If you need crisis support, call Lifeline on 13 11 14, or call Kids Helpline on 1800 55 1800, 24 hours a day. For general support, talk to your GP or local health professional.

7 Ways of preventing and reducing suicide by young people by the Department of Health

7.1 Introduction

Chapter 4 identifies that a total of 12 (33 per cent) of the 36 young people were recorded as having been diagnosed with a mental illness. Eight of the 12 young people were recorded as having allegedly experienced at least one form of child maltreatment. These young people have been included in Group 1. In addition to child maltreatment, these eight young people were also recorded as having experienced many of the other factors associated with suicide, including self-harming behaviour, suicidal ideation and previous suicide attempts.

The remaining four young people who were recorded as having been diagnosed with a mental illness were also recorded as having demonstrated self-harming behaviour, suicidal ideation and previous suicide attempts. However, none of these four young people were recorded as having allegedly experienced child maltreatment or any adverse family experiences other than a parent with a mental illness. These young people have been included in Group 2.

The research literature identifies mental illness as a factor associated with suicide. The Child and Adolescent Mental Health Service (**CAMHS**), administered by the Department of Health, has a central role in providing assessments, case coordination and treatment services for children and adolescents under 18 years of age who have severe, complex and persistent mental illness. Services provided by CAMHS include:

- outpatient services provided in the community; and
- inpatient services (including at Princess Margaret Hospital and the Bentley Adolescent Unit).

CAMHS also provides specialist programs and services, including:

- intensive intervention programs for specific illnesses or circumstances including the Eating Disorders Program and the Family Pathways and Multi Systemic Program; and
- youth services including Youth Link and Youth Reach.[179]

There are a number of ways a young person may be referred for assessment and potential treatment by CAMHS, the most usual being referral by a general practitioner or by a hospital emergency department. All of the 12 young people who were recorded as having been diagnosed with a mental illness were referred for assessment by CAMHS at some point in their lives. This contact presents an important opportunity to recognise and respond to mental illness and thereby to reduce the risk of suicide. This chapter examines referrals to CAMHS, acceptance of referrals by CAMHS, risk assessments, treatment and discharge planning for the 12 young people who were recorded as having been diagnosed with a mental illness.

[179] Government of Western Australia, Department of Health, Child and Adolescent Health Service, *About Child and Adolescent Mental Health Service*, 2013, viewed 26 September 2013, <http://pmh.health.wa.gov.au/general/CAMHS/>.

7.2 Legislative requirements applicable to mental health services

The primary piece of legislation setting out the requirements for the care, treatment, and protection of people who have a mental illness in Western Australia is the *Mental Health Act 1996* (**the Mental Health Act**). The objects of the Mental Health Act include:

> (a) to ensure that persons having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity;
>
> (b) to ensure the proper protection of patients as well as the public; and
>
> (c) to minimize the adverse effects of mental illness on family life (section 5).

The Mental Health Act also defines the governing structure of mental health care in Western Australia, including the functions of the Minister for Health and the responsibilities of the Chief Psychiatrist. The functions of the Minister for Health include:

> (a) to promote the development and co-ordination of services for the care and treatment of persons who have mental illnesses; and
>
> (b) to promote the integration of, and co-operation between, health and welfare services at State, regional, and local levels; and
>
> (c) to encourage the development within the community of services emphasizing —
>
> (i) the prevention of mental illness; and
>
> (ii) the early detection and treatment of mental illness;
>
> and
>
> (d) to promote the development of voluntary and self-help groups and other community agencies for assisting persons who have mental illnesses and their families (section 8).

The responsibilities of the Chief Psychiatrist in relation to patients are:

> (1) The Chief Psychiatrist has responsibility for the medical care and welfare of all involuntary patients.
>
> (2) In respect of other patients, the Chief Psychiatrist is required to monitor the standards of psychiatric care provided throughout the State (section 9).

7.3 Policies and standards for referrals, acceptance of referrals, risk assessments and discharge planning by mental health services

7.3.1 Priorities for acceptance of referrals by CAMHS

The *WA Country Health Service Child and Adolescent Mental Health Service Access Criteria Policy* sets out priorities for acceptance of referrals to CAMHS outpatient services (also referred to as 'intake'), for assessment upon intake and/or treatment, which states that young people are a priority for intake if they:

- have been discharged from an inpatient mental health unit;

- are likely to be diagnosed with a mental disorder;
- are at high risk due to the severity of their suicidal ideation, self-harming behaviour or present a risk of harm to others; and/or
- are exhibiting severe symptoms leading to substantial impairment of functioning. This could be in the context of family breakdown, delinquency, educational risk, vocational risk, school refusal and risk to peer relationships.[180]

Policies applied in analysing the young peoples' acceptance of referrals to CAMHS were relevant at the time of referral. The Department of Health advises these policies have been subsequently updated.

7.3.2 Policies and standards for risk assessments and discharge planning

The Department of Health's policy entitled *Clinical Risk Assessment and Management in Western Australian Mental Health Services: Policy and Standards* (**the CRAM Policy**) outlines a standardised approach that all WA Health mental health services are required to follow to manage clinical risk, thereby ensuring the proper protection of patients as well as the public. The policy defines three main risk areas:

- risk of harm to self (including self-harm and suicide);
- risk of harm to others (including violence and aggression); and
- risk of harm by others (physical, sexual or emotional harm or abuse by others).[181]

The CRAM policy applies to all hospitals and health services comprising WA Health, including CAMHS, mental health in-patient units and emergency departments of all hospitals.

The CRAM Policy also sets out requirements for risk assessments, and a corresponding risk management plan, once a decision has been made to accept a young person for intake and treatment (admission), as well as when a young person's circumstance changes. These requirements are as follows:

> Clinicians [will] assess patients for risk on admission routinely, when their condition changes and before discharge. Informed by this assessment, clinicians [will] develop an individual risk management plan in collaboration with the patient (and family, where legal and where patient wishes allow).[182]

In his 2012 review of admissions and discharge of mental health presentations at Fremantle Hospital, the Chief Psychiatrist identified that risk management plans should be reviewed when a person's condition changes, when they are transferred to other mental health services and on discharge from a mental health service, as follows:

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[180] Government of Western Australia, Department of Health, *WA Country Health Service Child and Adolescent Mental Health Service Access Criteria Policy*, Perth, 2010, p. 2.
[181] Government of Western Australia, Department of Health, *Clinical Risk Assessment and Management (CRAM) in Western Australian Mental Health Service: Policy and Standards*, Department of Health, Perth, 2008, p. 8.
[182] B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, Department of Health & Mental Health Commission, Perth, 2012, p. 35.

> It is preferable to use a standardised tool, such as the CRAM which includes the level of risk, formulation of risk and the risk management plan. The patient record should demonstrate adequate risk assessment in that risk has been reviewed at clinical review meetings, when discharged or transferred, if there is a change in the patient's status or when there are clinical concerns about risk.[183]

The CRAM Policy acknowledges that not all clinical risk can be eliminated as suicide is a complex event, the risk factors vary with each individual and are changeable. Even over short periods of time:

> ...some degree of risk is inherent in the patient's lifestyle, the changing balance of provocative and suppressive factors for a suicide attempt and initial mental illness, in the nature of clinical care and of human performance in stressful conditions - but some risks are avoidable, some are remediable and the process of identifying, assessing and managing them will contribute to improving professional practice and the quality of healthcare provision.[184]

The CRAM Policy also sets out requirements for the planning process when young people are discharged from mental health services. Discharge planning is to be a structured process for ensuring safe and successful transition of people with a mental illness across episodes of care from time of acceptance of referral to post-discharge. The *WA Suicide Prevention Strategy 2009–2013* recognises that:

> A particularly high-risk time for suicide is after a person has been discharged from an inpatient mental health service. Therefore, careful discharge planning and continuity of care for people with mental health problems who are returning to the community is critical.[185]

In addition to the CRAM Policy, all Western Australian mental health services, including CAMHS, are required to comply with the *National Mental Health Standards 2010* (**the Standards**).[186] The Standards require that:

> Discharge planning results in a formal written discharge plan, the aim of which is to ensure continuity of services that are necessary for successful community living. The discharge plan is a negotiated enterprise between the consumer, carer or family, referring doctor, community mental health team and the inpatient unit. It includes medical information, follow-up appointments and the desired outcomes of treatment.[187]

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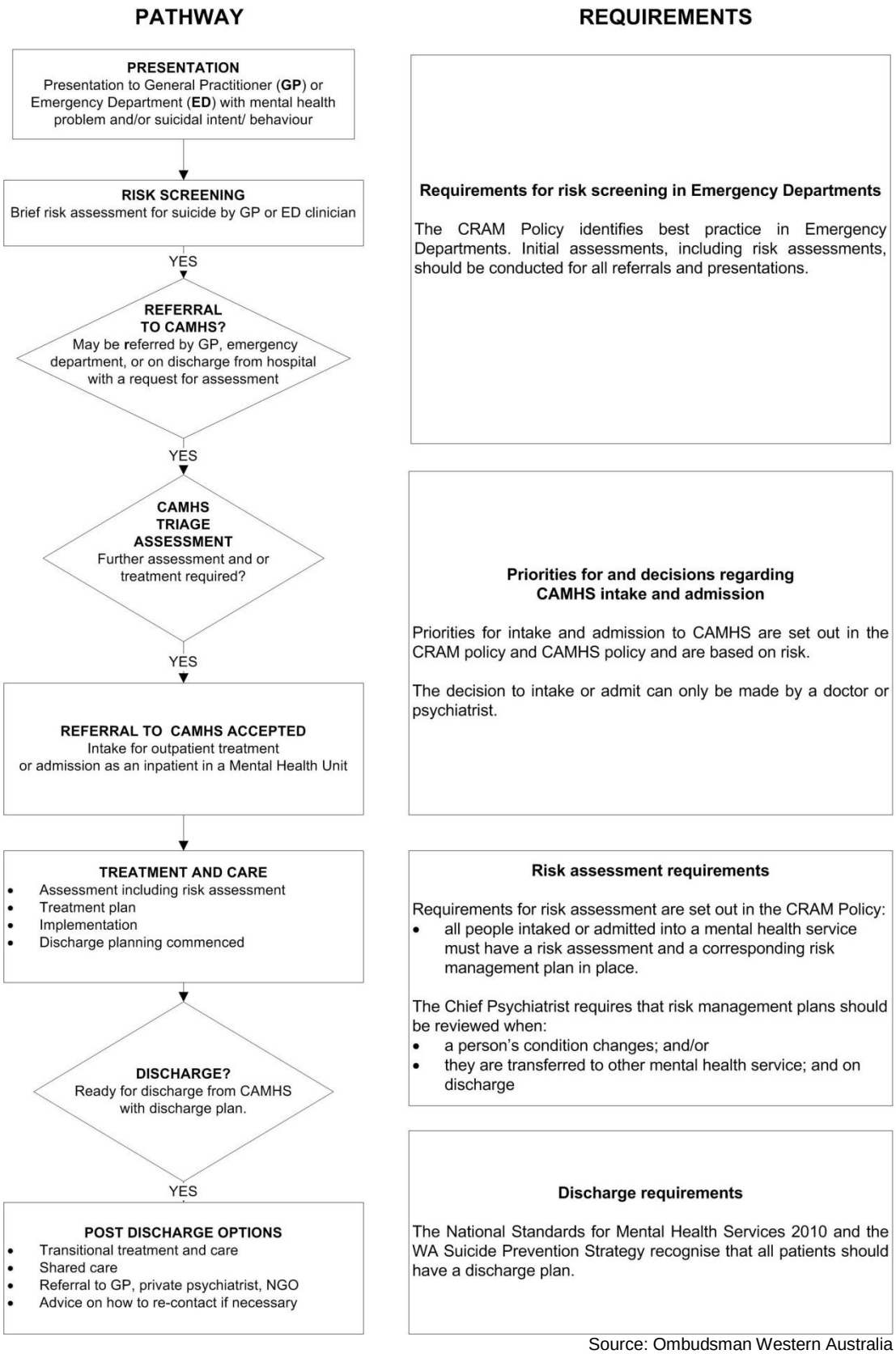
[183] Government of Western Australia, Department of Health, *Chief Psychiatrist's Review of Clinical Practice:*, *Admissions and Discharges of Mental Health Presentations Fremantle Hospital*, Department of Health, Perth, 2012, p. 12.
[184] Government of Western Australia, Department of Health, *Chief Psychiatrist's Review of Clinical Practice:*, *Admissions and Discharges of Mental Health Presentations Fremantle Hospital*, Department of Health, Perth, 2012, p. 3.
[185] Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 45.
[186] Government of Western Australia, Department of Health, *Chief Psychiatrist's Review of Clinical Practice*: *Admissions and discharges of mental health presentations Fremantle Hospital*, Department of Health, Perth, 2012, p. 8.
[187] Australian Government, Department of Health and Ageing, *National Standards for Mental Health Services 2010*, Commonwealth Government Printing Services, Canberra, 2010, p. 32.

The framework of legislation, policy and standards that set out the requirements for referral, acceptance of referrals, risk assessment, treatment and discharge planning of young people by mental health services, including CAMHS, is depicted in Figure 34 below.

Figure 34: Requirements for referral, acceptance of referrals by CAMHS, risk assessments and discharge planning



Source: Ombudsman Western Australia

7.4 Referral to and acceptance by the Child and Adolescent Mental Health Service for young people in Group 1

7.4.1 All eight young people in Group 1 who were recorded as having been diagnosed with a mental illness had been referred to CAMHS and, for six young people, these referrals had been accepted by CAMHS at some point in their lives

Of the 20 young people in Group 1, eight young people were recorded as having been diagnosed with a mental illness. Of these eight young people:

- all were referred to CAMHS at some time in their lives. Seven of these eight young people were referred to CAMHS services on more than one occasion, with a total of 36 referrals for the eight young people; and
- all were referred by either a general practitioner (22 referrals) or following attendance at a hospital emergency department (14 referrals).

The 36 referrals resulted in acceptance of the referral by CAMHS on 15 occasions, comprising nine instances of intake as an outpatient of CAMHS and six instances of admission to an inpatient unit of CAMHS. Two young people were referred but not accepted on referral to outpatient or inpatient units of CAMHS at any time in their lives.

7.4.2 During the last year of their lives, six of the eight young people were referred again but three young people were not accepted by CAMHS even though they met the priorities for acceptance

The policies regarding priorities for acceptance of referrals by CAMHS are set out in 7.3 above. Applying these priorities for acceptance of referrals, the Office found that all eight young people in Group 1 presented with at least two of the criteria for priority acceptance by CAMHS, as follows:

- four young people (50 per cent) were recorded as having been discharged from an inpatient mental health unit at some time in their life;
- five young people (62 per cent) were recorded as having been diagnosed with a mental illness and having been accepted and treated by an outpatient mental health service (now known as CAMHS) in the period preceding the last 12 months of their life;
- six young people (75 per cent) were recorded as having been at high risk due to self-harming behaviour and risk to self, that is, they were identified in health records as both self-harming and as having attempting suicide on at least one occasion; and
- eight young people (100 per cent) were recorded as exhibiting substantial impairment in functioning (as defined by the policies discussed in section 7.3.1). In particular:
    - all were recorded as having allegedly experienced multiple forms of child maltreatment including family and domestic violence, sexual abuse, physical abuse or neglect;
    - all were recorded as having experienced family breakdown;
    - four of the eight young people had contact with the Department of Corrective Services; and

- all were attending school less than 90 per cent of the time and therefore classified as being at educational risk (Figure 35).

Figure 35: Young people in Group 1 – priorities for acceptance by CAMHS

	Discharged from an inpatient mental health unit	Recorded as having been diagnosed with a mental illness	Recorded as having demonstrated self-harming behaviour	Recorded as having exhibited substantial impairment of functioning
Young person*	■	■		■
Young person	■	■	■	■
Young person	■	■	■	■
Young person		■	■	■
Young person		■	■	■
Young person		■		■
Young person		■	■	■
Young person*	■	■	■	■

*Note: these two young people were not referred to CAMHS during the last year of their lives
Source: Ombudsman Western Australia

Six of the eight young people had been referred to CAMHS in the year prior to their death. The remaining two young people had been discharged from CAMHS between two and three years prior to their death and were not referred to CAMHS again.

The six young people who were referred to CAMHS during the last year of their lives appeared to meet at least two of the priorities for acceptance on referral to CAMHS (as shown in Figure 35). Three young people were accepted on referral to CAMHS. The Office found that, in the last year of their lives, five of the six young people had not received services provided by CAMHS, as follows:

- two young people were on the waitlist for CAMHS or waiting for an initial appointment between two and five months before they died; and
- three young people who were referred to CAMHS in the year prior to their death either had the referral closed as attempts to contact them failed, they were referred to a specific CAMHS service but the referral was not pursued or the referral was not accepted.

Recommendation 4: The Department of Health considers the findings of this investigation in determining their state-wide provision of mental health services for young people.

Recommendation 5: The Department of Health ensures that the Child and Adolescent Mental Health Service applies the priorities for acceptance of referrals set out in its policies.

Recommendation 6: The Department of Health, where services are available, assists with the coordination of services from other government and non-government mental health services for young people who have been placed on a waitlist for services from the Child and Adolescent Mental Health Service.

Recommendation 7: Where a young person is referred to the Child and Adolescent Mental Health Service but not accepted by the Child and Adolescent Mental Health Service, the Department of Health notifies the referrer that the young person has not been accepted.

7.5 Referral to and acceptance by the Child and Adolescent Mental Health Service for young people in Group 2

7.5.1 Four young people in Group 2 were recorded as having been diagnosed with a mental illness and had been referred to CAMHS, and three of these young people received CAMHS services

Of the five young people in Group 2, four were recorded as having been diagnosed with a mental illness. These four young people were recorded as having been diagnosed with a mental illness during the last two years of their lives by a general practitioner and/or psychiatrist and were referred to CAMHS. These four young people had no prior history of mental health problems and had not previously been referred to CAMHS.

All of the four young people were accepted on referral by CAMHS and received CAMHS services or were waitlisted to receive services. Two of the young people receiving CAMHS services were admitted to an inpatient mental health unit of CAMHS.

The priorities for admission to CAMHS are set out at 7.3. Applying the priorities for admission, the Office found the four young people in Group 2 who were referred to CAMHS services experienced at least two of the criteria for admission, as follows:

- two (50 per cent) had been discharged from an in-patient mental health unit;
- four (100 per cent) were recorded as having demonstrated self-harming behaviour; and
- two (50 per cent) were recorded as having previously attempted suicide (Figure 36).

Figure 36: Young people in Group 2– priorities for acceptance by CAMHS

	Discharged from an inpatient mental health unit	Recorded as having been diagnosed with a mental illness	Recorded as having demonstrated self-harming behaviour	Recorded as having exhibited substantial impairment of functioning
Young person				
Young person				
Young person				
Young person				

Source: Ombudsman Western Australia

Of the four young people referred to and accepted by CAMHS, three young people were receiving out-patient services at the time of their death. These three young people received out-patient services on a weekly to fortnightly basis and were hospitalised when they attended emergency departments with suicidal ideation or behaviour or episodes of self-harm. The families of these young people were offered, and engaged in, family therapy.

7.6 Risk assessments for young people with a mental illness

The CRAM policy, discussed in section 7.3 and depicted in Figure 34, requires clinicians to undertake a risk assessment at several points: when a client presents to an emergency department with suicidal intent and/or behaviour; when a client is assessed for intake into an inpatient and outpatient mental health service; when a client is admitted to a mental health unit; when a client's condition changes; when the client is transferred from one mental health service to another; and when the client is discharged from a mental health service.

The CRAM policy was implemented in 2008. Accordingly, the Office reviewed risk assessments for young people presenting at an emergency department, referred to CAMHS, and admitted to a mental health unit, from 1 January 2009.

7.6.1 Risk assessments were not consistently undertaken for young people in Group 1

For the eight young people in Group 1 who had been diagnosed with a mental illness, the Office examined whether risk assessments were undertaken at three key points required by the CRAM policy. These points were: on presentation to an emergency department, on acceptance by CAMHS outpatient services and on admission to an inpatient mental health unit. The Office found that, for the eight young people in Group 1:

- risk assessments were not consistently undertaken at the three points where they were required by the CRAM policy; and
- risk assessments were more frequently undertaken on admission to an inpatient mental health unit (two risk assessments were undertaken on four admissions) than on

presentation to an emergency department with self-harm, suicidal ideation and/or behaviour (six risk assessments undertaken for 14 presentations).

7.6.2 Risk assessments were consistently undertaken for young people in Group 2

For the four young people in Group 2 who were recorded as having been diagnosed with a mental illness, the Office found that risk assessments were generally undertaken when the young people presented at emergency departments, were referred to CAMHS, and admitted to an inpatient mental health unit. The Office found that:

- risk assessments were frequently undertaken on presentation to an emergency department with self-harm, or suicidal ideation and behaviour (five risk assessments were undertaken for six presentations), on admission to an inpatient mental health unit (three risk assessments were undertaken on four admissions), on acceptance of referrals by CAMHS (three risk assessments were undertaken on five referrals); and
- the risk assessments undertaken by CAMHS included a psychosocial and biological component. All three young people for whom a risk assessment had been conducted also had a risk management plan in place.

Recommendation 8: The Department of Health ensures that risk assessments undertaken by the Child and Adolescent Mental Health Service are conducted in accordance with the Clinical Risk Assessment and Management policy and the findings of the Chief Psychiatrist, including for young people who present with a history of child maltreatment.

7.7 Discharge planning for young people who were recorded as having been diagnosed with a mental illness

As discussed above, discharge planning is critical in the successful transition of people with a mental illness across episodes of care, and all young people who have been discharged from CAMHS are required to have a discharge plan.[188]

For the three young people in Groups 1 and 2 who had been inpatients of CAMHS, discharge planning had been conducted.

7.8 Aboriginal young people

As identified in Section 7.1, 12 of the 36 young people were recorded as having been diagnosed with a mental illness. Eight of the young people were included in Group 1 (these young people were all recorded as having allegedly experienced child maltreatment) and four young people were included in Group 2 (none of these young people were recorded as having allegedly experienced child maltreatment). Three of the eight young people included in Group 1 were Aboriginal and five were non-Aboriginal. All of the young people in Group 2 were non-Aboriginal.

[188] Australian Government, Department of Health, *National Standards for Mental Health Services 2010*, Australian Government Printing Services, Canberra, 2010, p. 32.

For the three Aboriginal young people who had been recorded as having been diagnosed with a mental illness, the Office found that:

- all three had been referred to CAMHS, and for two young people the referral had been accepted by CAMHS, at some point in their life;
- all had been referred to CAMHS on more than one occasion, with a total of 11 referrals for the three young people; and
- during the last year of their lives, two Aboriginal young people were referred again to CAMHS. Neither of these young people received services from CAMHS as a result of these referrals.

These findings are consistent with research literature which has described the limitations of mental health service delivery to Aboriginal young people in Western Australia as follows:

> …While some comfort might be taken from the fact Aboriginal children and young people are receiving mental health services at all, the burden associated with their treatment and care is higher.…When referrals are made there is frequently a much lower level of engagement and follow through with treatment than with non-Aboriginal children. This may reflect the current paucity of culturally sensitive mental health services for such children and families.[189]

The research literature has shown the effectiveness of culturally appropriate mental health services successfully engaging Aboriginal young people.[190] This was also recognised in the 2012 *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, which recommended that government:

> Continue to resource the currently COAG Closing the Gap funded Specialist Aboriginal Mental Health Services to assist Aboriginal people to access culturally secure Mental Health Services.[191]

The findings of this investigation support this recommendation.

7.9 Conclusion

Twelve of the 36 young people were recorded as having been diagnosed with a mental illness. However, these young people were recorded as having experienced different patterns among the other factors associated with suicide. For this reason, for the purposes of our analysis, eight of the young people were grouped into Group 1 (these young people were all recorded as having allegedly experienced child maltreatment) and four young

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[189] S Zubrick, S Silburn, D Lawrence, F Mitrou, R Dalby, E Blair, J Griffin, H Milroy, J De Maio, A Cox & J Li, *The Western Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal Children and Young People*,*Volume Two*, Curtin University and Telethon Institute for Child Health Research, Perth, 2005, pp. 574-575.
[190] Australian Institute of Health and Wellbeing, *Strategies and practices for promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people,* Resource sheet No 19, 2013, viewed 24 February 2014, <http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2013/ctgc-rs19.pdf>.
[191] B Stokes, *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*, Department of Health & Mental Health Commission, Perth, 2012, p. 14.

people were grouped into Group 2 (none of these young people were recorded as having allegedly experienced child maltreatment).

The Office identified different patterns in referral, acceptance of referrals by CAMHS, and risk assessment between the two groups of young people. The young people in Group 1 appeared to meet similar priorities for acceptance by CAMHS as the young people in Group 2, however:

- while all eight of the young people who were recorded as having been diagnosed with a mental illness in Group 1 were referred to CAMHS services at some point in their lives, only six of these young people were referred again during the last year of their lives. Ultimately, five of the six young people had not received services provided by CAMHS in the last year of their lives;
- three of the four young people in Group 2 received CAMHS services upon their first referral, which occurred during the last two years of their lives. These three young people and their families received extensive services from CAMHS.

In addition, risk assessments were undertaken more consistently for young people in Group 2 than Group 1.

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