Original Article

"Too Young to be Worried!" Psychiatric Assessment and Follow-up of Young People after Severe Physical Assault in an Inner City Hospital of South London

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Abstract

Background: Interpersonal violence amongst youth is on the rise world-wide and London is no exception. The resulting injuries can be very serious and even result in death. This is a difficult to engage subgroup of patients and there is likely to be significant unmet social and mental health needs. **Aim:** The current paper discusses the results of immediate psychiatric and social assessment of young people following a serious physical assault as assessed by a pediatric liaison Child and Adolescent Mental Health Service (CAMHS). CAMHS in Kings College Hospital, London in one calendar year and also the help seeking behavior of the young people following the assault. **Subjects and Methods:** The Department of Pediatric Liaison Psychiatry is based within the Kings College Hospital and has a multidisciplinary team comprising of nurses, consultant child and adolescent psychiatrists and social workers who reviewed all patients who were referred to them following an episode of assault. All young people who were referred to the department of pediatric liaison psychiatry based within Kings College Hospital over one calendar year were included in the analysis. **Results:** 83% (29/35) of the victims were male and 83% (29/35) were from minority ethnic backgrounds. Although 70% (25/35) of the young people included in this study had significant safe guarding concerns, only 17% (6/35) turned up for their follow-up appointments with child mental health teams. **Conclusions:** Innovative models of service delivery are required to cater to the unique needs of this group of extremely vulnerable young people.

Keywords: Adolescent, Africa, Assault, Psychiatric illness

Introduction

Violence among young people is a world-wide problem[1] and London is no exception. However it's important to note that there is far more number of young people who are not violent as compared to those who are. One study on intentional physical trauma in the pediatric age group found that the leading causes of intentional physical trauma are child abuse, assault with a blunt object, assault with a sharp object and also trauma due to suicidal intent.[2] London, Manchester, Birmingham, Leeds and other cities in UK recently witnessed violent riots by young people in 2011.[3] Due to proximity and associations with peers, young people can be perpetrators and also the victims of violent acts. These patients are often referred to hospital based child and adolescent psychiatry departments during their stay in the hospital, but there is lack of any systematic data on the referred sample and also the mental health needs of this population immediately after the physical trauma. The young people by virtue of their age and peer group affiliations often are suspicious of services and as a result do not open up to talk about their psychological distress. To our knowledge, there is very little information on immediate psychological impact following an episode of very serious physical assault. The present paper is on the nature of the psychological impact of this group of young people who presented to Kings College Hospital and their help seeking behavior following the psychological assessment.

Access this article online

Quick Response Code:

Website: www.amhsr.org

DOI: 10.4103/2141-9248.126607

There have been a plethora of theories speculating causes and models of violence.[4] There are likely to be genetic, familial, developmental, and environmental factors that play important roles in violence among the youth and young adults. Anti-social peers and early alcohol intake are important predictors of violence in adolescents.[5] Availability of drugs, delinquent peers, parent rated hyperactivity, and low academic performance predicted violence at 10.14 and 16 years of age.[6]

Following media interest in violence amongst young people, the medical fraternity realized the paucity of data on the topic in spite of the significant amount of the resource being taken up by these issues.[7] Doctors and other medical professionals are now encouraged to systematically report violent incidents.[4] After the initial treatment, the challenge is to engage these young people for ongoing psycho-social interventions. Engaging young people into mental health service has been a known challenge all over UK.[8] This is more so when the young person has been a victim of violence and from a minority ethnic background. There could be perceived racial factors as barriers in the process of engagement. A paper[9] on adults from minority ethnic background from North America highlights various factors that may be at work leading to the disengagement: (1) "Disconnecting" during the aftermath and perceiving the injury as trivial, (2) Institutional mistrust and blurred boundary between the health-care staff, social services, and the police, (3) Self-reliance to "fix" the problem and (4) Structural barriers as post-injury disability, mental health symptoms, and safety concerns.

Kings College Hospital has one of the busiest A and E departments of United Kingdom and serves a wide geographical area of south London. The Kings College Hospital is situated in Denmark Hill, which is not far from some of most deprived areas of South London. The recent London riots had seen many of the victims from Southwark and Lambeth attending Kings College Hospital. The department has become busier since the closure of the some of the neighboring A and E departments and more so since the Kings College Hospital became the South East London Trauma Center in 2010. In the past 23 years, there has been a 550% increase in number penetrating neck injuries in south east London and a marked increase in gun crime.[10] Over 2 years between 2006 and 2008, a total of 1126 children attended Kings College Hospital with a head injury, of which 8 boys required admission for treatment of a head injury following alleged inter-juvenile assault.[8] The current service in Kings College Hospital is built on the arrangements within the hospital of having a young person evaluated by the hospital based child and adolescent psychiatry services following an episode of serious assault specially if the child appear to be in need of psychological support or the degree of the physical injury is serious. All children and adolescents are seen within a few hours of the referral. The pediatric liaison psychiatry team in Kings College Hospital is one of the oldest and the largest in the Europe. It's now a part of the National and Specialist Pediatric Liaison service of the Maudsley Hospital's Child and Adolescent Mental Health Service. It is led by two consultant child psychiatrists and has specialist nurses, family therapists, psychologists and other supportive staff. The current study wanted to find the pattern of violence on the young people who were referred to the psychiatry services and see if there is any specific pointers towards potential interventions. The mean age, gender, and ethnic back ground of seriously assaulted youth and circumstances around the incidence was also an important outcome that was of interest to us. The other important outcome that we wanted to explore was the psychiatric diagnosis made at the initial assessment usually after a day or so of the physical trauma.

Subjects and Methods

The pediatric liaison child and adolescent psychiatry team in Kings College Hospital maintains a data base for all children and young people who are referred to the department. Currently this is a national service for pediatric liaison psychiatry under the Child and Adolescent Mental Health Services (CAMHS) directorate of the South London and Maudsley NHS Mental Health Trust and works jointly with the St Thomas' hospital. Records of all young people who were assessed by clinicians between 1st January 2011 and 31st December 2011 were screened for the purposes of this project. The project was cleared by the Clinical Governance Committee of the South London and Maudsley Mental Health NHS Foundation Trust. Since, this was a service audit the Clearance by the Clinical Governance Committee was adequate. Soumitra Datta (SD), Paulina Bystritsky Sheriden (PBS), and Teresa Lax-Pericall (TLP) developed a template for data collection that included socio-demographic data, variables on important predictors and consequences of youth violence, psychiatric assessment data, family related data, past exposures to violence and data on the assessing staff member's adherence to the psychological management protocol of young people who have been assaulted. The proforma included some sections where free text could be written so as to get an idea on the circumstances around the assault. The electronic case notes of the young people who were identified as referrals to the department of child and adolescent psychiatry were screened by Shonima Viswanathan (SV). The data were analyzed by using the SPSS software, UK (Version 18). The results are mainly expressed in absolute terms or percentages. Due to small numbers, regression analysis was not performed.

Assessment procedure

The A and E department and the wards of Kings College Hospital referred young people to the department of child and adolescent psychiatry when they had serious and grievous injuries or when the patients were seen to be psychologically upset during their stay or for assessment of possible psychiatric disorder. For the majority of cases, the hospital has a robust social services department and this department would usually cover the social and safe guarding aspects of all the children who are victims of assault. In addition, there are youth workers

in the department of child health who attempted to engage the young people in the community following their treatment in the hospital. In case, the social services agencies felt that the young person needed psychological help they referred the young person to the child psychiatry department. Often the senior clinicians from the department of child psychiatry would be involved in child protection case conferences and mental health issues would be flagged up at these meetings. The mental health workers would always offer an initial appointment to the young people following discharge and liaise with the local CAMHS team and social services agency if the child was out of the area and had to be referred out.

Results

During the 1 year period of study, of the 550 referrals to the hospital based department of child and adolescent psychiatry, 35 were identified as specific referrals following an episode of serious assault to the young person. Nearly, 100% (35/35) of the records that met the criteria for the study could be tracked and included.

The mean age (SD) of the young people assessed by the department of child psychiatry following an assault was 15.85 (2.35) years and the age range was from 6 years to 19 years.

The circumstances around the assault varied from one young person to another. One young person said "the assault happened as a result of a 'friend' taking a play fighting too seriously" and another one was assaulted while being in a party with friends. Only one young person said that he was assaulted by "a group of 15-16 boys when he refused to hand over his stuff including his mobile phone." So stealing or robbing did not come out as a prominent motive behind the attacks. Five of the young people were injured in a fight "following an argument with another young person." The arguments mostly happened outside home and often in public places as the O2 arena. Two of the young people were in a relatively safe place when the attacks happened one being in his home where a shot was fired through the door and another boy being in a car during the attack.

Six of the thirty five people included in this paper said the attacks were unprovoked; two also confessed about the attacks being retaliatory and associated with various gang affairs. An over whelming number of people were guarded about their where-abouts at the time of attack and did not give any information about their activity during the attack to the mental health staff during the interview. Other socio-demographic data and family variables are presented in Table 1. Nature of the injuries, as mentioned in Table 2, sustained by youngsters was such that the young people often need prolonged hospitalization.

Psycho-social assessment

Only four of the thirty five (less than 10%) of the young people included in this project said that they have been moving around as part of a "gang." Similarly, only 4 of the young people were known to the social services previously and one of the four young people had been assessed and closed by the social services. For the other three who were open to social services, there were previous child protection concerns or concerns regarding mother's parenting capability or had been taken into care following serious concerns. Seven of the thirty five young people had been known to their local Youth Offending Service. Seven of the thirty five young people had a previous history of arrest and three of the young people assessed were out on bail and were being tried for a serious offence. Nearly, 28.6% (10/35) young people said that they have been assaulted previously.

The notes suggested that for 80% (28/35) of young people who were assessed, a valid mental state examination could be performed. 17% (6/35) young people included in this paper had a previous diagnosis of substance misuse disorder, one of the young people had a previous diagnosis of serious mental health disorder and only one of the young people had a diagnosis of conduct disorder.

A total of 8 teenagers reported nervousness following the assault and 3 teenagers reported hopelessness. We examined the notes for the mention of specific coping strategies that young people may have mentioned to clinicians, e.g., being more careful while walking, trying to be less "visible," moving to a new home, use more drugs and alcohol, felt-need of carrying a weapon or any 'stuff' to be used in self-defense etc., However young people hardly ever said anything in the above line except 1-2 cases.

The parents were also interviewed; 10% (3/35) of parents felt the need for increased supervision and 14% (5/35) wanted

Table 1: Demographics (age, gender, family variables)

Variables	
Age in years (mean (SD))	15.8 (2.3)
Gender (number/percentage)	
Male	29 (83)
Female	6 (17)
Ethnicity	
White	6 (17.1)
Black or black British	21 (60)
Asian or British Asian	3 (8.6)
Mixed ethnic group	2 (5.7)
Others	3 (8.6)
Family constitution (%)	
Lives with mother	19 (54.3)
Lives with father	1 (2.9)
Lives with both parents	6 (17.1)
Lives with one step parent and one biological parents	1 (2.9)
Lives with family members other than parents	2 (5.7)
Lives in foster care	1 (2.9)
Not known/not documented	5 (14.3)

SD: Standard deviation

Table 2: Weapon used and nature of assaults

Type of weapons used	Frequency (%)	Nature of resulting injury
Knife	20 (57.1)	Liver laceration following a stab injury, stabbed on back, stab injury on limbs, stab injury of limbs, stabbed on the right shoulder; Stabbed and flicked knife to chest, stabbed on the neck; stabbed on the back and developed pneumo-thorax, stabbed on the shoulder 3 times and once on the elbow, stabbed multiple times on the back and chest, stabbed on both thighs, stabbed on the calf, stabbed on the chest, stabbed and resulted in having hemo-pneumothorax, stabbed and had liver laceration that needed surgery, stabbed on the left side of the neck that required sutures, stabbed and needed stay in Intensive Care Unit (ICU).
Gun	3 (8.6)	Gun shot on the right cheek and right shoulder, gunshot wound to face but no brain injury and superficial laceration to thigh, Multiple gunshot wound and fractured ribs
Improvised weapon (bottle)	3 (8.6)	Assaulted by a knuckle duster and sustained a fracture in the mandible and lacerated lip, assaulted on the head by a cricket bat resulting in head injury, head injury
Fist	2 (5.7)	Punched on the nose
Combination of knife and other weapons	2 (5.7)	Assault by a sharp object and shot and stabbed at the same time, hit on the head by a wooden object and stabbed multiple times
Others/not known	4 (11.4)	Serious injury to the eye, mother purposefully drove the car into a brick wall with patient (girl aged 6 years) in the front seat that resulting in fracture of skull, femur, laceration of spleen and pneumothorax

to relocate from the region for fear of repeat attacks on their children. A considerable group of parents were quite guarded when discussing their plans, circumstances, and reactions to the assault with clinicians.

There were various specific safe-guarding concerns that were recorded in the notes by professionals for 71% (25/35) of the young people assessed. For all cases included in the paper, the young people were either seen by a consultant child and adolescent psychiatrist or discussed with the consultant. Nearly, 31% (11/35) young people, who were assessed, were deemed to be at risk for future assaults, 11.4% (4/35) were at risk of gang violence and one of them were specifically deemed to be at risk for future bullying and theft. Nearly, 9% (3/35) of the young people were judged to be at risk of assaulting others. There was safe guarding concern regarding the sole parent's mental health difficulties for one of the young persons. The other safeguarding concerns that were documented were risk of running away from home and being at risk for domestic violence for two young people who were assessed.

The management protocol was to offer at least one follow-up appointment to the young person and family; however, only six of the thirty five young people were followed by either the same CAMHS team or another CAMHS team. 31% (11/35) refused formal psychiatric help or follow-up. The rest 51% (18/35) did not turn up for their 7 day follow-up appointment.

All cases were discussed in a multidisciplinary team meeting and most of them were referred to social services for follow-up or information. Only two of the young people had a formal assessment after 1 month to screen for Post Traumatic stress disorder (PTSD) if we exclude the young people who were being already seen by CAMHS prior to the assault.

Discussion

The children reported in this paper, is only a small proportion of children who attended Kings College Hospital, but they were probably the most concerning. These were the children who were formally referred to the child and adolescent psychiatric services following an assault. It is extremely worrying that only six out of thirty five young people and their families attended for follow-up. Many of the young people came to Kings after being referred by various other regional hospitals out side of the local catchment area and hence a regional policy would be more appropriate than just addressing the practices of only the local services. Only four of the young people reported that they were part of a gang and this low level of self-report of delinquent peer group affiliation could be due to the fact that these young people might have found it difficult to confide in clinicians whom they possibly perceive as authority figures. Majority of victims had a minority ethnic background and were male. This is not surprising given the local population in the area surrounding Kings College Hospital has a large representation of ethnic minority population. The question of being a victim of inter-personal violence and its association with ethnicity is complex to answer. In the current lay press, the words such as "race," "ethnicity," and "culture" are often used interchangeably. Our project recorded the ethnicity data from the data base of hospitals and would in some extent be biased by the same practices. Race is a person's biological inheritance, ethnicity is the way the person thinks about his/her biological inheritance and culture is the social network within which young people and their families live. The current study is not powered to answer the question of association of ethnicity with the chances of being a victim of severe physical assaults. More studies are probably required to examine issues of life style choices, self-esteem, environmental adversity (racism), family and community dynamics, coping vulnerabilities, life-time psychopathology, cognitions, and peer support as suggested by another author in a slightly different context.[11] Many of the victims came from single parent families. Although the numbers of couple families

with dependent children in UK have reduced from 92% in 1971 to 75% in 1991,[11] the victims of assaults who were staying with both parents were significantly low in number at only 17% of all the children included in this study. This is an interesting finding and probably more research is needed on the protective role of having both parents together. There was no data on rating scales used on the young people as regards mental state as most of these assessments were carried out under difficult circumstances and where the clinician was trying to make sense of the circumstances around which the young person was assaulted. The priority for many of the assessments was on deciding if it was safe to discharge the patient once the initial medical treatment was over. The safety was assessed from medical, psychological and social point of view for all the young people seen by CAMHS. The mental health assessment performed in the ward or A and E was limited because of time constrains and its emphasis on cross-sectional clinical picture as opposed to a longitudinal pattern and it could be argued that a more thorough assessment that includes information from multiple informants as school teachers may have picked up other mental health disorders. However, it is important to note that many of the young people and their families were reluctant to be assessed further. The main aim of the assessment was to exclude psychiatric disorder and to assess safety and also to inform young people and their families about the possibility of developing psychiatric disorders such as PTSD. Given the low rates of follow-up, one option would be to develop community based follow-up arrangements, rather than within CAMHS teams who may have constraints of assessing youngsters in a clinical frame-work. Knife crime being quite rampant in London one needs to offer medical appointments for those children who need it and at the same time not to medicalize a social problem. Our results show that it's extremely difficult to engage very high-risk young people in mental health services following an episode of serious physical assault requiring medical hospitalization. These young people are likely to be sceptical about formal mental health services. It may be that a mental health service is not the best agency to follow-up. One of the main risks is that these young people may be involved in violence in the future. There are some innovative services that are hoping to prevent young people becoming more involved in gangs and it may be that agencies such as social services and mental health should be referring into these projects. The services could develop ways to effectively screen for PTSD after the young person is discharged as it is difficult to engage and design services for young people following gang violence and physical assault once the medical treatment is completed. There have been concerted efforts between the primary care trusts, public agencies and the acute hospitals in South East London in order to reduce the harm caused by the violent incidents by efficient case management and community out-reach services.[12] Youth empowerment has also shown promising results[13] in North America. Developmentally appropriate prevention policies have also shown some results. Some authors have speculated that problem behaviors that increase the short-term or long-term likelihood of morbidity and mortality, including substance use, mental health problems, risky and unsafe driving, and violence are often preventable.[14] However, in-spite of all these efforts and innovations, the follow-up of this group of youngsters continue to be a challenge. More research is needed on service models catering to the emotional needs of this very vulnerable group of youngsters. Clinicians and policy makers need to be flexible and mindful of the unique nature of service acceptability for these young people.

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How to cite this article: Viswanathan S, Datta SS, Sheridan PB, Lax-Pericall T. "Too young to be worried!" Psychiatric assessment and follow-up of young people after severe physical assault in an Inner City Hospital of South London. Ann Med Health Sci Res 2014;4:85-9.

Source of Support: Nil. **Conflict of Interest:** None declared.