Whittington Health NHS

Overdose, deliberate self-harm and alcohol intoxication in young people under 18 years

Subject:	Overdose, deliberate self-harm and alcohol intoxication in young people under 18 years
Policy Number	N/A
Ratified By:	Clinical Guidelines Committee
Date Ratified:	Version 4 ratified June 2011. Version 5 reviewed with minor amendments, August 2014, v6 October 2014 and v7 September 2015
Version:	7.0
Policy Executive Owner:	Clinical Director for Children's Services ICSU
Designation of Author:	Dr S Kraemer, Consultant Child and Adolescent Psychiatrist Dr J Roberts, Consultant Child and Adolescent Psychiatrist Dr G Armstrong, Consultant Paediatrician
Name of Assurance Committee:	As above
Date Issued:	September 2015
Review Date:	September 2018 (3 years hence)
Target Audience:	Paediatric, ED and nursing staff, paediatric mental health team
Key Words:	Overdose, Deliberate self-harm, Under 18 years

Version Control Sheet

Version	Date	Author	Status	Comment
4.0	June 11	Dr S Kraemer, Consultant Child and Adolescent Psychiatrist Dr J Roberts, Consultant Child and Adolescent Psychiatrist Dr G Armstrong, Consultant Paediatrician	Off line	Ratified at CGC
5.0	August 2014	As above	Off line	Version 5 reviewed with minor amendments
6.0	October 2014	As above		Version 6 reviewed with minor amendments
7.0	Sept 2015	Dr G Armstrong Dr J Roberts	LIVE	Minor changes: • Addition of third sentence under 'Criteria for Use' • Addition of third sentence under 'Principles' • Addition of Dr Reshmi Verma in the Contact list (replacing Dr Sebastian Kraemer)

➢ Criteria for use

For use by all staff dealing with patients in the Emergency Department (ED) up to their 18th birthday who have harmed or may harm themselves deliberately* by overdose or other means:

All must be referred directly to paediatrics with a view to admission as the default.

The only exception is where the young person is an inpatient in a mental health unit and is brought to ED purely for first aid / medical care (see below)
** this means that the person wanted to harm themselves, even if the dose or harm is minimal and including the use of alcohol as a drug of self-harm.*

➢ Principles

- In any case of a child or young person (up to their 18th birthday) who presents with any form of psychiatric presentation, the default path is **admission to the children's ward** under the ultimate care of a consultant paediatrician.
- In any such case, the responsible consultant is the consultant paediatrician, irrespective of where the child or young person is physically located within the acute hospital. This remains the case until the child or young person is either discharged or transferred to another unit.
- Young people brought to the ED from an inpatient mental health unit, do not need to be automatically admitted to the paediatric ward, as they already have ongoing mental health care. These patients can have their medical / first aid needs treated by the ED team and can then be transferred back to their unit once they are medically fit for discharge. They do not need to be referred to the paediatric team unless they require inpatient admission for medical reasons.

- Exceptionally this pathway will be varied when professionals together judge that the young person is too disturbed or disruptive to be cared for on a paediatric ward.
- Alcohol misuse in adolescents is common. In most cases these will be one-off episodes, associated with teenage experimental behaviour and these patients should not be considered to be engaged in self-harming behaviour.
- Alcohol abuse, as a form of deliberate self-harm, can also occur in adolescence and **this should be considered when assessing any alcohol intoxicated child** (e.g. multiple episodes of intoxication, use of other drugs alongside alcohol, background of depression or social problems, such as parents who refuse to visit the young person)
- If a child is too intoxicated for clinical staff to be able to assess the reasons behind their drinking, and alcohol self-harm cannot be excluded, they should be admitted to hospital until this is possible (i.e. until they are sober).

➢ Non-DSH /overdose patients

- Very rarely children or young people will present with other psychiatric symptoms, including (but not limited to) psychosis or aggressive behaviour
- In cases where patients present with these more unusual symptoms guidance can be found in the Whittington Hospital guideline

Please see Whittington Health Guideline:
'Behaviour in Young People: odd and unusual, but is it psychotic?

- In all such cases the patient must be referred to and assessed by the paediatric SpR on call **before** contacting the duty child & adolescent psychiatrist
- The remainder of this guideline refers to actual or potential self-harm or overdose.

- **ED staff**

1. Assess need for emergency treatment

- Obtain as much detail as possible around any substances taken as an overdose and the timing of the overdose.
- Specific advice on management of medication overdoses can be obtained from Toxbase. The log-in for the on-line Toxbase can be obtained from the nursing shift-leader in ED.
- Paracetamol & salicylate levels should be taken on all children who are known to have taken an overdose.
- Paracetamol poisoning:

	Please see Whittington Health Guideline: ***'Medical Management of Paracetamol Overdose'*** *see also* **Management of paracetamol poisoning *BMJ* 2011; 342:d2218 doi: 10.1136/bmj.d2218 (Published 20 April 2011)**

- Any lacerations should be cleaned, closed and dressed as per standard management of lacerations.
- If a wound requires surgical closure which can not be provided on site (e.g. requires Plastic Surgery) and the child needs to be transferred to another hospital then:
  - The child must be assessed by the paediatric team **prior** to any transfer
  - The child must also be referred to the inpatient paediatric team at the receiving hospital by the paediatric team at the Whittington Hospital.
  - The child must be transferred by ambulance and **cannot self-transfer or be transferred in the care of family or friends.**
  - After the child has been transferred, the receiving hospital must be contacted to confirm the child has arrived and this must be documented in the child's medical records.

2. Contact on call paediatric Specialist Registrar

- In all cases a responsible adult must be contacted to attend ED immediately and must remain with the patient until s/he has been admitted to Ifor ward.
- Work on the basis that there are no grounds for concealing the fact of deliberate self harm from the person with parental responsibility for any patient under 18. Exceptions are very rare.
- **A teenager not wanting her parents to know that she has harmed herself is not in itself sufficient reason for withholding this information from them**
- Discharge direct from the Emergency Department is not acceptable practice (unless exceptionally the child has been assessed by the on-call child and adolescent SpR, while the patient is in the ED)

3. If the child leaves before being seen / without being treated.

- Immediately inform the on-call paediatric Specialist registrar and the ED nursing shift leader that a vulnerable child or young person has left the department.
- Refer to the trust guideline on missing paediatric patients for further advice and guidance.

	*Please see Whittington Health Guideline:* ***'Absconding / Missing paediatric patient'***

4. Document the child's attendance in the Safeguarding Yellow folder.

- The Yellow folder is kept locked up in paeds ED. The nursing staff in paeds ED have the keys for the cupboard where it is kept.

All children who have engaged in any form of self-harm and **all** alcohol intoxicated adolescents (irrespective of whether or not it is felt to be self-harm at the time of attendance) should be documented in the folder.

➢ Paediatric medical and nursing staff

1. Arrange admission for the young person

- The paediatric ward should be informed as soon as a child or young person with self-harming behaviour has been identified.
- Before the child is transferred to the ward, an assessment should be made as to the risk the child or young person poses both to themselves and to other patients (see below).
- If there is concern that the child or young person presents a risk to other patients then this should be discussed with the on-call paediatric consultant.
- Arranging admission to an adult ward is not normally a 'safer option' either for the child or for other patients (remember adult wards often have vulnerable elderly in-patients).
- If there is concern about the risk posed, then the options are:
  - To admit them to a side room on the children's ward with the support of additional nursing staff / psychiatric nursing staff.
  - To keep the child in the emergency department until a full mental health assessment has been completed or until an appropriate placement has been found.
- The site-manager on-call can be contacted for assistance in obtaining additional nursing staff at short notice.

2. Take detailed history

- Record accurately all significant names, addresses and phone numbers including those of relevant professionals~~,~~ who have been involved with the patient or his or her family.

3. Assess *intent* to self-harm

- Refer to the advice at the end of this guideline for more detailed advice on assessment. Do not hesitate to talk of suicide. It cannot make things worse, and may help.
- Deliberate self-harm is self-inflicted injury and/or ingestion of substances with intent to self-harm or to commit suicide. This may include alcohol intoxication but only if the young person is using alcohol to relieve symptoms or feelings of despair/depression or (more rarely) the alcohol was consumed with intent to self harm. 'Cutting' is a serious symptom of

despair and shame, even when the risk of suicide may be lower than that following overdose.

- *The judgement as to whether the harm is accidental or deliberate is a clinical one* to be made by ED and paediatric staff. Accidental poisoning in younger children is obviously different but some adolescents who have drunk too much alcohol may be desperate or even suicidal. Get a story and a background social history. Are parents concerned and involved, or not?
- The dosage or method is less significant than the intent.

4. Refer the child / young person the Whittington Paediatric Mental Health Team

- This would usually be carried out on the first working day after the child or young person's admission.
- The referral should be confirmed with the attending / on-call paediatric consultant before the paediatric mental health team are contacted. The consultant should confirm via the paediatric on-call rota who the duty paediatric mental health team consultant is.
- A referral should be made by email to the paediatric mental health team using the group email whh-tr.Paed-Mental-Health@nhs.net and copied to the attending paediatric consultant & the safeguarding email whh-tr.ChildProtection@nhs.net
- The first step in making a referral is to ascertain the child's usual borough of residence. The on-line post code checker on the intranet (on the referral forms & guidance homepage) can be used for this. **Please include the child's borough clearly in your email.**
- The email should be sent as soon as the patient has been admitted and the paediatric mental health team will then contact the ward with the planned assessment time & who will be required to be present.
- The email message **should be routinely followed up by a confirmatory phone call** to the duty psychiatrist as indicated on the monthly paediatric rota.
- Following discussion with duty consultant paediatrician patients admitted on Friday or Saturday nights are normally seen the following day by the on call child and adolescent psychiatric SpR for full assessment regarding risk and suitability for discharge
- If urgent advice is required during working hours, the duty paediatric mental health consultant can be contacted via the list on the paediatric monthly on call rota.

- If urgent out-of-hours advice is needed or it is not thought the child can wait until the next working day (e.g. if the young person is demanding to leave, or over a long weekend) then discuss with the on-call paediatric consultant whether to contact the on-call Child & Adolescent Psychiatry SpR

- [NB for mental health assessments in under 18s out of hours there is one doctor at a time covering three hospitals, UCLH, Royal Free and Whittington].

- If agreed with the on-call paediatric consultant, contact the Child & Adolescent Psych SpR via switchboard. Make sure you clearly specify to switchboard that **you do not want the adult psychiatry team.**

5. Checking with children's social care and referring

- In any case where a child or young person is admitted with an episode of actual or potential self-harm, a check should be made with the relevant children's social care.
- In all cases a telephone call should be made to the duty social worker for the relevant borough (after checking using patient's postcode as above).
- All the referral forms and advice for contacting children's social care can be found on the Whittington Hospital intranet, under 'Services A-Z' > 'Child Protection & Children's Safeguarding' > 'Child Protection Referral Forms & Guidance'
- Use the contact details in Form B on the referral and guidance homepage to contact the duty social worker
- If the child already has an allocated social worker, then every attempt should be made to contact the allocated social worker the next working day to ask them to attend the Whittington Hospital for the child's mental health assessment
- The paediatric ward day team should formally take over the responsibility for contacting any allocated social worker and arranging for them to attend.
- If the child is not already known to social care, then the default would be for a referral to be made. The final decision should be taken by the attending paediatric consultant and a final decision may be delayed pending the mental health review.
- If a new referral is being made, then a Form A should be completed and shared as per the guidance in Form B.

➢ Sources of advice, information and contact

- Paediatric consultant attending or on call (via switch)
- Whittington Consultant Child and Adolescent Psychiatrists, Dr Jane Roberts, Dr Lopa Winters & Dr Rashmi Verma Whittington Hospital (ext 5356/3061 or via switch) These are part time staff who *between them* provide 0.8 WTE per week and backup on call for duty ST/SpRs out of hours.
- **For Islington Residents only** - Islington Children & Families Social Work Team, Whittington Hospital (ext. 5260 ~ office hours)

GUIDELINES FOR PSYCHOSOCIAL RISK ASSESSMENT BY DOCTORS AND NURSE

*This is **not** a protocol. i.e. don't just tick boxes, be curious about the self harm and its personal and social context*

- What method did you use?
- If tablets were taken, were they yours or is there someone close to you who is ill or taking medication, or who has tried to harm themselves?
- Have you been ill or been given medication?
- Do you drink or use drugs?
- Did you plan to kill yourself?
- If so, for how long have you been thinking about it?
- How were you found; did you expect to be found?
- Did you regret what you did?
- What did you wish would happen?
- Have you made any previous attempts to harm yourself?
- Were the previous attempts more or less dangerous than this one?
- Did you leave a note? (ask patient to show it to you or to repeat what it said)
- Do you think a lot about death?
- How do you view yourself as a person?
- Could you be mistaken (i.e. concealing the facts) about the time or quantity of overdose?
- What do you wish could happen now?

- **You can ask the patient to score themselves on a scale of 0-10 of suicidal risk (Almost everyone can respond quickly to this)**
- **It is safer to assume there was a wish to die, however transient, than to miss it. You can speak openly with the patient about suicidal thoughts. There is no risk of putting the idea into their head.**
- **Danger signals that increase the risk of suicide are**
  hopelessness about the future
  hostility
  negative self concept **(i.e. the patient thinks s/he is a useless no-good person)** ***isolation***

ASSESSMENT OF THE PATIENT'S SOCIAL NETWORK

- With whom do you live?
- Who and where are your parents and grandparents? (if dead ask for cause of death)
- Use this data to make a *three generational family tree*
- Who are your closest friends/associates?
- Have you experienced any bullying, either face-to-face or via mobile or on line?
- Who are the most important people in your life?
- Is there anyone close to you that you are worried about?

- Besides parents or step parents, do you have adult friends, a teacher/tutor, religious minister, young offenders worker, counsellor, social worker, psychiatrist, probation officer or other person whom you trust or who might be able to help? Have you seen such a person recently?
- Who is most likely to be able to help and why?
- What contact do you have with your GP?
- Has anyone close to you recently left, died or become ill?

Look out for recent, or forthcoming, *exits* (separation, leaving home, death) or *entrances* (new baby, new partner, other relative or friend) in the family or social network

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval

		Yes/No	Comments
1.	**Does the procedural document affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the procedural document likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the procedural document without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any procedural document when submitted to the relevant committee for consideration and approval.

	Title of document being reviewed:	Yes/No	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	

	Title of document being reviewed:	Yes/No	Comments
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is it clear that the relevant people/groups have been involved in the development of the document?	Yes	
	Are people involved in the development?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
5.	**Evidence Base**		
	Are key references cited in full?	N/A	
	Are supporting documents referenced?	N/A	
6.	**Approval**		
	Does the document identify which committee/ group will approve it?	Yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	

	Title of document being reviewed:	Yes/No	Comments
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Executive Sponsor Approval			
If you approve the document, please sign and date it and forward to the author. Procedural documents will not be forwarded for ratification without Executive Sponsor Approval			
Name		Date	
Signature			
Relevant Committee Approval			
The Director of Nursing and Patient Experience's signature below confirms that this procedural document was ratified by the appropriate Governance Committee.			
Name		Date	
Signature			
Responsible Committee Approval – only applies to reviewed procedural documents with minor changes			
The Committee Chair's signature below confirms that this procedural document was ratified by the responsible Committee			
Name		Date	
Name of Committee		Name & role of Committee Chair	
Signature			

Tool to Develop Monitoring Arrangements for Policies and guidelines

What key element(s) need(s) monitoring as per local approved policy or guidance?	Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others if any.	What tool will be used to monitor/check/observe/Assess/inspect/ authenticate that everything is working according to this key element from the approved policy?	How often is the need to monitor each element? How often is the need complete a report ? How often is the need to share the report?	What committee will the completed report go to?
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**
1. All children <18 years presenting to ED should be referred to Paeds for admission 2. All admissions should be notified to the whh-tr.Paed-Mental-Health@nhs.net email	1. Giles Armstrong 2. Whittington Consultant Child and Adolescent Psychiatrists	1. Review at weekly ED & Peadiatric MDT with exception 2. Weekly review at paediatric MDT	1. Weekly 2. Weekly	1. By exception reporting to ED board. 2. By exception reporting to paediatric consultant meeting