Life Matters: Management of Deliberate Self Harm in Young People

Report 11 – November 2001

Background

Youth suicide has been on the increase worldwide since the early 1950s. In most countries suicide is one of the three major causes of death in the 15-24 year age group. In Australia the number of deaths by suicide is approaching the number of deaths from motor vehicle accidents.

Deliberate self-harm, which includes attempted suicide, is a predictor of death by suicide with the greatest risk being in the initial weeks after discharge from hospital.

Growing community concern over the increasing incidence of suicide and deliberate self-harm in young people prompted State and Federal Governments to implement a variety of suicide prevention initiatives.

As part of these initiatives, Guidelines were issued in June 2000 by the Australasian College for Emergency Medicine and the Royal Australian and New Zealand College of Psychiatrists to provide a framework for the management of deliberate self-harm within Emergency Departments and for linkages to ongoing care in the community and focusing on care and treatment of patients.

What the examination found...

- Only 3 out of every 4 of the reviewed files indicated an adequate level of service provided to deliberate self-harming young people in Emergency Departments.
- Deliberate self-harm patients are not always treated with the appropriate level of urgency, wait longer for treatment than other patients with similar levels of medical need, and do not always receive an appropriate psychiatric assessment.
- Opportunities for patients to ‘slip through the gaps’ occur at a number of points throughout the patient’s care, particularly during the waiting periods and transition between services.
- The Guidelines have not been uniformly distributed and implemented across the health system.
- Duty of care for the patient during the period between leaving the hospital and accessing support and treatment in the community is unclear.
- Waiting times for accessing community-based services by deliberate self-harm patients can be excessive.
- Community-based mental health services have limited capacity to assertively maintain engagement with at-risk clients.
- Little or no summary information is collated and used by community-based mental health services to assist in identifying and addressing specific issues in relation to the management of deliberate self-harm in young people.
- The Department of Health is not systematically monitoring or evaluating the achievement of strategies outlined in the Mental Health Plan for Western Australia.
- No clear responsibilities for outcomes in relation to youth suicide prevention have been assigned, no priorities articulated and no review process set in place.
- The Ministerial Council for Suicide Prevention (MCSP) is an advisory committee that is effective in facilitating inter-agency coordination.
What the examination recommended...

Major recommendations made in the report are that:

- The Department of Health should endorse the Guidelines for the Management of Deliberate Self-Harm in Young People and ensure their implementation across the Western Australian health system.

- The Department of Health should, in consultation with community mental health clinics, develop and implement minimum service specifications, for example, in relation to after-care planning, timely follow-up treatment and assertive follow-up where a client does not attend an appointment.

- Hospitals should develop and implement local strategies for providing effective care for managing deliberate self-harm patients in accordance with the Guidelines. These local strategies should be set out in a detailed action plan.

- Hospitals and community mental health services should develop local protocols for timely referral of patients to care in the community, timely transmission of relevant details and effective collaboration and coordination between hospitals, community-based services and other relevant local groups.

- Community mental health services should ensure that adequate management information is available and utilised to improve service delivery.

- State strategies for suicide prevention need to be regularly reviewed and evaluated and progress on achievements publicised via a regular reporting mechanism.