



**Auditor General**

Western Australia

**Life Matters:  
Management of  
Deliberate Self-Harm  
in Young People**

**Report No. 11  
November 2001**



## Auditor General

Western Australia

THE SPEAKER  
LEGISLATIVE ASSEMBLY

THE PRESIDENT  
LEGISLATIVE COUNCIL

### **PERFORMANCE EXAMINATION: Life Matters - Management of Deliberate Self-Harm in Young People**

This report has been prepared consequent to an examination conducted under section 80 of the *Financial Administration and Audit Act 1985* for submission to Parliament under the provisions of section 95 of the Act.

Performance examinations are an integral part of the overall Performance Auditing program and seek to provide Parliament with assessments of the effectiveness and efficiency of public sector programs and activities thereby identifying opportunities for improved performance.

The information provided through this approach will, I am sure, assist Parliament in better evaluating agency performance and enhance Parliamentary decision-making to the benefit of all Western Australians.

A handwritten signature in black ink, appearing to read 'K O O'NEIL'.

K O O'NEIL  
ACTING AUDITOR GENERAL  
November 28, 2001

# Contents

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<b>1 Auditor General's Overview</b>	<b>4</b>
<b>2 Executive Summary</b>	<b>5</b>
Background	5
Overall Findings and Conclusions	5
<i>Service Quality</i>	5
<i>Hospital Systems, Policies and Resources</i>	6
<i>Follow-up by Community-Based Services</i>	6
<i>Achievement of State Mental Health Policies and Strategic Directions</i>	7
Summary of Recommendations	7
<b>3 Introduction</b>	<b>9</b>
Incidence of Suicide	9
Risk Factors for Suicide	10
Recent Initiatives	11
Examination Objectives and Methodology	13
<b>4 Service Quality</b>	<b>15</b>
Introduction	15
Service Quality and Documentation	15
Conduct and Reporting of Risk Assessment	17
Triage and Waiting Times	18
Physical and Psychological Examination	20
Discharge Planning and Follow-up	21
Recommendations	23
<b>5 Hospital Systems, Policies and Resources</b>	<b>24</b>
Introduction	24
Awareness and Implementation of the Guidelines	25
Hospital Resources	25
Training and Education	27
Information Systems	28
Continuity of Care	29
Deliberate Self-Harm Social Workers	31
Recommendations	32
<b>6 Follow-up by community-based services</b>	<b>33</b>
Introduction	33
Transition between Hospitals and the Community	34
Barriers to Effective Community Follow-Up	35
<i>Engagement and Assignment Protocols</i>	35
<i>Age of Client</i>	36
<i>Location of Residence</i>	37
<i>Resourcing</i>	37
<i>Management Information</i>	38
Recommendations	39
<b>7 Achievement of Health Policy and Strategic Directions</b>	<b>40</b>
Background	40
Health Policy	40
Inter-Agency Coordination	41
Accountability for Outcomes within the Health Sector	43
Recommendations	44
<b>Previous Reports of the Auditor General</b>	<b>45</b>

# 1 Auditor General's Overview

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The death of a young person by suicide is a tragedy, the impact of which is felt beyond immediate family and friends. The loss of so much potential affects the whole community because young people are the future of our community.

Our first response on hearing of the suicide of a young person is to ask what can be done or are we doing enough as a community to prevent deaths from suicide in young people.

Both Federal and State governments in Australia have put in place strategies to address youth suicide in the form of the National Youth Suicide Prevention Strategy and State mental health plans. However, it is equally important to ask how well these strategies and plans are being implemented and how effective they are in preventing or reducing youth suicide.

This report focuses on assessing the management of cases of deliberate self-harm in hospital Emergency Departments in order to evaluate the effectiveness of current services to young people who exhibit this behaviour. Deliberate self-harming behaviour, which includes attempted suicide, is one of the major predictors of suicide. The effectiveness of the management of deliberate self-harm patients has been examined in terms of the quality of service in Emergency Departments and follow-up by community-based services. In addition hospital systems, policies and resources were also examined.

The issue of accountability in the health sector is fundamental to this report. There is a lack of transparency in reporting on the achievement of health outcomes and clear responsibilities have not been assigned for the youth suicide prevention components of the Mental Health Plan for Western Australia. Additionally, there has been inadequate monitoring and review of the progress of health outcomes.

Clearly, the challenge for the health sector is to turn the high-level policies and strategies into a practical, achievable and effective implementation plan. This is an issue that this Office has addressed before in reports, most recently in the performance examination of the State's stroke management strategy, which was launched without an effective implementation plan.

We have been mindful of the complexity of the medical and social concerns involved in this area and to ensure that the examination targeted the appropriate information and issues I have used the services of medical practitioners who are experts in the field of youth suicide to undertake a review of medical files of deliberate self-harm patients. In addition, throughout this report wide consultation with clinicians and mental health professionals has been undertaken.

I am also mindful of the recent media coverage of the pressures on Emergency Departments. It must be recognised though that this report simply reflects on how the Western Australian health system measures up against Guidelines set by the medical profession itself.

This is an important issue which remains the concern of the whole community and as such is not the exclusive province of any one group of experts. Instead it requires integrated, whole-of-community solutions to which government must be a significant contributor.

# 2 Executive Summary

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## Background

Western Australia has one of the highest rates of youth suicide in Australia and, given the increasing pressures on young people and the global trend in youth suicide, it is possible that this number could rise despite recent suicide prevention initiatives.

Deliberate self-harm is defined as the intentional poisoning or injury of one's self, irrespective of the underlying purpose of the act. Admission to hospitals because of deliberate self-harming behaviour is 17 times more common than death due to suicide.

Growing community concern over the increasing incidence of suicide and deliberate self-harm in young people prompted Federal and State governments to implement a variety of suicide prevention initiatives, including the National Youth Suicide Prevention Strategy, an initiative of the Commonwealth Government, which aims to reduce the rate of suicide, attempted suicide, suicidal behaviour and suicidal ideation in young people.

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

State suicide prevention initiatives have also been introduced to supplement the National Strategy. In 1996, *Making a Commitment: the Mental Health Plan for Western Australia* and the *Report of the Ministerial Taskforce on Mental Health* were launched by the Department of Health to provide a comprehensive policy framework for the development of mental health services.

## Overall Findings and Conclusions

This examination focuses on assessing the management of cases of deliberate self-harm in hospital Emergency Departments against the Guidelines, in order to evaluate the effectiveness of current services to young people who exhibit self-harming behaviour. The focus is on deliberate self-harming behaviour because one of the major predictors of suicide is a previous episode of deliberate self-harm, including previous suicide attempts.

### Service Quality

There was a high correlation between the quality of service provided and the quality of documentation. The quality of care received in Emergency Departments by deliberate self-harm patients and the quality of documentation in patient files was adequate in only three quarters of the cases reviewed.

A simple three-tier risk classification is recommended by the Guidelines to guide treatment and follow-up. None of the hospitals in the review had assessed the risk category in accordance with the Guidelines. This resulted in risk assessment processes being inconsistent and generally not based on the identified risk indicators.

The review found that 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. There is a clear need for waiting times to be kept to a minimum and for appropriate plans and appointments to be in place before deliberate self-harm patients leave hospital.

### Hospital Systems, Policies and Resources

Metropolitan hospitals have implemented the Guidelines to varying degrees. However, there is a large gap between policy and practice. The situation in regional hospitals was quite different in that most staff in regional hospitals reviewed were unaware of the Guidelines.

In both the metropolitan and regional areas, there were no training programs in place to educate staff about the Guidelines. Training tended to be either clinical, in the form of case reviews, or about specific issues, such as risk assessment.

Teaching hospital information systems were adequate. Problems with consistency of coding, however, limited the capacity to readily identify deliberate self-harm patients. This problem was apparent in regional hospitals, most of which were unable to adequately identify deliberate self-harm cases.

A wide range of specialist staff providing services to deliberate self-harm patients were available on-call in the teaching hospitals. In regional areas the situation was again different with after hours access to community facilities only being available in Kalgoorlie.

Issues of privacy were of concern to the deliberate self-harm patients who took part in the review. Despite this, privacy and confidentiality policies remain unclear particularly for patients aged 16-18 years and not living at home.

### Follow-up by Community-Based Services

In the period immediately following an act of deliberate self-harm there is an increased risk of a subsequent self-harming episode or suicide. The transition from hospital-based to community-based treatment should be as smooth as possible and it is recognised that the quick initiation of community-based treatment is vital to managing the risk of further self-harm episodes.

It is therefore of great concern that the review showed waiting times for accessing community-based mental health services by deliberate self-harm clients can be excessive.

In addition, delays in providing discharge summaries to community-based mental health service can be lengthy, which compromises community-based mental health services already limited capacity to assertively maintain engagement with at-risk clients.

There is very little management information available to assist with service planning and provision for deliberate self-harm clients. For example 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.

## Achievement of State Mental Health Policies and Strategic Directions

The Department of Health is not systematically monitoring or evaluating the achievement of strategies outlined in the Mental Health Plan for Western Australia.

In relation to the components of the Plan dealing with youth suicide prevention, no clear responsibilities for outcomes have been assigned, no priorities articulated and no review process set in place.

The Ministerial Council on Suicide Prevention (MCSP) is an advisory committee with wide and diverse representation. The MCSP is effective in facilitating inter-agency coordination.

For policies to be achieved however, individual agencies must commit to an achievable strategy and implementation plan including details of resourcing, timelines and priorities, monitoring, evaluation and reporting.

## Summary of Recommendations

*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.

## 2 EXECUTIVE SUMMARY (continued)

- 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.

# 3 Introduction

## Incidence of Suicide

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. The Australian youth suicide rate is in the upper third of those for all industrialised countries. In Australia in 1999 there were 380 deaths from suicide in this age group accounting for 22 per cent of male deaths and 15 per cent of female deaths. The number of deaths from suicide has decreased from 446 in 1998 and 520 in 1997. This is the first time in 12 years that there has been a decrease in the number of deaths from suicide in Australia. It is not yet clear whether the decrease is the result of chance variation or whether it reflects the impact of measures introduced to address youth suicide.

Western Australia has one of the highest rates of youth suicide in Australia with 47 deaths in 1999 and 65 in 1998. However, given the increasing pressures on young people and the global trend in youth suicide, it is possible that this number could rise despite recent suicide prevention initiatives.

Figure 1 below shows the age-specific death rate from suicide for young people and all ages within Australia.

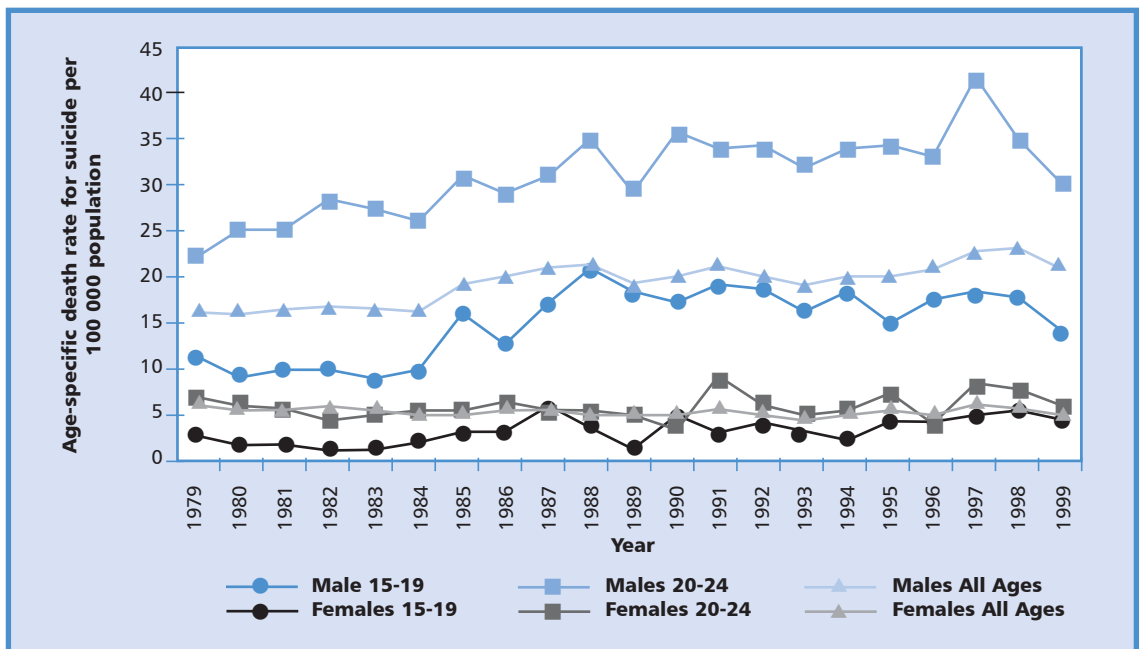


Figure 1: Suicide death rates per 100 000 population within Australia.

*Suicide by young males rose steadily over 20 years. There has been a recent reduction in suicide numbers although it is too soon to know if this will continue.*

Source: Australian Bureau of Statistics

The number of deaths from youth suicide is approaching the number of deaths from motor vehicle accidents. As a result, youth suicide has been identified as one of the major problems facing our society over the next decade and, unless appropriate prevention strategies are put in place, the cost of youth suicide to the community in human and financial terms will continue to be significant.

## Risk Factors for Suicide

There are a number of factors which increase the risk of suicide. Psychiatric illness, in particular depression and mood disorders, is associated with many youth suicides. As well as use of alcohol and other drugs, unemployment and social disadvantage are also associated with increased rates of suicide. One of the major predictors of suicide is instances of deliberate self-harm which includes previous suicide attempts. Figure 2 illustrates the prevalence of risk factors and number of young people potentially at risk.

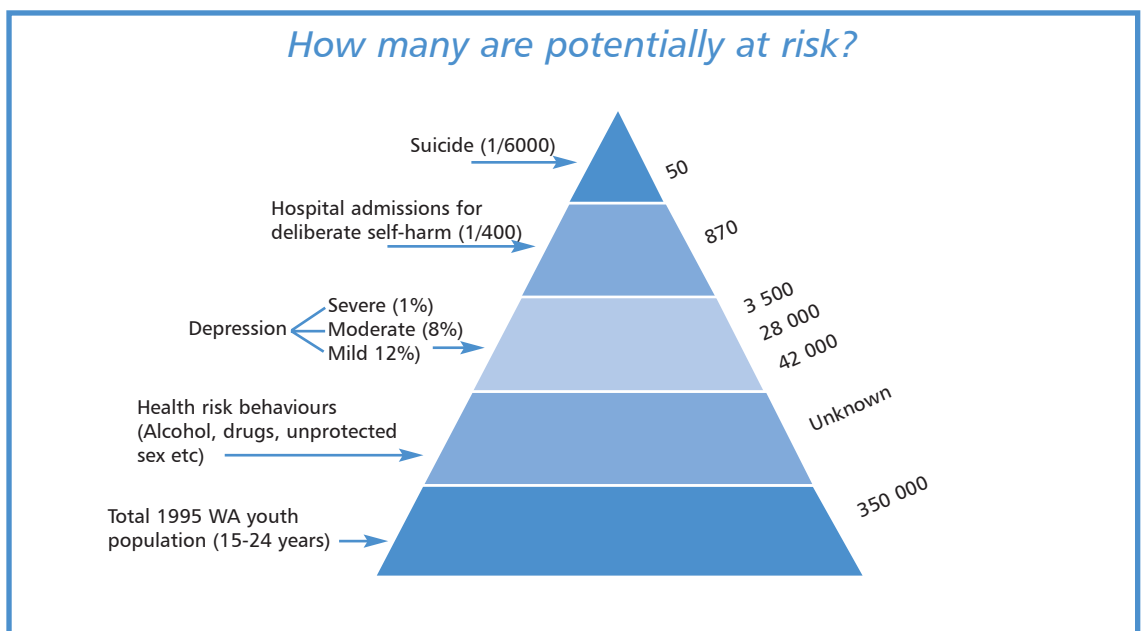


Figure 2: Potential risk of suicide.

*Deliberate self-harm is one of the key risk factors associated with later suicide.*

Source: TVW Telethon Institute for Child Health Research

Deliberate self-harm is defined as the intentional poisoning or injury of one’s self, irrespective of the underlying purpose of the act. Not all self-harming behaviour is an attempt at suicide however and it is often difficult to determine when the motivation behind self-harming behaviours is the intent to die. Even when there is no suicidal intent accompanying the

*Previous deliberate self-harming behaviour is a risk factor for suicide*

deliberate self-harm, the risk of accidental death is very real. Conversely, attempts at suicide may result in minimal injury. Attempted suicide can be difficult to study because there are no generally accepted reporting procedures or well-accepted definitions and hospital information systems do not differentiate self-harming behaviour by the degree of suicidal ideation.

Of all people hospitalised for deliberate self-harming behaviour over the period 1981 to 1997, 22 per cent were subsequently either readmitted due to injuries sustained in deliberate self-harm or died by suicide with their next episode. A large proportion of deliberate self-harm episodes occurred within the first year after initial discharge, with the risk of repeating highest within the first month of initial discharge.

A recent report, titled “Duty to Care”, by the University of Western Australia’s Departments of Public Health and Psychiatry and Behavioural Science examined suicide patterns for mental health patients of all ages. The report noted that:

*“The highest rate [of suicide] was observed in males with a previous history of suicide attempts but such limited contact with mental health services that a diagnosis of mental illness was never made. The majority of these people had only one short contact with a mental health service immediately following a suicide attempt. They had subsequently committed suicide before receiving any follow-up. This suggests that more attention should be paid to people who are hospitalised following a suicide attempt. The initial assessment should be comprehensive and a case exists for improved follow-up and ongoing risk assessment. A review of policy might be appropriate to ensure that a minimum standard of diagnosis and risk assessment is applied, with a period of intensive follow-up in the community.”*<sup>1</sup>

Admission to hospitals because of deliberate self-harming behaviour is 17 times more common than death due to suicide. Although the rate of attempted suicide is harder to determine, an indication of the extent of the problem can be gauged from the recent Child Health Survey. This survey found that 16 per cent of adolescent males and 29 per cent of adolescent females aged 15 to 16 in Western Australia reported having suicidal thoughts in the previous six months.

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

## Recent Initiatives

The National Youth Suicide Prevention Strategy was an initiative of the Commonwealth Government. The Strategy was allocated \$31 million from July 1995 to June 1999 to provide a coordinated approach to youth suicide prevention throughout Australia. Its goals were to reduce the rate of suicide, attempted suicide, suicidal behaviour and suicidal ideation in young people.

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<sup>1</sup> Coghlan R, Lawrence D, Holman CDJ, Jablensky AV (2001) *Duty to Care: Physical Illness in People with Mental Illness*, Perth: The University of Western Australia.

### 3 INTRODUCTION (continued)

The Strategy included direct prevention approaches such as:

- primary prevention and cultural change;
- early intervention;
- crisis intervention and primary care;
- treatment, support and postvention; and
- access to means/injury prevention.

System level activities such as policy and planning, research and evaluation, and education and training are also an important part of the Strategy. In practice, however, there is considerable overlap between direct and system level activities.

Between 1995 and 1999, the National Youth Suicide Prevention Strategy funded several projects evaluating crisis intervention and primary care. An evaluation conducted by the Australian Institute of Family Studies of these projects identified five main areas of interest. These are:

- recognition and assessment of deliberate self-harm in hospital Emergency Departments;
- post discharge follow-up;
- attendance at follow-up appointments;
- reduction in the rates of repeat deliberate self-harm; and
- facilitating a more comprehensive and systematic response to deliberate self-harm.

*Guidelines for the management of deliberate self-harm in young people by Emergency Departments were issued in June 2000.*

One of these projects was the development of guidelines for the management of deliberate self-harm in young people. These Guidelines were issued in June 2000 by the Australasian College for Emergency Medicine and the Royal Australian and New Zealand College of Psychiatrists. The Guidelines provide a framework for the management of deliberate self-harm within Emergency Departments and for linkages to ongoing care in the community, focusing on the care and treatment of patients.

The Guidelines establish:

- triage and assessment procedures within Emergency Departments;
- categorisation of patients into three broad groups of relative risk, with level of care depending on the risk category;
- requirements for immediate and continuing management;
- recommendations on the physical resources and personnel required for optimal management; and
- a structure with the potential for the evaluation of outcomes by a multi-centred approach.

State suicide prevention initiatives have also been introduced to supplement the National Strategy. In 1996, *Making a Commitment: the Mental Health Plan for Western Australia* and the *Report of the Ministerial Taskforce on Mental Health* were launched by the Department of Health to provide a comprehensive policy framework for the development of mental health services. These were endorsed by Government as draft plans and set out a number of specific strategies to be implemented and an indication of the year by which the strategy is to be achieved.

## Examination Objectives and Methodology

It has been shown that good service quality and assertive follow-up care can reduce repeated attempts at self-harm. This highlights the importance in investigating the adequacy of the services available to young people who deliberately self-harm.

This examination assessed the management of cases of deliberate self-harm in hospital Emergency Departments against the Guidelines, in order to evaluate the effectiveness of current services to young people who exhibit self-harming behaviour.

The objectives of the examination were to:

- assess the:
  - quality of services provided by hospital Emergency Departments to youth presenting with deliberate self-harm;
  - adequacy of hospital systems, procedures, policies and resources to provide quality services;
  - adequacy of post-discharge planning and continuity of care for youth presenting with deliberate self-harm;
- obtain views on service provision by hospitals from patients, service providers and patients' relatives; and
- determine the extent to which Western Australia has achieved policy objectives in the field of deliberate self-harm and how well this has been monitored and evaluated.

The methodology included the following elements:

- a review of the medical files of 220 deliberate self-harm patients was undertaken by medical experts. These files were randomly selected from the records of seven hospital Emergency Departments which together comprise more than 70 per cent of deliberate self-harm admissions for the State. The medical records were for patients treated during the period from June 2000 to March 2001. Both metropolitan and major regional hospitals were included in the sample. At all times, measures were in place to assure patient confidentiality;

### 3 INTRODUCTION (continued)

- an audit assessment of hospital systems, policies and resources was undertaken at 11 hospital Emergency Departments, including the hospitals in respect of which the patient file review was conducted;
- interviews were conducted with key Emergency Department staff, community service providers and deliberate self-harm patients;
- focus groups were conducted with deliberate self-harm patients, parents and community service providers;
- a Patient Satisfaction Survey was sent to 309 deliberate self-harm patients; and
- a review of literature was undertaken.

# 4 Service Quality

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- *Only three out of four of the reviewed files indicated that the deliberate self-harm patients received adequate quality of care in the Emergency Departments by emergency and mental health staff.*
- *Only three out of four of the reviewed patient files recorded essential information.*
- *Risk assessment processes are inconsistent and generally not based on the identified risk indicators.*
- *Deliberate self-harm patients:*
  - are not always treated with the appropriate level of urgency;*
  - wait longer for treatment than other patients with the same triage assessment; 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 waiting periods and transition between services.*

## Introduction

Quality of care in Emergency Departments is critical in terms of dealing with both the physical and psycho-social manifestations of self-harm. It is also critical that an effective assessment is made in the Emergency Department of the need for ongoing care and treatment for the issues underlying the particular instance of self-harm and that steps are put in place for linkages to that ongoing care. It is also likely that the manner in which young people are dealt with in Emergency Departments will influence their preparedness to follow-up on the ongoing care offered.

A random sample of patient files was examined by medical experts and conclusions were drawn as to whether both the treatment received and the records of that treatment were consistent with the best practice outlined in the Guidelines. The assessment focused on risk assessment, triage and waiting times, physical and mental assessment and discharge and follow-up. In addition, a rating of the quality of the documentation and service provided was also undertaken.

## Service Quality and Documentation

While the importance of the quality of service is self-evident, a sound approach to the quality of documentation about the patient and the particular presentation is also critical to assist with appropriate care on future occasions. Rating categories, explanations and results are provided in Table 1.

#### 4 SERVICE QUALITY (continued)

	Quality of service	Percentage of cases	Quality of documentation	Percentage of cases
Completely Inadequate	No recommendations met	1.3	Most essential information not recorded	2.3
Less than Adequate	Some recommendations met	22.3	Some essential information not recorded	23.6
Adequate	Minimum number of recommendations met	45.0	Essential information recorded	49.5
More than Adequate	Most recommendations met	25.5	Requirements fulfilled and additional information documented	21.4
Completely Adequate	All services recommended by Guidelines met	5.9	Requirements fulfilled and additional information documented. Files legible and identity of author is clear	3.2

Table 1: Rating of quality of service and documentation by expert reviewers.

*In only three out of four cases of deliberate self-harm, the quality of service and of documentation was rated as adequate or better.*

Source: OAG review of hospital records.

*The quality of service provided and documentation of files was adequate or better in only 75 per cent of the cases reviewed.*

The reviewers found a high correlation between quality of service provided and quality of documentation. This is not unexpected as service quality was determined by the content in the documentation. The absence of documentation can present problems for future presentations as the treating health professional cannot be certain whether the service was provided but not documented; or whether the service was not provided. This may hinder the provision of appropriate treatment. The reviewers also considered that the discipline of completing more comprehensive medical or psychiatric notes could focus the health professional on the individual patient's requirements thus improving that patient's quality of service.

The Guidelines also recommend that periodical file reviews should be conducted to assess the quality of documentation. Only one hospital in the review reported the conduct of any quality assurance checking of deliberate self-harm patient files.

The expert reviewers expressed concern about the general standard of documentation and in particular noted that the identity of the treating health professional was not always evident and discharge summaries lacked sufficient detail to assist adequate follow-up. This observation was echoed by community mental health services who commented on the paucity of information they receive, hindering the provision of care in the community.

While some concerns were expressed about the appropriateness of including psychiatric notes on medical records, particularly from a confidentiality perspective, inadequate or incomplete documentation clearly has the potential to compromise the continuity of care for patients. This risk increases in Emergency Departments where there is a high turnover of health professionals.

## Conduct and Reporting of Risk Assessment

Assessment of suicide risk is a critical component in the management of deliberate self-harm patients. Admitting and follow-up practices centre on the assessed probability of suicide and subsequent self-harm attempts. The assessment includes factors such as access to means to commit suicide, previous or current psychiatric illness and the seriousness of the current attempt.

*The Guidelines recommend a simple three-tier risk classification to guide treatment and follow-up.*

The Guidelines recommend a simple risk classification for the management of deliberate self-harming patients. The risk classification is based on a checklist of risk factors categorised according to immediate risk, serious risk and lesser risk.

The most frequently recorded factors used to determine immediate risk were major psychiatric illness, evidence of determined suicidal intent and treatment requiring more than routine observation. For serious risk, the most frequently recorded factors were evidence of serious psychiatric illness, history of psychiatric illness, previous suicide attempts, alcohol or drug abuse and continuing suicidal ideation.

Once the risk assessment is undertaken, the following care is recommended:

- *Immediate risk:* – patient to be admitted to an appropriate inpatient service and receive urgent psychiatric consultation. These patients will also require comprehensive and long-term follow-up.
- *Serious risk:* - patient usually requires an inpatient admission. Patients in this category may require short-term (24 hours) observation, particularly if they are recovering from the effects of poisoning or abuse of alcohol or drugs. In these cases, a mental health assessment should be performed once the patient is lucid and it is recommended that patients be followed up within 48 hours of being discharged.
- *Lesser risk:* - patient does not require inpatient admission although short-term observation may be necessary. Patients in this category should have a review appointment made prior to discharge or be contacted within three days of discharge.

None of the 220 files reviewed indicated that the risk category had been assessed in accordance with the Guidelines. The expert reviewers then determined the appropriate risk category from information contained in the files. The reviewers considered 79 persons to be immediate risk, of

## 4 SERVICE QUALITY (continued)

which only 65 were admitted to hospital. In the 14 cases where the patient was not admitted, files indicated that three patients refused to be admitted, four files did not give any reason for not admitting, three patients had other arrangements made for them, and four cases were not considered serious enough for admission.

There were 108 cases that were considered by the reviewers to be serious risk, 22 lesser risk and 11 that were unable to be determined. Half of the serious risk cases were admitted to hospital.

The Guidelines risk assessment factors were often not noted in the files. For example, more than 95 per cent of the files reviewed failed to record whether or not the patient had access to a firearm. This omission is particularly serious as access to firearms is closely correlated with successful suicides.

*Major risk factors were often not noted on file.*

The recording of the presence or absence of risk factors was often inadequate, for example:

- 22 per cent of cases did not record whether or not there was a previous suicide attempt.
- 22 per cent of cases did not record any history of alcohol or drug abuse.
- 14 per cent of cases did not record evidence of continuing suicidal ideation.
- 33 per cent of cases did not record whether or not the patient had chronic physical illness.
- 13 per cent of cases did not record if the patient had a history of psychiatric illness.

The most significant risk factor in eventual death by suicide is a previous attempt. The review of files found that at least half of the patients had a known previous suicide attempt.

The benefits to patients of assessment protocols for deliberate self-harm are not easily measured. However, when used as a tool to guide the ongoing management of deliberate self-harm patients they can prove very useful for health professionals to ensure that best management practice for each patient occurs.

## Triage and Waiting Times

On arrival at hospital all patients are assessed and prioritised by a registered nurse with specialist training in triage in order to prioritise the treatment of patients according to medical need. Each patient should be assigned a score on the Australian Triage Scale (ATS). This has five categories with ATS1 the most urgent.

The Guidelines recommend that all patients presenting with deliberate self-harm be categorised ATS3 as a minimum, which requires a maximum waiting time of 30 minutes. The longer that a deliberate self-harming patient is required to wait for treatment, the greater the risk of that patient leaving before treatment is commenced.

In 40 files (18 per cent) there was not sufficient information recorded to determine how long the patient waited for medical treatment.

Of the 220 patient files reviewed, 40 files contained insufficient information to allow a determination of whether the waiting time was consistent with the triage category and with the Australasian College for Emergency Medicine (ACEM) performance thresholds.

The majority of files (163) were given triage categories of ATS3 to ATS1. However, a significant number of immediate risk patients (46) were rated as not requiring medical assessment within 30 minutes.

There was no correlation between triage score and suicide risk: the expert reviewers found that seven patients they considered to be of immediate risk were not given triage scores, another immediate risk patient was categorised as ATS5 and 16 others as ATS4. This situation seems to be the result of assessing urgency in terms of medical need rather than suicide risk, a practice that does not comply with the Guidelines or ACEM recommendations. Because the full extent of suicide risk may not be made known until a more thorough assessment is made it is important to ensure deliberate self-harm patients are categorised according to these recommendations.

A comparison of waiting times against the performance benchmarks established by the Australasian College for Emergency Medicine are listed in Table 2.

ATS category	Maximum waiting time recommended by ACEM	Per cent of patients seen within maximum waiting times (%)		
		ACEM benchmark	All patients in 2000-01 at reviewed hospitals	This study of deliberate self-harm presentations
ATS 1	Immediate	100	80-100	50 <sup>(1)</sup>
ATS 2	10 minutes	80	65-99	50
ATS 3	30 minutes	75	54-100	58
ATS 4	60 minutes	70	51-99	44
ATS 5	120 minutes	70	58-100	100

Table 2: Comparison of study results and ACEM recommended waiting times and performance benchmarks for Australian Triage Scale categories.

*Deliberate self-harm patients are not treated within the recommended waiting time*

<sup>(1)</sup> Only two patients in sample.

Source: ACEM policy document, Health Service Performance Indicators 2000-2001, OAG.

In addition to establishing that deliberate self-harm patients are not treated in accordance with recommended waiting times this review found that their waiting times were longer than those for other patients assessed with the same medical urgency at the same hospitals as illustrated in Table 2. Seven patients were required to wait more than two hours for medical treatment, one of whom should have been seen within 10 minutes according to the triage score.

This is supported by findings from the survey and focus groups conducted as part of this review through which young people expressed concerns over long waiting periods for assessment.

## Physical and Psychological Examination

The Guidelines recommend that all deliberate self-harm patients receive a physical assessment and basic mental health assessment by a doctor. A comprehensive mental health examination by a psychiatrist or mental health clinician is also recommended. This examination includes the detailing of the patient's mental health and social history.

The expert review of files revealed that a physical assessment was carried out in 88 per cent of cases. Seventy per cent were reviewed by a mental health professional prior to discharge, of which 37 per cent had a basic mental health assessment by a doctor and 61 per cent had a full mental health status examination.

Twenty-eight per cent of the patient files reviewed had no evidence of any mental health assessment and three per cent had no evidence of a physical or mental assessment having been conducted. Where mental health status examinations were conducted, 92 per cent were rated as adequate.

The crisis that precipitated the self-harming behaviour was noted in 83 per cent of reviewed files. The Guidelines also recommend that collateral information be obtained from friends and family however this was only noted in 50 per cent of the files. It was not evident whether the reason for 50 per cent not containing collateral information was because the patient did not have friends or family present or denied permission for the health professional to interview them. The patient's social history was recorded in 74 per cent of the files.

The review noted however that some of the lack of documentation can be explained by the physical state or sobriety of patients on attendance. Following medical treatment, unless there is a basis for involuntary admission, it can be a challenge to persuade the patient to remain for further psychiatric assessment.

*It can be a challenge to persuade deliberate self-harm patients to remain for psychiatric treatment.*

## Discharge Planning and Follow-up

Research has shown that many persons presenting for deliberate self-harm will repeat this behaviour. Identifying ‘at risk’ patients and linking them with ongoing support and treatment is critical to reducing subsequent self-harm or suicide. Discharge planning and assertive post-discharge follow-up can be instrumental in providing this link to ongoing care.

*Engagement of the patient into ongoing care can be facilitated by treating the patient with dignity and respect.*

In addition, treating the patient with dignity and respect is crucial to facilitate them engaging in ongoing care and support. A survey of deliberate self-harm patients attending Emergency Departments indicated that many felt they were not treated courteously or shown respect by Emergency Department staff and that staff were rude and judgmental.

When treatment is not well coordinated and efficiently provided there are opportunities for patients to leave before the full range of recommended services are provided. This is illustrated in Figure 3.

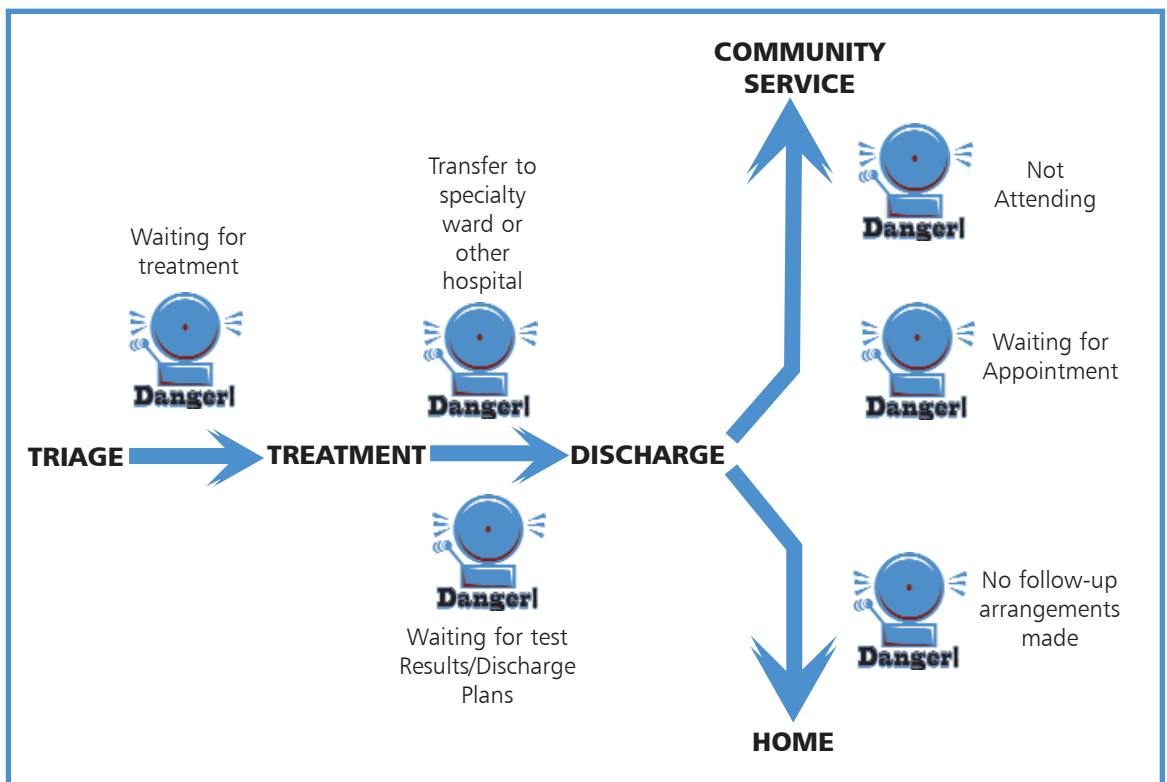


Figure 3: Points in the care process where the patient may exit the system.

*Opportunities for patients to ‘slip through the gaps’ occur at a number of places throughout the patient’s contact with the hospital, particularly during the waiting periods between services.*

Source: OAG

#### 4 SERVICE QUALITY (continued)

It is imperative that waiting times are kept to a minimum and appropriate plans and appointments are in place before the patient leaves hospital. The Guidelines state that discharge and follow-up arrangements should be the responsibility of the mental health staff. Appropriate follow-up arrangements would include such things as a discharge plan, informing the patient's GP, establishing contact with a community based support agency or the use of follow-up appointment cards.

In 73 per cent of the reviewed files the follow-up arrangements that were made were appropriate to the risk that the person posed to himself or herself.

Most patients (77 per cent) received a discharge plan. However, 10 per cent of patients were discharged without a discharge plan when, on expert review, one was clearly required.

A general practitioner was advised of the attendance at the Emergency Department in 45 per cent of cases. In 11 per cent of cases it was not applicable to advise the GP, 22 per cent did not have a GP advised and it was not possible to tell from the documentation in a further 22 per cent of cases.

In just over half of the cases a community service or other community-based professional other than a GP was advised.

Overall, 27 per cent of the files did not indicate that either a GP or other health professional was advised of the patient's attendance for deliberate self-harm, potentially leading to lack of follow-up in the community.

The use of appointment cards was very low. Only 14 per cent of files clearly stated that an appointment card was provided. A further 11 per cent stated that one was not provided and 13 per cent did not require one. Documentation was not sufficient to make a determination in 62 per cent of files.

## Recommendations

### ■ 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 which includes:

- a statement of objectives;
- assignment of responsibilities and accountabilities;
- setting of timelines;
- commitment of resources necessary to achieve the objectives; and
- establishment of mechanisms to regularly evaluate the effectiveness of the strategy.

As part of this action plan, effective measures need to be implemented to ensure:

- triage arrangements deal with deliberate self-harm patients in accordance with established risk categories;
- care is provided in accordance with the Guidelines;
- case documentation includes all essential information;
- opportunities for patients to 'slip through the gaps' are minimised; and
- an effective discharge plan is put in place.

# 5 Hospital Systems, Policies and Resources

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- *While the Department of Health expected hospitals to have already implemented the Guidelines, the Guidelines had not been uniformly distributed and implemented across the hospital system.*
- *Most metropolitan hospitals had either adopted the Guidelines or were developing their own policy consistent with the Guidelines. There was often a gap between policy and practice.*
- *Regional hospitals have yet to fully implement the Guidelines.*
- *In regional areas, after hours access to community mental health support was only available in Kalgoorlie.*
- *There were no training programs in place to educate staff about the Guidelines. Related training tended to be either clinical, in the form of case reviews, or about specific issues, such as risk assessment.*
- *A variety of information systems are in place to support management of Emergency Department patients. Consistency of data coding however limits the capacity to readily identify deliberate self-harm patients.*
- *Duty of care for the patient during the period between leaving hospital and accessing support and treatment in the community is unclear.*
- *Privacy and confidentiality policies are unclear particularly for patients aged 16-18 years and not living at home.*

## Introduction

The effective management of deliberate self-harm patients in Emergency Departments is contingent on the availability of adequate physical resources and appropriately trained clinical staff. The Guidelines make recommendations about the availability of resources, systems, protocols and policies that are necessary to support the provision of quality services to deliberate self-harm patients. These recommendations allow for differing local requirements in clinical infrastructure and needs to be accommodated. Implementation of these recommendations is also likely to benefit deliberate self-harm patients of all ages.

A review of systems, policies and resources was conducted at eleven hospitals including those where a file review was done. This review evaluated awareness and implementation of the Guidelines, availability of resources, training and education, information systems and continuity of care. The audit assessment sought to determine whether hospital Emergency Departments were aware of the Guidelines, and to what degree hospitals had implemented them or used them as a basis for developing their own guidelines more suitable to their particular clinical environment.

## Awareness and Implementation of the Guidelines

In June 2000, the Australasian College for Emergency Medicine and the Royal Australian and New Zealand College of Psychiatrists endorsed the Guidelines and distributed them to Fellows of the Colleges, that is, to specialist emergency physicians and psychiatrists.

The Department of Health has yet to formally endorse the Guidelines but advised the review that despite this, it expected that the Guidelines were being applied within the Western Australian health system. However, because the Department has not taken action to distribute the Guidelines it became apparent to the review that general practitioners and other doctors not affiliated with either of these medical colleges may not have received the Guidelines. This is of particular concern given that Emergency Departments in regional and rural areas are staffed by general practitioners and other doctors who may not be College members.

Similarly, many other health professionals such as social workers and nursing staff were unaware of the Guidelines and their roles as established by the Guidelines.

All teaching hospitals have adopted the Guidelines to varying degrees. One hospital adopted the Guidelines in total as its policy on the management of deliberate self-harm and two others had guidelines being developed that were reportedly consistent with the Guidelines.

*Staff are often not aware of the Guidelines.*

Most staff in regional hospitals interviewed as part of the review were unaware of the Guidelines. However, some regional hospitals had provided doctors with copies as part of their induction program and one hospital had the Guidelines available in the Emergency Department for medical staff. The review of files indicated that the level of implementation and compliance with the treatment aspects of the Guidelines was poor and there was little evidence that the Guidelines had been included into hospital policy.

While the Guidelines are intended for overall practice, they may not be applicable to all patients. The patients' circumstances and the availability of health care resources vary and management will be dependent on the judgement of the physician in charge.

## Hospital Resources

The Guidelines recommend that suitable interview and observation rooms be available for deliberate self-harm patients and their friends and family in Emergency Departments. These areas should balance the need for privacy and confidentiality with the need for adequate medical and security observation.

*Facilities appropriate for local need were available for interviewing and observing patients.*

All teaching hospitals examined had purpose-built interview rooms. All but one of the non-teaching hospitals had a room available for interviews, although the room was often used for other purposes as well. All hospitals had either a specific room for interviewing family and friends or used private offices.

Once patients have been medically stabilised it is often necessary to have ongoing observation for up to 24 hours before the patient is ready for discharge from the Emergency Department. Where observation is required, usually when overdoses or intoxication is involved, there should be an appropriately staffed observation ward separate from the Emergency Department should the clinical workload be sufficient to warrant it.

An emergency observation ward was available to some Emergency Departments. Where no dedicated ward was available, cubicles or rooms close to the nurses' station were used for observation.

It is important that Emergency Department staff have access to mental health professionals to provide urgent advice or assessment of deliberate self-harm patients.

The teaching hospitals have a wide range of specialist staff available. These include social workers engaged specifically to provide services to deliberate self-harming young people and the services of an on-call psychiatrist.

Regional hospitals, however, rely on the services of community-based mental health staff who are typically only available during normal office hours. The exception to this is Kalgoorlie Hospital, which has access to a 24-hour on-call service for deliberate self-harm patients provided by the community mental health team.

The Guidelines recommend that immediate risk patients be admitted to an appropriate inpatient service. To satisfy this recommendation it is necessary for inpatient beds to be available as required.

All hospitals in the review had access to inpatient beds should the patient require admission for medical reasons. However, availability of psychiatric inpatient beds in the metropolitan area is limited and considerable time can be taken attempting to locate one. Patients requiring a psychiatric inpatient admission can and have been sent home due to a lack of beds. In part this is due to a reluctance to admit adolescents to adult psychiatric wards. There are two child and adolescent psychiatric inpatient facilities in Perth, with only one having secure (involuntary) beds.

Deliberate self-harm goes beyond cultural boundaries. In the focus group of deliberate self-harm patients, Aboriginal young people expressed a great degree of shame at their self-harming behaviour and indicated that because of this they were more likely to leave the Emergency Department before receiving treatment.

Special resources are needed when dealing with culturally and linguistically diverse patients. All hospitals in the examination had access to appropriate interpreter services. Depending on the patient's language there can be delays of a few hours before an interpreter is engaged. While hospitals were reluctant to rely on multi-lingual staff members to act as interpreters, staff members would be used in emergencies.

*Kalgoorlie community mental health team provides a 24-hour on-call service to the hospital for managing deliberate self-harm patients.*

*Finding an inpatient bed in a psychiatric facility can be time consuming.*

Appropriate support services are important for all patients but particularly so for Aboriginal and Torres Strait Islander people. Although most hospitals have the services of an Aboriginal liaison officer available, these officers are not specifically trained to deal with deliberate self-harm patients. However, the Aboriginal liaison officer can provide advice to deliberate self-harm social workers and other health professionals who are dealing with Aboriginal deliberate self-harm patients.

Dealing with deliberate self-harm behaviour in young people can also be traumatic for the health professionals treating or looking after the patient. Access to debriefing or counselling should be available if required. Although debriefing or counselling can be arranged for staff on request, most hospitals indicated that such requests are not often received as debriefing tends to occur informally among peers.

## Training and Education

Appropriately trained clinical staff are vital for the effective management of deliberate self-harm patients. The Guidelines recognise that staff turnover means that there needs to be continuing education and training of emergency, psychiatric and community-based clinicians in the management of deliberate self-harm patients. The Guidelines recommend that policies and procedures be in place to meet the ongoing training requirements in assessment and treatment of deliberate self-harm patients.

*No hospitals had training programs dedicated specifically to deliberate self-harm.*

None of the hospitals in the examination have training programs dedicated to the management of deliberate self-harm patients. The teaching hospitals have structured training programs that include aspects of management for deliberate self-harm. A major focus of these programs is broad-based risk assessment and risk management, which are generic and often included in induction training.

In regional areas, training tends to be provided on an ad hoc basis by the community mental health service. Some hospitals acknowledged that a high level of staff turnover resulted in training time and resources being expended on induction at the expense of training in specific areas. Staff shortages also meant that where specific training was available attendance at training sessions was often low.

The Guidelines recommend that ongoing training for professional development should be based on the discussion of clinical cases. Such case reviews involve retrospective discussion and analysis by clinicians of difficult cases, particularly those cases with a negative outcome.

*Case reviews for professional development purposes are rarely conducted.*

However, structured case reviews for professional development purposes occur rarely. Although some hospitals schedule weekly or monthly meetings to discuss cases, case reviews tend to occur informally. Informal reviews are often simply discussions between the attending doctor and psychiatrist or take place during ward rounds where there is no opportunity for structured learning.

When the deliberate self-harm results in the death of the patient, cases are formally reviewed in all teaching hospitals. The social workers continuously review cases of deliberate self-harm and can provide feedback to other clinicians if necessary.

## Information Systems

Good quality information is essential for the ongoing management of patients and to assess patient outcomes. Policies and procedures should be in place regarding searching and accessing past hospital and health records including those from other hospitals.

For ease and validity of benchmarking comparisons across Australia, information systems should use nationally accepted data definitions. Coding practices also need to be consistent in order to facilitate easy identification of deliberate self-harm patients. In one hospital, for example, the expert reviewers had to return 21 patient records coded as deliberate self-harm when in fact they were accidental heroin overdoses.

The review found that medical records contained within the treating hospital could be obtained without difficulty. However, in some hospitals patients' mental health notes are not kept on the medical record and may be stored off site with access only available during working hours.

Where the patient advises of a prior admission to another hospital, details of the previous treatment can be obtained by fax. The efficient sharing of information that may be required where a patient presents at a different hospital is assisted in the metropolitan area where all public hospitals have access to a global patient information system (TOPAS). Joondalup Health Care Campus, which provides emergency services to a significant population under contract to the Government, no longer has access to this system and in lieu now operates its own system, which does not facilitate the exchange of information with other metropolitan hospitals.

In addition to TOPAS, teaching hospitals utilise the Emergency Department Information System (EDIS) to monitor patients. The system is used for monitoring waiting times and facilitates the identification of deliberate self-harm patients for social worker follow-up. However, inconsistencies in diagnosis coding inhibit effective identification and follow-up of deliberate self-harm patients. Thus, it is still necessary for the deliberate self-harm social workers to review daily logs and medical records to ensure no patients are overlooked.

In addition, each Teaching hospital also has its own specific database for tracking deliberate self-harm patients. The database was an initiative set up by the Youth Suicide Advisory Committee (YSAC), now the Ministerial Council for Suicide Prevention, in conjunction with its initial funding of deliberate self-harm social worker positions in teaching hospitals. This database is the only system that can adequately facilitate the tracking of patient outcomes.

More recently the Mental Health Division (MHD) of the Department of Health has assumed responsibility for funding the deliberate self-harm social worker positions. Appropriate arrangements for the maintenance, upgrading and back-up of the database, software and

*Identification and follow-up of deliberate self-harm patients is inhibited by inconsistencies in coding.*

*The HCare information system used in regional hospitals did not facilitate the identification of deliberate self-harm patients.*

computers is yet to be made, putting at risk valuable information. In addition, YSAC is experiencing difficulty in gaining access to the information, hindering valuable research in this area. Other limitations include coding inconsistencies between hospitals and the use of three separate databases in isolation. Greater sharing of, and access to, information would facilitate a more coordinated approach to intervention for mutual patients by deliberate self-harm social workers.

Regional hospitals use a system called HCare to manage patient information. However, limitations to the system meant that data concerning deliberate self-harm was not readily available to the review nor is it generally available in Emergency Departments. Most hospitals supplement this information system with a paper-based Emergency Department attendance register.

## Continuity of Care

The Guidelines recommend that because of the need for close collaboration between emergency services and mental health teams, regular meetings be held to review the management of mental health patients. This is to aid the continuity of patient care across medical boundaries. There must be a clear understanding between these parties as to who is responsible for the ongoing management of the patient at the various phases of care. To ensure effective care on discharge from the Emergency Department there is a need for effective collaboration and information exchange between the hospital, community mental health services and other agencies including drug and alcohol services and non-Government community services.

Most hospitals conduct meetings between Emergency Department staff and mental health staff to review management of mental health patients. teaching hospitals and some regional hospitals schedule regular meetings, while others conduct review meetings as required.

All the hospitals in this examination stated that there is a clear understanding of who is responsible for various phases of patient care whilst a patient is in the hospital. Such responsibilities, however, are rarely documented.

*Responsibility for patient care once they leave the Emergency Department is not clear.*

There is some uncertainty however as to duty of care for the patient once the patient leaves the Emergency Department and prior to community-based treatment. There may be a considerable gap in time between leaving the Emergency Department and the next contact with health professionals. During this time there may be ongoing contact with the deliberate self-harm social workers, in the case of those who attended teaching hospitals.

It is recommended that the patient not leave the Emergency Department without a friend or relative being informed. This can be difficult for privacy reasons, especially when the patient is over 18 or is a minor not living at home. The consensual view is that patient safety is paramount and overrides privacy and confidentiality requirements.

All hospitals reported that appointment cards of some description are provided to deliberate self-harm patients. However, the file review found that hospitals did not consistently document follow-up plans on patients' medical records and that appointment cards were not always used for deliberate self-harm patients.

The review found that teaching hospitals have clear policies and procedures regarding informing appropriate health professionals responsible for continuing management of deliberate self-harm patients. This includes an effective system for the referral of patients to community-based services. Most referrals are managed by deliberate self-harm social workers who often have close ties with community-based services, both government and non-government.

*Albany Regional Hospital has a discharge coordinator to engage patients with community services.*

Regional hospitals have close relationships with community-based mental health services and an understanding of referral requirements although these are not always formalised. Albany Regional Hospital has a discharge coordinator based in the mental health ward to link patients with appropriate community services. Hospital staff do not have access to advice and services from community-based mental health professionals outside of normal business hours except in Kalgoorlie.

Assertive follow-up by community services is essential to improve long-term outcomes for deliberate self-harm patients. The teaching hospitals have policies regarding follow-up of patients. Follow-up plans are provided to deliberate self-harm patients who are discharged from the Emergency Department and it is policy that the follow-up plans are documented on the medical record.

When patients are admitted to specialist wards, such as plastic surgery and orthopaedic wards, there can be inadequate coordination of follow-up arrangements.

Of the regional hospitals reviewed only Kalgoorlie Hospital had specific policies regarding the follow-up of patients. Although most regional Emergency Departments do not provide a formal follow-up plan, the hospitals use their close relationship with community-based mental health services to provide some degree of follow-up for deliberate self-harm patients. It is unclear whether this information would appear on the medical records. In many regional areas the treating doctor at the hospital is also a general practitioner and will be involved in follow-up. This scenario may lead to less than adequate documentation in the hospital medical record.

*Health professionals based in schools are not routinely informed of self-harming behaviours by one of their students.*

A gap exists in the continuing management of young people who self-harm as no appropriate process or protocols exist for informing school psychologists or school nurses of the self-harming behaviour. This can mean that these health professionals are not in a position to appropriately assist the young person.

## Deliberate Self-Harm Social Workers

The deliberate self-harm social worker positions, a good example of best practice, were set up and funded through the YSAC in 1989. More recently, the MHD assumed responsibility for providing recurrent annual funding to the teaching hospitals for these positions. These positions play an important role in bridging the gap between hospital and community-based care.

The primary responsibilities of the deliberate self-harm social workers are to:

*The deliberate self-harm social workers have a key role in ensuring continuity of care for the patient.*

- provide assertive intervention while in the hospital environment;
- coordinate follow-up arrangements for ongoing community-based treatment;
- provide support and short-term counselling as required until care is taken over by a community service (up to three months);
- keep up-to-date a database of deliberate self-harm patients for outcome monitoring and epidemiological research; and
- provide an annual report to the Department of Health that includes details on patient demographics, methods of self-harm, admission and follow-up statistics.

The hours of coverage are primarily in business hours with some weekend availability. These services are generally not available after 5pm.

At present, the protocol for advising the deliberate self-harm social workers of attendances by deliberate self-harming patients is not formalised or working efficiently.

The review noted that the employment arrangement for these positions vary and impact on the provision of services and ability to fill positions. In the case of one hospital, the social worker had been engaged on renewable three monthly contracts for over five years. This was remedied during the period of this review.

The review noted conflicting information regarding the current funding arrangements regarding coverage for these positions during periods of leave or while attending professional development courses. The view obtained from hospitals was that, where possible, hospitals meet this commitment through their existing resources but often the service cannot be provided. The Department of Health maintains that funding arrangements include provision for leave cover and that the issue lies with hospital administration.

## Recommendations

■ **The Department of Health should:**

- review its mechanism for endorsing and implementing across the Western Australian health system guidelines and policies endorsed by professional bodies.
- endorse the Guidelines for the Management of Deliberate Self-Harm in Young People and ensure their implementation across the Western Australian health system.
- develop clear policies regarding confidentiality for patients between 16-18 years and duty of care while waiting for community-based treatment.

■ **The Department of Health and hospitals should:**

- review information system requirements to support the implementation of the Guidelines and monitoring of outcomes for deliberate self-harm patients.
- clarify employment arrangements for the deliberate self-harm social workers.

■ **As part of their action plan to support the Guidelines, hospitals should:**

- ensure all relevant staff are adequately trained in the requirements of the Guidelines.
- ensure policies and procedures are developed and implemented.

# 6 Follow-up by community-based services

- *Local policies and practices mean there is great variation in the manner in which community mental health services provide services to their clients.*
- *Waiting times for accessing community-based mental health services by deliberate self-harm clients can be excessive.*
- *Delays in providing discharge summaries to community-based mental health service can be lengthy.*
- *Community-based mental health services have limited capacity to assertively maintain engagement with at-risk clients. The exception is in relation to those services with a staff member focusing on suicide intervention.*
- *Little to 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.*

## Introduction

The Guidelines recommend that young people treated at an Emergency Department for deliberate self-harm should receive timely follow-up services in the community that are appropriate for their assessed level of risk. Research has shown that during the period following the deliberate self-harm act there is a much higher risk of subsequent self-harm and suicide and so the time between leaving hospital and first community-based appointment should be minimised. In addition, assertive actions are necessary to ensure the patient attends and continues to attend the community-based service.

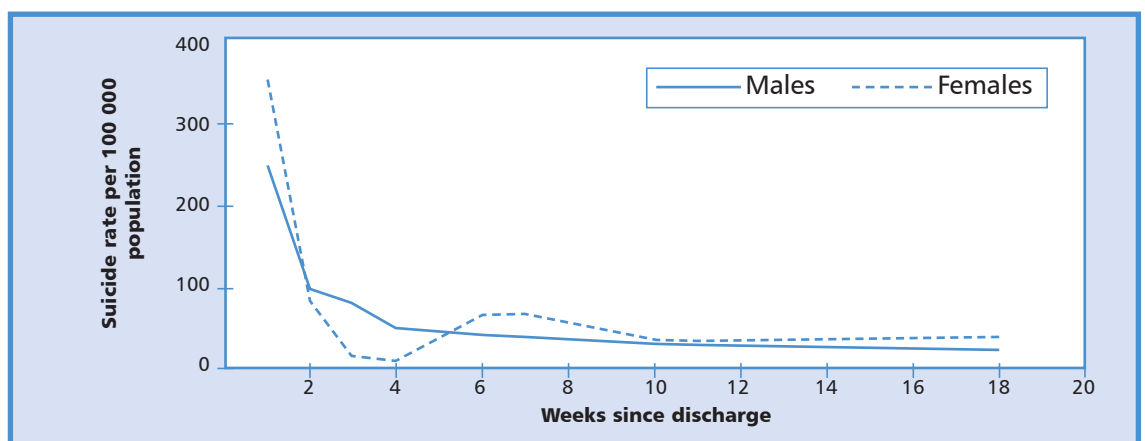


Figure 4: Suicide rates by time of discharge from inpatient care.

*The highest risk of suicide for mental health patients of all ages is in the first seven days after discharge from inpatient care.*

Source: University of Western Australia Department of Public Health.

Establishing post-discharge treatment plans and making contact with community-based clinicians prior to discharge can be instrumental in maintaining continuity of care and minimising risk of subsequent deliberate self-harm and suicide. The current process of maintaining client engagement during this period has been identified by community service providers as a point “where the system falls down”. Implementing these recommendations requires action by both the hospital and the community-based service provider.

In “Duty to Care”, the authors note the current approach of treating acute mental illness in the community wherever possible has raised several issues for patients at risk of suicide. These are:

- adequate resourcing for community-based care;
- effective continuity of care between inpatient and community-based care;
- difficulties in monitoring the transition between the two; and
- identification of responsibilities for patient well-being at each stage of care.

### Transition between Hospitals and the Community

Arrangements are in place for the regional community-based services to provide assistance with assessment and follow-up planning during the period that a patient is in hospital. These arrangements contribute to a shorter waiting time and smoother transition to community-based treatment than in the metropolitan area. Hospitals, however, can tend to rely on this service which has its limitations, as most community-based services are open only during normal business hours. Kalgoorlie is the only regional hospital where the community mental health team provides a 24-hour on-call service for deliberate self-harm patients presenting at the hospital.

*There can be a long gap between discharge from hospital and admission to community-based services.*

Deliberate self-harm social workers and hospital outpatient clinics provide support for patients during the transition period to community-based services. However, there can be a long gap between discharge from hospital and admission to community-based treatment. This waiting period can result in disruption to the patient’s continuity of care with the possible result of increasing the risk of subsequent self-harming behaviour.

Research suggests that bridging the gap between hospitals and community-based services will be more effective where:

- clients are provided with an after-care plan prior to discharge from hospital;
- clients receive follow-up treatment or contact according to assessed risk with this contact to occur within at least three days; and
- services assertively follow-up when clients do not attend routine clinic appointments.

It is well recognised that quick initiation of treatment is vital to managing the risk of repeated attempts at self-harm. The review found that deliberate self-harm patients may wait longer for follow-up than is recommended for their assessed risk. Barriers to more timely treatment may include unclear or cumbersome engagement protocols and case assignment procedures, client age and location of residence, resourcing, and poor utilisation of information systems. All of these may contribute to difficulties in engaging with clients and maintaining that engagement.

## Barriers to Effective Community Follow-Up

### Engagement and Assignment Protocols

On discharge from hospital, deliberate self-harm patients can be referred to Government child and adolescent or adult mental health services for ongoing support and treatment. Other referrals to these services may come from other sources. The formal referral processes for Child and Adolescent Mental Health Service (CAMHS) clinics are summarised in Figure 5 below.

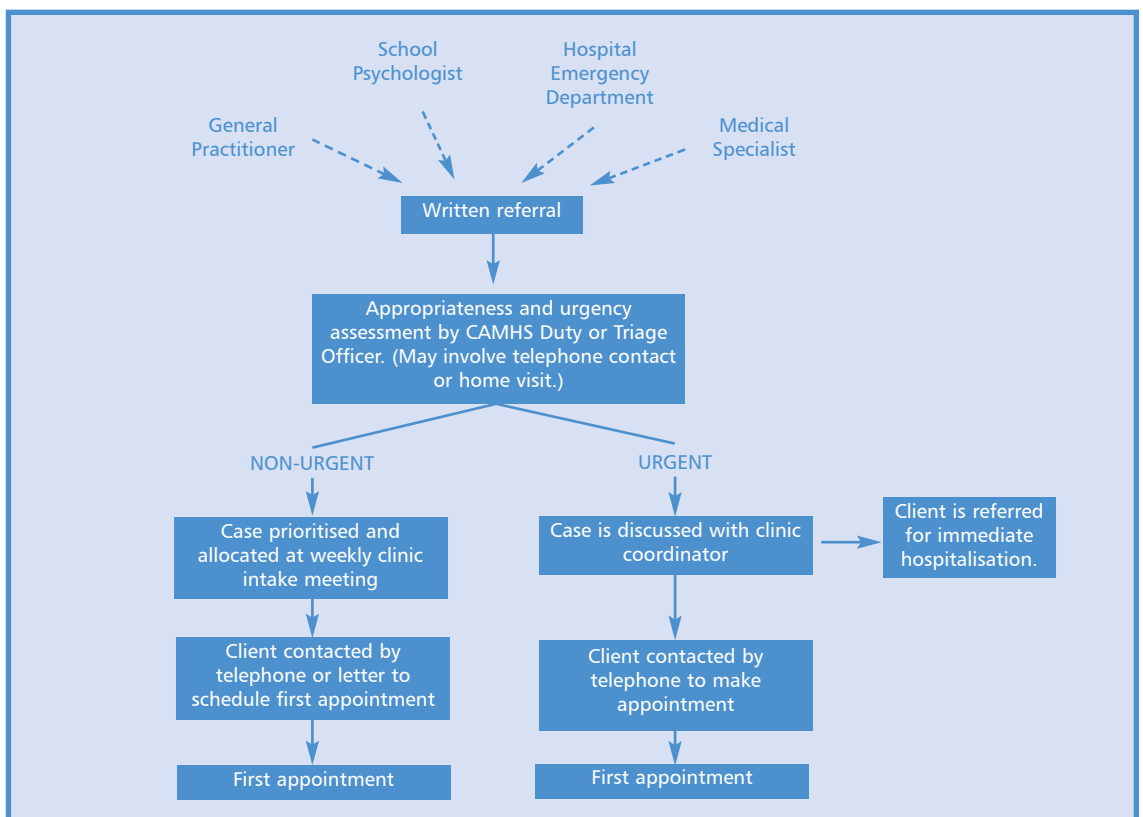


Figure 5: Summarised referral process for Child and Adolescent Mental Health Services.

Source: OAG

There is variation across clinics as to referral processes. Some CAMHS clinics will accept self-referrals on the basis that a self-referral presents an opportunity to engage a client at a point when they are actively seeking help. Other clinics follow operational guidelines that require referrals to be in writing from a primary service provider. This means that clients or their families who make direct contact with CAMHS are redirected to an appropriate primary service provider, such as a local general medical practitioner, to obtain a formal referral. This effectively delays access to treatment for clients who are actively seeking treatment.

The transition from hospital inpatient wards to community-based treatment is not necessarily automatic or smooth. It requires the admitting hospital to notify the appropriate clinic that a patient from the relevant catchment area has been admitted. A community-based clinician then becomes involved in meeting the patient, becoming familiar with the presenting issues and inpatient treatment, establishing a case management plan with the patient and hospital clinicians, and arranging the first post-discharge appointment. Duty of care for clients during this period is not clearly defined.

*Involving community mental health services pre-discharge can help bridge the gap between hospital and community care.*

CAMHS have indicated that they are rarely notified of inpatient presentations at the time of admission and often do not become aware that a patient from the catchment area is in hospital until discharge is imminent. This does not allow sufficient time for community-based clinicians to attend discharge meetings and, as a result, the first contact with the patient is often post-discharge by telephone or letter to arrange a first appointment. In a recent instance, CAMHS was not made aware of an inpatient stay until nine months after discharge.

For patients being discharged from hospital Emergency Departments, the referral process requires the Emergency Department to forward (usually by facsimile) details to CAMHS for follow-up. This notification does not always occur or can contain incomplete details that hinder the ability of community-based service providers to contact clients for follow-up appointments.

CAMHS personnel find it difficult to get face-to-face contact with clients while they are still in the Emergency Department because of their workloads, geographical separation and the short time a client remains in the Emergency Department. The review noted that ease of access was facilitated in some locations where community mental health services were adjacent to the hospital.

### Age of Client

The target population for CAMHS is 0-18 years. Older clients are serviced by community-based adult mental health services. The appropriateness of adolescent versus adult mental health services can, however, represent a 'grey area' for clients between the ages of 16-20 years, depending on the maturity of the client and the nature of the treatment issue.

Most CAMHS clinics are flexible in relation to accommodating older clients for whom adult services might not be appropriate. For example, most clinics will accept clients who are over 18 or are likely to turn 18 during treatment, particularly when a young person is already a client of the clinic and the treatment issue is a developmental one. Similarly, adult mental health services have some flexibility to treat adolescents approaching adulthood. Adult services are willing, for example, to treat 16 and 17 year olds on the basis of developmental maturity, independent living status, no longer attending school, and whether the presenting issue is an adult, rather than an adolescent, issue.

## Location of Residence

Community mental health services are regionally based, with formal client catchment areas. Some services adhere rigidly to these catchment boundaries even though the Department of Health policies prohibit this practice. This means that new clients who live outside the catchment area are referred onwards to the appropriate local service and existing clients are transferred when they move residence. However, in relation to existing clients who move out of the formal catchment area, the clinics were prepared to make exceptions.

Other services take a more flexible approach to geographic boundaries, accepting new clients who live outside of the formal catchment area and continuing to see clients who move to different areas. Services that operate without rigidly adhering to formal catchment areas do so in order to facilitate access for people who work or go to school near the clinic, as well as out of a more general operational philosophy of not turning away clients in need.

## Resourcing

While non-urgent patients may wait many months prior to being engaged in treatment, serious cases, including deliberate self-harm are engaged sooner. Research shows that risk of suicide is highest within the first seven days after leaving hospital. The Guidelines recommend that serious risk patients receive follow-up within 48 hours of discharge and lesser risk patients should be reviewed or contacted within three days, while the Department of Health general recommendation for mental health patients discharged from psychiatric inpatient facilities is for follow-up to occur within five days regardless of risk.

Staff in community-based clinics have significant caseloads and as a result delays in engaging a deliberate self-harm patient may occur. In addition, staffing levels and opening hours limit the capacity of services to see these patients sooner.

Although deliberate self-harm patients were prioritised as requiring urgent treatment, the review noted that services could not readily supply details of the number of deliberate self-harm patients being seen, how soon they were engaged and frequency of treatment.

*Services could not readily supply service delivery details for deliberate self-harm patients.*

The ongoing management of deliberate self-harm can also be compromised by the resource intensive nature of the patients. Services described deliberate self-harm as either:

- arising in response to a crisis and requiring short-term and relatively simple management; or
- symptomatic of more chronic illness requiring longer term treatment.

Although the former is typical of the majority of cases, the latter cases tend to be more resource intensive to manage in the community. These cases may be characterised by compounding psychosocial problems, including a profound lack of social support for the young person, and can be highly resource intensive, particularly in terms of maintaining engagement with the client. The need for assertive follow-up, frequent clinical contact, and back-up clinical personnel can all contribute to the resource intensity of treatment for these clients.

Community mental health services vary in their follow-up practices for clients who fail to attend appointments or respond to telephone contact. Follow-up practices range from a “three strikes and you’re out” approach to highly assertive strategies that involve multiple telephone calls, home visits, and follow-up with people within the young person’s support network, including parents, teachers, school psychologists, friends, and general medical practitioners.

Although no management information is kept regarding follow-up activity and outcomes, the two services with a dedicated suicide intervention officer were notably more positive about their ability to conduct assertive follow-up and successfully maintain engagement with self-harming and suicidal clients. In both of these services, clients are managed by the Suicide Intervention Officer (SIO) for three months and then referred onwards for longer-term care. This dedication of the SIO position to acute care enables a quick response to urgent referrals as well as more assertive follow-up of clients who do not attend appointments. These services are also active in forming links with school psychologists and nurses, youth agencies, general practitioners, and other health services.

### Management Information

CAMHS clinicians estimate that deliberate self-harm and suicidal ideation is an issue for up to 80 per cent of the client population at some time during treatment. However, there is very little management information available to assist with service planning and provision for deliberate self-harm clients.

No summary information describing the incidence, management, or outcomes for clients with self-harming behaviours is collected and utilised by CAMHS. The one exception is Kelmscott where a separate statistical database for self-harming and suicidal clients is maintained which assists with the effective management of this population. The information is actively used to identify issues impacting on the management of clients, for example, identifying the propensity for transient or homeless youth to refuse contact or drop out of treatment.

A Local Area Mental Health Information System (LAMHIS) supports the management information requirements. However, inconsistencies in data coding and definitions and incomplete data limit its effectiveness. It is not clear yet whether recently introduced procedures will improve this situation.

## Recommendations

### ■ 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 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, for example school based counsellors.

### ■ Community mental health services should:

- ensure that adequate management information is available and utilised to improve service delivery.

# 7 Achievement of Health Policy and Strategic Directions

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- *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 effective in facilitating inter-agency coordination. However for objectives to be achieved, individual agencies must commit to an achievable strategy and implementation plan including details of resourcing, timelines and priorities, monitoring, evaluation and reporting.*

## Background

The nature of deliberate self-harm and attempted suicide means that no one State agency is fully responsible for the provision of care and support. While instances of self-harm may be linked to mental illness or psychiatric conditions, other community, societal and personal issues may also be contributory factors, such as homelessness, unemployment and relationship crises.

While the Mental Health Division of the Department of Health is responsible for government policy in relation to the provision of psychiatric care in hospitals and in the community, other government agencies have primary policy and/or service delivery responsibility in related areas and in addition, non-government organisations may also contribute to the provision of care and support.

This suggests that an effective plan or strategy is required to guide the provision of various State services to young people at greater risk of suicide and to coordinate State services with those provided by non-government agencies. Effective implementation of such a plan is also likely to require a formal assignment of responsibility and regular monitoring and evaluation of progress towards meeting the identified policy objectives.

## Health Policy

As part of a wider health review, the Department of Health launched *Clinical Health Goals and Targets for Western Australia* in 1994, as a State response to a set of national health goals and targets. In relation to deliberate self-harm, the Goals and Targets focused on providing mental health support to people treated for deliberate self-harm in teaching hospitals and the Department continues to fund social work positions within the Emergency Departments of teaching hospitals to facilitate this work and to assist with follow-up support after the emergency treatment.

While the Department has advised this review that the Goals and Targets strategy has now been largely superseded, no formal evaluation was conducted of the Goals and Targets strategy and

there is no evidence of any formal reporting regime to enable regular review of progress, prior to its abandonment. In addition, mental health services have advised that they are unaware that these strategies have now been superseded.

In 1996, *Making a Commitment: the Mental Health Plan for Western Australia* and the *Report of the Ministerial Taskforce on Mental Health* were launched to provide a comprehensive policy framework for the development of mental health services. These were endorsed by Government as draft plans to enable adjustments to be made to specific strategies as required.

*The Department advises that the State Goals and Targets and the Mental Health Plan have been superseded.*

The 1996 Plan sets out a number of specific strategies to be implemented and an indication of the year by which the strategy is to be achieved.

While an account of changes made in mental health services has been published, in *Mental Health Service Reforms- 2 Years on* (1998) and *Mental Health Reforms in Western Australia: a Report of the Government Reform Program* (2000), these accounts set out in broad terms what has occurred, with no clear linkages to the detailed strategies established in the 1996 Plan. It is therefore unclear which of the 1996 strategies have been achieved, which are no longer considered priorities and which are still in the process of implementation.

In relation to deliberate self-harm and suicide, this review noted that the 1998 and 2000 documents are virtually identical, that is, the documents are set out in terms of things yet to be done, rather than an account of what has been achieved.

An analysis of documents provided by the Department in response to a request for details of progress made against the previously stated objectives indicates that while some progress is evident, there has not been a systematic attempt to drive the implementation of the Plan and that no clear accountabilities have been assigned for achieving the various objectives in relation to deliberate self-harm. Hence it is not possible to conclude the status of the Plan or its achievements. The Department has advised this review that the Plan has also been effectively superseded.

The Department claims that it has been regularly monitoring its youth suicide prevention strategies and that the deficiency is in the systematic recording of this action.

## Inter-Agency Coordination

The Youth Suicide Advisory Committee (YSAC) was established in December 1988 as an inter-departmental and inter-sectoral committee to coordinate efforts to reduce the rising toll of suicide and self-harm among Western Australian youth. The committee reports directly to the Minister for Health and makes recommendations to him as appropriate. Its initial terms of reference required that it:

- report to the Minister for Health annually on progress to reduce deliberate self-harm and suicide, and make recommendations to him as appropriate;

## 7 ACHIEVEMENT OF HEALTH POLICY AND STRATEGIC DIRECTIONS (continued)

- oversee the implementation of recommendations initially made by the 1988 Ministerial Task Force on Youth Suicide and monitored by the Committee in the areas of research, service delivery, and containment of suicide clusters with reference to:
  - maintenance of ongoing research and project evaluation;
  - support maintenance of the WA Schools' Strategy for suicide prevention, and implementing universal preventative school programmes in government and non-government sectors;
  - provision of in-service suicide prevention education and training for professionals State-wide to identify and promote best practice;
  - development of networking arrangements for relevant Departments and agencies, in particular extension to country areas; and
  - encourage implementation of youth suicide prevention curriculum in tertiary education targeting health and other professionals dealing with youth.
- function as a coordinating body to ensure that the various departments and non-government agencies involved are aware of current activity in the area, and to ensure good communication between those groups; and
- ensure that the recommendations, once implemented, continue to be carried out appropriately.

The Committee has been, and continues to be, a unique and innovative policy response to youth suicide which has become a model for other States and Territories and the establishment of the National Advisory Council for Youth Suicide Prevention and the National Suicide Prevention Strategy in 2000.

However, it should be noted that the YSAC is an advisory committee with wide and diverse representation. It has no line management or patient service delivery responsibilities either within Health or other areas of the public service. Thus, it cannot be accountable for achievements against the State Strategy, but rather works to facilitate debate and policy development that must then be the subject of line agency consideration and commitment in order to secure the appropriate changes to service delivery and the achievement of policy objectives.

In September 2001, the WA Minister for Health recommended that YSAC should broaden its remit to include the prevention of fatal and non-fatal suicidal behaviour across all age groups in Western Australia. This brings the Committee's objectives in line with those of the current National Suicide Prevention Strategy. It also acknowledges the fact that suicide is now most frequent among people in their late twenties and early thirties and that hospital admissions for deliberate self-harm occur most commonly among those in their late teens and early twenties.

*Suicide prevention strategies are to be widened to focus on all ages.*

*The MCSP can facilitate cross-agency collaboration and strategy development.*

The committee will continue to report to the Minister for Health but is now also required to advise all Ministers represented on the Cabinet Standing Committee on Social Policy. In recognition of these changes the Committee has been renamed the Ministerial Council for Suicide Prevention (MCSP). The Council has also been asked to prepare a three year Strategic Plan for the prevention of fatal and non-fatal suicidal behaviour in Western Australia to be presented at the Cabinet Standing Committee on Social Policy in November 2001.

The Council adopted the following guiding principles in July 2001. Suicide prevention:

- is a shared responsibility across the community, professional groups, non-government agencies and the government sectors;
- requires a diversity of approach, targeting the whole population, specific population subgroups and individuals at risk;
- must be evidence-based and outcome-focused;
- must incorporate community and carer involvement and expert input;
- activities must be accessible to those who need them, and appropriate and responsive to the social and cultural needs of the groups or populations they serve; and
- must be sustainable, to ensure continuity and consistency of service for communities, and evaluation must be an integral part.

*The responsibility for the implementation and achievement of suicide prevention strategies remains with individual agencies.*

Suicide and deliberate self-harm are social problems that need to be dealt with by a number of public sector agencies. YSAC (or MCSP) is now positioned to facilitate across agency coordination. However, it remains the responsibility of individual agencies to ensure the development of strategies and implementation plans. Those plans should include:

- statements of principles and objectives;
- estimation and allocation of the resources needed to bring about change;
- clear timelines for the achievement of the plan;
- assignment of responsibilities and accountabilities; and
- preparation of evaluation criteria and systems to capture the required measurements.

## Accountability for Outcomes within the Health Sector

Recent reports have identified the issue of accountability in the health sector as needing clarification. In particular, the structure of the health system is said to preclude clear lines of accountability for health outcomes resulting in a lack of accountability and transparency in reporting on the achievement of health outcomes.

The recent Machinery of Government report comments on the Health portfolio in the following terms:

- there is fragmentation in the portfolio and unclear linkages contribute to blurred lines of accountability for services and an “us and them” perception;
- there is no locus of accountability for health outcomes; and
- there is no apparent rationale or principles behind the portfolio structure.

It is evident from this examination that these concerns are also applicable in relation to deliberate self-harm and suicide prevention.

While the establishment of consultative mechanisms such as the Ministerial Council for Suicide Prevention is a positive step towards ensuring that important issues are given cross-Government consideration at the highest levels, there remain some deficiencies in current practice in that individual agency commitments to the State strategy for suicide prevention are not articulated, monitored or evaluated.

### Recommendations

- **State strategies for suicide prevention need to be regularly reviewed and evaluated and progress on achievements publicised via a regular reporting mechanism.**
- **Agencies need to develop implementation plans consistent with the State strategy for suicide prevention, with these clearly articulating agreed timelines, the resources allocated and the evaluation strategy.**

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