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Guidelines for the Management of Deliberate Self Harm in Young People

The Royal Australian and New Zealand College of Psychiatrists

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Introduction

Deliberate self harm (DSH) in young people is a serious clinical and public health problem with an estimated 10,000 presentations to hospital emergency departments and over 400 completed suicides per annum. While DSH and suicide are apparently increasing due to a range of social and psychological factors (rather than recognised mental illness), many who make a serious suicide attempt may have a treatable mental disorder or substance abuse problem at the time of presentation to hospital.

Although formal scientific evidence is currently lacking, there is a reasonable basis to believe that the quality of acute health services (emergency medical and mental health) provided to young people in these circumstances has the potential to reduce the risk of completed suicide in at least some cases.

These guidelines represent a consensus overview on the reasonable management of DSH in young people in Australasian Emergency Departments. They have been jointly developed in a project sponsored by the Australasian College for Emergency Medicine (ACEM), the Royal Australian and New Zealand College of Psychiatrists (RANZCP), and the Commonwealth Department of Health and Aged Care as part of the National Youth Suicide Prevention Strategy. The methodology and literature review can be obtained in the full report of this project "Hamilton T, Cook C. The Management of Deliberate Self Harm in Young People" available from ACEM.

Presentation

It is recommended that patients presenting to emergency departments with evidence of deliberate self harm should:

- Be triaged on presentation to an appropriate category on the Australian Triage Scale (ATS). Staff performing triage should have training and experience in mental health triage and may use a Mental Health Triage Scale consistent with the ATS. A presentation with evidence of acute deliberate self harm is normally assigned to ATS 3 or higher. Assessment and management by all staff should take place in a timely manner having regard to the triage category.

- Be assessed by an emergency physician or a doctor acting as their delegate who will perform a physical examination and a basic mental health assessment.

- Be reviewed by a psychiatrist or a mental health clinician acting as their delegate who will take a mental health and social history and conduct a mental health examination.

Privacy and Security

It is important that the interviews and examinations be conducted in a private and secure location within the emergency department.

Collateral History

Wherever possible a collateral history should be obtained from a family member, partner, or friend. Where the patient is an adolescent, a family assessment may be indicated.

Health Records

Hospital and other health service records should be searched for a past history of psychiatric illness or self harming behaviour.

The current presentation should be thoroughly documented and include a suicide risk assessment.

Clinical Classification of Deliberate Self Harm for Suicide

Patients should be classified into one of three risk categories.

Group 1 — ***Immediate risk***

attempted hanging
or self-inflicted gun shot wound
or carbon monoxide poisoning
or serious laceration requiring suture
or requiring medical treatment beyond activated charcoal or routine neurological observation
or requiring admission to a critical care unit
or major psychiatric illness/psychosis
or evidence of serious suicide intent.

Group 2 — ***Serious risk***

evidence of psychiatric illness such as depression, schizophrenia, personality disorder
or a history of psychiatric illness and treatment
or alcohol, drug abuse
or previous suicide attempt
or access to a firearm
or chronic physical illness
or evidence of continuing suicidal ideation or intent.

Group 3 ***Lesser risk***

first episode of deliberate self harm with

no evidence of major psychiatric disorder

no evidence of continuing suicidal ideation or intent

no history of drug or alcohol abuse

and evidence that the "crisis" has resolved.

Particular attention is required regarding co-morbidity and the potential additive effect of multiple risk factors.

Management

Group 1

Admission
Group 1 patients should be admitted to the appropriate inpatient service and receive urgent psychiatric consultation.

Follow-up
On discharge Group 1 patients should receive rigorous and long term follow-up.

Group 2

Admission
Group 2 patients will usually require in-patient admission to facilitate appropriate assessment.

Some patients, for example, those with borderline personality disorders, or those still suffering the effects of poisoning or alcohol/ drug abuse, may require short term admission (24 hours) to an emergency department observation ward or other suitable inpatient unit.

Those patients who receive short term admission will require further mental health assessment before discharge.

Follow-up
All Group 2 patients should be followed up within 48 hours of discharge.

Group 3

Admission

Group 3 patients do not require in-patient admission unless short term observation is necessary.

Follow-up

Group 3 patients should be provided with a review appointment or be contacted within three days.

Contact Information

At the time of discharge, patients of all 3 groups should be provided with a card or pamphlet informing them of:

- The identity of the mental health clinician who assessed them (unless contra-indicated).
- The time and place of their follow-up appointment.
- Other relevant information, including contact details for help in crises.

Responsibility

The responsibility for the assessment and management of these patients will be shared by the consultant emergency physician and the consultant psychiatrist. They will be responsible for the supervision of clinicians within their service teams and the recruitment of appropriate in-hospital and community services. While in the emergency department the emergency physician will have primary responsibility. The mental health team will be responsible for liaison and discharge and follow-up arrangements.

Records and Record Audit

A database to facilitate tracking and outcome analysis should be developed. This may require intersectoral cooperation. As a part of quality assurance there should be regular record audits to assess the quality of information and the appropriateness of clinical decisions.

Collaboration

Because of the need for very close collaboration between emergency departments and mental health services, regular meetings should be held to review the management of mental health patients.

Guideline Implementation

The implementation in emergency departments of the Guidelines for the Management of Deliberate Self Harm in Young People will depend on the availability of adequate physical resources and appropriately trained clinical staff. The acceptance of the following recommendations should be seen as an essential step to guideline implementation:

- That emergency departments in all major hospitals employ a mental health nurse or appropriately trained allied health professionals to assist in the timely assessment of deliberate self harm patients, to obtain a collateral history from accompanying relatives or friends, and to provide on-going support for these very distressed patients and their families. These workers may also assist in the formulation and implementation of discharge plans and will be responsible to either an emergency physician or liaison psychiatrist.
- That, for adolescent patients, clinicians with an understanding of adolescent development and a working knowledge of family assessment and therapy be involved in the assessment and management wherever possible.
- That where the assessment is carried out by a community based mental health team, the team be geographically close to the hospital emergency department and available through one point of contact. This is particularly important where more than one team is providing services to an emergency department. The department mental health nurse may also be a member of a community based team.
- That because of turnover in staff, there needs to be continuing education and training of emergency, psychiatry and community based clinicians in the management of DSH and other mental health problems. Much of this training should be based on the discussion of clinical cases. There should be a retrospective discussion and analysis by clinicians of difficult cases and particularly those cases with a negative outcome.

- That interview and observation rooms be available which strike a balance between the need for privacy and confidentiality and the need for adequate medical and security observation.
- That a room be available which is suitable for interviews with family and friends of self harming patients.
- That adequate infrastructure be available for the rapid production and transmission of clinical information to care providers.
- That emergency departments produce protocols for the assessment and management of these patients, based on these guidelines and appropriate to the resources and clinical climate of the particular department.

It is emphasised that these guidelines are intended for overall practice and are not necessarily applicable to all individuals, the care of whom will always remain the responsibility of the physician in charge. The personal and family circumstances of these patients and the health care resources available varies widely and management will be dependent on the judgment of that physician.

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