Young People and Self-Harm: Accident & Emergency Department Audit

Case I D	Agency ref	Current status	Date
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Last Name:	First Name:	Age:	G.P.: Dr
Address:		D.o.B.:	G.P. Address:
Postcode:		Sex: 1. Female <input type="checkbox"/> 2. Male <input type="checkbox"/>	Religion: Ethnic:
Name & Address of Mainstream School:		Statement: 0.No <input type="checkbox"/> 1.Yes <input type="checkbox"/> 99.Not known <input type="checkbox"/> <i>Details:</i>	
Excluded: 0.No <input type="checkbox"/> 1.Yes <input type="checkbox"/> 99. Not known <input type="checkbox"/> <i>Details:</i>		Individual Education Plan: 0.No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 99. Not known <input type="checkbox"/> <i>Details:</i>	
Date of Index Self-harm:		Date of Initial Referral to Agency (recd): 1 ST REFERRAL:	
Nature of Index Self-harm:		Referrer: 1 ST REFERRAL:	
		Reason: 1 ST REFERRAL:	
		Dates of First/Last Contact: 1 ST REFERRAL:	
		Reason for Closure: 1 ST REFERRAL:	
Family/Social history (include ages/D.o.B.s):			
Primary Carer(s):		Siblings:	
Subject's position in family:			
History of Self-Harm {re index}: 0. No <input type="checkbox"/> 1.Yes-Undetermined Time <input type="checkbox"/> 2.Yes-Less than 1 year <input type="checkbox"/> 3.Yes-More than 1 year <input type="checkbox"/> 4.Other <input type="checkbox"/> 99.Not known <input type="checkbox"/> <i>Details:</i>			
Psychiatric Assessment i.r.o. index: 0.No <input type="checkbox"/> 1.Yes <input type="checkbox"/> 99.Not known <input type="checkbox"/> <i>Details:</i>			
Psychiatric Assessment i.r.o. other: 0.No <input type="checkbox"/> 1.Yes <input type="checkbox"/> 99.Not known <input type="checkbox"/> <i>Details:</i>			
Medical History: 0.No <input type="checkbox"/> 1.Yes <input type="checkbox"/> 99.Not Known <input type="checkbox"/> <i>Details:</i>			
Developmental History: 0.No <input type="checkbox"/> 1.Yes <input type="checkbox"/> 99.Not Known <input type="checkbox"/> <i>Details:</i>			

Family Medical/Psychiatric/Developmental History: 0.No [] 1.Yes [] 99.Not known [] Details:									
Circumstances surrounding subsequent referrals (I.e. date referred/referrer/reason/dates first & last contact/closure details):									
Episodes (count number of discrete episodes):									
Out of Borough Placement(s): 0. No [] 1. Yes [] 99. Not known [] Details:									
Careplan(s)/Outcome(s)/End of Episode date(s):									
Number of Contacts by type Pre-Index Episode. Note: dash indicates 12 month point									
Agency & Subject:	Tcall	Letter/Fax	Face	Other	Agency & Agency:	Tcall	Letter/Fax	Face	Other
---	---	---	---	---	---	---	---	---	---
Number of Contacts by type Post-Index Episode. Note: dash indicates 12 month point									
Agency & Subject:	Tcall	Letter/Fax	Face	Other	Agency & Agency:	Tcall	Letter/Fax	Face	Other
---	---	---	---	---	---	---	---	---	---
Liaison Activity (list all agencies/services recorded):									
Liaison Contacts by type:									
Work/Interventions undertaken with outcomes:									
Treatments undertaken with outcomes:									
Any Person with whom contact Restricted: 0.No [] 1.Yes [] 99.Not known [] Details:									
Child Protection Concerns: 0.No [] 1.Yes [] 99.Not known [] Details:									
Any Additional Comments:									

Appendix B**Drug listings**

Alcohol	6
Analgesia	
Paracetamol	29
Junior paracetamol	1
Calpol (liquid paracetamol for infants/children)	1
Panadol (paracetamol)	1
Hedex (paracetamol)	2
Cocodamol (paracetamol & codeine phosphate)	2
Coproxamol (paracetamol & dextropropoxyphene hydrochloride)	6
Aspirin	3
Anadin (aspirin & quinine)	4
Musculoskeletal & Joint Diseases	
Nurofen (brufen)	1
Central Nervous System	
Manerix (meclobemide - an antidepressant)	1
Zimovane (an hypnotic/anxiolytic)	1
Gastro-Intestinal System	
Bisodol	1
Gaviscon	1
Alverine	1
Infections	
Amoxycillin	3
Respiratory System	
Nyctol	1
Skin	
Unknown tablet preparation for acne	1
Antihistamine	
Piriton	1
Other	
Unknown tablet preparation for treating worms in dogs	1
Total (excluding alcohol)	62

Appendix C

General Practice Appointments: Alphabetical Order

Subject of Consultation	Pre-Index	Post-Index
Abdominal pain	9	1
Acne	2	1
Allergy	1	-
Assaulted	1	-
Ankle	-	1
Back pain	2	1
BCG injection	1	1
Breathing	2	1
Cancelled	4	4
Child Guidance	1	1
Cold Sores	1	-
Contraception	1	2
Corns	1	-
Cough	2	1
Cut Finger	-	1
Depression	3	4
Did not attend	2	8
Dysuria	1	1
Ear	7	5
Eczema	1	-
Epigastric Pain	1	-
Eye problems	2	6
Excessive sweating	-	1
Gynaecological	1	-
Hayfever	1	-
Head Lice	1	1
Headache	4	-
Hip	-	4
Index Episode Reported	-	3
Index Episode aftercare	-	2
Infection	5	2
Influenza	-	1
Insect bite	1	-
Knee	3	1
Letter for school	-	1
LFT results	-	1
Lump - breast	-	1
Lump - not specified	-	1
Lump right foot	1	-
Maxillary pain	-	1
Medical Examination	-	3
MSU	1	-
Nose bleeds	1	2
Oral ulcers	1	-
Periods	4	5
Urinary tract	2	4
Pregnancy test/results	-	7
Rash	4	2
Throat	4	4
Psychosocial problems	-	2
Spot on abdomen	1	-
Submandular swelling	1	-
Swollen glands	1	1
Swollen gums	-	1
Temperature & bradycardia	-	1
Thrush	1	-
Verrucas	-	2
Vomiting	1	-

The column totals exceed the total number of appointments as some individuals were recorded as having multiple problems/reasons for consulting their GP.

General Practice Appointments: Descending Numerical order

Subject of Consultation	Pre-Index	Subject of Consultation	Post-Index
Abdominal pain	9	Did not attend	8
Ear	7	Pregnancy test/results	7
Infection	5	Eye problems	6
Cancelled	4	Ear	5
Headache	4	Periods	5
Periods	4	Cancelled	4
Rash	4	Depression	4
Throat	4	Hip	4
Depression	3	Urinary tract	4
Knee	3	Throat	4
Acne	2	Index episode reported	3
Back pain	2	Medical examination	3
Breathing	2	Contraception	2
Cough	2	Index episode aftercare	2
Did not attend	2	Infection	2
Eye problems	2	Nose bleeds	2
Urinary tract	2	Rash	2
Allergy	1	Psychosocial problems	2
Assaulted	1	Verrucas	2
BCG injection	1	Abdominal pain	1
Child Guidance	1	Acne	1
Cold sores	1	Ankle	1
Contraception	1	Back pain	1
Corns	1	BCG injection	1
Dysuria	1	Breathing	1
Eczema	1	Child guidance	1
Epigastric Pain	1	Cough	1
Gynaecological	1	Cut finger	1
Hayfever	1	Dysuria	1
Head Lice	1	Excessive sweating	1
Insect bite	1	Head lice	1
Lump right foot	1	Influenza	1
MSU	1	Knee	1
Nose bleeds	1	Letter for school	1
Oral ulcers	1	LFT results	1
Spot on abdomen	1	Lump - breast	1
Submandular swelling	1	Lump - not specified	1
Swollen glands	1	Maxillary pain	1
Thrush	1	Swollen glands	1
Vomiting	1	Swollen gums	1
		Temperature and bradycardia	1

The column totals exceed the total number of appointments as some individuals were recorded as having multiple problems/reasons for consulting their GP.