Inquiry into Prevention of Youth Suicide in New South Wales – HNECC Additional Information

What makes youth suicide different? Is there value in having a youth suicide-specific prevention plan?

Statistics show youth generally use different means and methods than adults and that the problems they experience are also largely different to those of adults how attempt or successfully complete suicide. The main cause of suicide is still by hanging (in youth and adults). The second cause of death in young people is by jumping and the third cause of death in young people is overdoses (Lifespan Newcastle data).

We know youth suicide for different reasons to adults in the majority of cases (but not always). Most youth are suiciding because of bullying at school, difficulties with parents, social isolation at school, coming to terms with their sexuality and so forth. Adults will generally suicide because of relationship breakdowns, financial difficulties, redundancy, depression, mental illness, chronic pain and loneliness etc. HNECC PHN sees value in having a youth specific suicide prevention plan that is designed to tackle the youth specific issues. Youth would also benefit from some resilience training and coping skills as part of a youth specific prevention plan. Youth need to be communicated with very differently from adults and we understand through research youth will respond better to follow up treatment via text messages and internet messaging services rather than other methods.

We acknowledge there are better ways of capturing the youth demographic and recognise the need for more screening targeted to identified “at risk” groups of youth so early intervention can occur.

According to Orygen, a recent analysis of suicide cluster data has shown a youth suicide is more likely to be part of a cluster than an adult suicide. As such researchers, sector experts and young people themselves have suggested responding to suicide among young people requires a different approach than for other age groups.

Why are the rates of suicide generally higher in young males rather than females? How can current services improve the way boys and young men are engaged and treated?

The rates of suicide are higher in men right across the various age groups, this is not just a youth problem. In actual fact, research and data shows more women attempt suicide than men but men are more likely to use a more violent and lethal means than women and, therefore are more likely to complete suicide than women. Women tend to overdose or ingest poisons and therefore will more likely to survive if found early enough. The number one cause of suicide for men is hanging (youth and adults), which is a method people are less likely to survive. Men typically use more lethal means of suicide than women, however, this is starting to change within Australia, with women now worryingly starting to choose more violent and lethal means of suicide.

All the data and research shows, survival of an attempt of suicide is more down to the method than anything else.

Why do methods of suicide differ by gender?

Women are more likely to suffer from depression than men and are more likely to suffer from a psychological illness, however, research suggests men are more intent on dying when it comes to acting on suicidal thoughts and as such are more likely to choose a more lethal means.

Similar research also suggests men are more likely to act on suicidal throughs with an element of impulsivity – the tendency to act without properly thinking through the consequences.

There appears to be an overall lack of public awareness regarding the high rates of suicide across the population, but particularly focussing on men, especially when considering the focus and public campaigns aligned to men's health, an example is HIV/AIDS, which accounts for far fewer premature deaths. It could be argued too that there are very few preventive efforts or policies specifically targeting male suicide which have been developed or evaluated it should be suggested that this contributes further to a lack of awareness / visibility of suicide as a major public health problem.

We know that in Australia, death by suicide is the number one cause of death for men aged 15-45 years of age and the second leading cause of death in women aged 15-45, yet there has been no notable public awareness campaigns in Australia to respond to such and that there is little funding allocated specifically to suicide prevention when compared to other public health issues and illnesses.

The 2016 Orygen report Raising the Bar on Youth Suicide Prevention stated the number of suicides by females under 18 had doubled in 10 years. What do you think are the reasons for this?

Research suggests women are now starting to choose more lethal and violent means and methods for completing suicide, with a steady shift from overdosing to hanging and other violent methods. This suggests, their intent to die is much stronger than perhaps it used to be. As detailed above the methods being utilised by youth have also changed.

While the reasons for the increase in the number of suicides for females under 18 are unclear suggestions could be increased stress and pressures, noting the age group issues at school, relationships break down and the new relentlessness pressure created by social media, the internet.

What are the main gaps in the current suicide prevention services available to children and young people?

We are aware the help-seeking rates are low among all young people experiencing suicidal thoughts or behaviours and that the suggested barriers to seeking help include fear, stigma, and embarrassment.

Increased education, availability of resources which support young people in a way that is easily accessible and friendly to them and the way the access information is important. Education programs about the resources that are available and easy pathways to support are all important.

More could be done to develop programs led by youth that are designed to reduce the stigma and perceived weakness that may be feared when seeking help.

A national Kids Helpline Survey of young people who reported experiencing suicidal thoughts (yourtown, 2016) found a greater proportion of young people who had sought help reported a subsequent reduction in suicidal thoughts compared to those who had not.

Suicide prevention training (which includes mental health first aid, language etc) being offered to parents and care givers through schools, TAFE and universities could also be beneficial.

We know most people find it difficult to navigate the health care system and have a lack of understanding about where to go to seek help. These types of courses, such as ASIST or SafeTalk are subsidised and funded through the Primary Health Networks, these courses will assist parents on where to go to get help for their child and also to help initiate any discussions that may need to be had with their children. The Kids Helpline (KHL) survey respondents indicated that, while they would be likely to seek help from a parent, more often they found them to be not as helpful as they could be (yourtown, 2016). Michelmore and Hindley (2012) also found limited studies into peer responses and those available indicated that less than a quarter of young people who supported a suicidal peer told an adult or encouraged their friend to seek adult help. Resilience training could also provide highly supportive prevention / early intervention.

There is a lack of focus on early intervention to depression, anxiety and risky behaviours. Early intervention is just as important as any other component of suicide prevention strategies, it is imperative that health services address the risks before it becomes chronic (and a bigger cost to the health care system). There is also a need to continue the rollout of Headspace clinics across Australia (with a big focus and funding on the rural and remote areas where Headspace has a smaller footprint). There also needs to be a bigger push to telehealth services for rural and remote people to be able to access mental health care, a response to this has been that many mental health and suicide prevention services are now reaching young people through TeleWeb services, web-based information, directed online self-help, mobile apps, online counselling and by using social media platforms. A barrier to a lot of these online programs from my experience has been, most medical professionals have largely been unaware of these platforms and even patients themselves are unaware of where to go to access services.

Is the current level of coordination between different levels of government sufficient? What could be improved?

According to Mental Health Services in Australia, an analysis of state data suggests that, nationally, only approximately a quarter of the demand for supported accommodation

services is met. Such services are linked to clinical support and help reduce the number of people having to go to hospital emergency departments,

particularly for avoidable reasons.

There is also a shortage of clinical specialist mental health services in the community to help people manage their illness and recover in the community. There is only 62 per cent of the estimated number of workers required to deliver services, and inadequate capacity in specialised child and adolescent services and crisis response services, both run through the states and territories.

This shortfall is producing a crisis-driven mental health system in which people are turned away from services until they are unwell enough to warrant hospital admission. The acute system is not well equipped to meet both the health and non-health needs of an individual.

In addition to this problem, the 2017 Federal Budget the mental health sector received the smallest investments into the sector in recent years. In 2014-15, mental health received around 5.25% of the overall health budget, while representing 12% of the total burden of disease.

As well as a lack of funding, as health care professionals, we need to be opening our lines of communication within the different parts of the health care sector (Acute, Primary Care, Allied Health etc) we need to be working across sections, working together collaboratively and be willing to change the way in which we work to better improve access to services for better patient outcomes.

What improvements can be made in the information and training provided to service providers in regional and rural areas?

Make suicide prevention training mandatory for all health care providers and professionals, not just in rural and remote areas but in all areas. Training needs to be face to face in a setting with other medical providers and needs to be run by an experienced mental health clinician. I would like to see it mandatory and forms part of their CPD. Everyone needs to play a part in the mental health space, the more people who are trained in suicide prevention and mental health first aid, the more likely it is that the stigma will lift, people will feed confident to talk about it and to reach out for help. Health professionals who are trained will also know how to best start the conversation, how to refer to the adequate specialist help and the more likely people will be referred to the best and most appropriate level of care and intervention.

With working with GP's, a large portion of them are unaware of what is happening in the eResource space, what the evidence is behind it and what benefits patients will get out of using eResources and eTherapy tools. A large part of my role is informing them about what tools are out there.

In the context of CAMHS, the NSW Government submission notes that demand for access to specialist mental health services for children and adolescents in NSW regularly outstrips the capacity to supply timely services, particularly in regional and rural areas. The 2016 Orygen Raising the Bar for Youth Suicide Prevention report also recommends that PHNs and Local Health Networks (LHNs) co-commission services. Are there opportunities for the PHNs and LHNs to co-commission services, including more CAMHS services or similar services in areas of need?

HNECC PHN has received funding to commission services for Youth Complex Mental Health services. The available funding is insufficient to commission effective and viable services across all LGAs in the HNECC footprint. Therefore, given the outcomes of the Mental Health & Suicide Prevention Needs Assessment, and estimated prevalence of youth experiencing severe and complex mental illness, four regions of need have been identified for the first round of funding.

These areas are:

- Gwydir/Inverell/Glen Innes/Tenterfield
- Moree/Narrabri
- Muswellbrook/Upper Hunter/Liverpool Plains
- Wyong

For the purpose of this exercise, and in accordance with the Mental Health & Suicide Prevention Needs Assessment, youth has been defined as 12-25.

As this is new funding and not an extension of existing services or contracts, part of the commissioning process requires clinical design. HNECC PHN have engaged Orygen, the National Centre of Excellence in Youth Mental Health, to support them with the elements of the commissioning stages, including diagnostics, facilitation of workshops, service design, and evaluation of tendering and commissioning processes.

Five co design workshops are currently underway. The first workshop was facilitated by Professor Pat McGorry AO, and was targeted for both Central

Coast & Hunter New England Local Health Districts, and our Clinical and Community Councils. The four remaining workshops are being held in Glen Innes, Narrabri, Muswellbrook and Wyong.

The purpose of the workshops is to discuss and gather feedback on how our region can design local primary care models that provide the best possible outcomes for young people with severe and complex presentations. Our aim is to increase the capacity within our region, to facilitate easier access and better pathways to the "right" care to suit a young person's needs.

The workshops have included representation from; Local Health Districts, Department of Education, Housing, Family & Community Services, young people, parents, carers, vulnerable groups, school principals & teachers, service providers, clinicians, deputy mayors, and those that work with young people.

With regards to co-commissioning, we are currently involved in a co-commissioning agreement with Central Coast Local Health District, Family & Community Services, Department of Education, Benevolent Society and the NSW Ministry of Health, for the Family Referral Service in school's program. This program is, aimed at the prevention and intervention of vulnerable children and families in Schools. It has been trialled in the

Brisbane Waters Learning Community, and will shortly be implemented in two more learning communities, being Wallarah and the Lakes Learning Communities. A formal evaluation of the program is expected in mid-2018.

Opportunities for further co-commissioning with both Local Health Districts are currently being explored.

Orygen's 2016 Raising the Bar for Youth Suicide Prevention report suggests that there is an opportunity to provide regionally tailored follow-up care for young people post-discharge.

What role does the PHN currently play in coordinating local service pathways been hospitals, primary care providers (including GPs and mental health nurses) and community agencies?

The PHN in conjunction with both the Central Coast LHD and Hunter New England LHD operates a program called *HealthPathways.*

HealthPathways is based on a highly successful model of collaboration developed in New Zealand by a group called the Canterbury Initiative.

HealthPathways came about as a response to improving access to outpatient clinics in hospitals and improve communication between primary care clinicians and specialists.

HealthPathways enable primary care clinicians to better help patients by outlining:

- the best management and treatment options for common medical conditions
- information on how to refer to the most appropriate local services and specialists
- educational resources and information for patients

HealthPathways develops localised clinical pathways by bringing GPs, specialists and allied health providers together to discuss the best ways to assess and manage medical conditions and when and where to refer patients. The result is localised pathways that are web based and accessible to primary care clinicians at the point of care.

To date we have over 450 pathways operating across the HNECC region. New pathways are constantly under development and existing pathways are regularly reviewed in light of changing evidence, technology and local circumstances.

HealthPathways is NOT designed to be used by patients or general community members and as such a user name and password are required to use the site.

Up to date, evidence based resources for patients are available on the companion ***PatientInfo*** site which is not password protected and freely available to all members of the community.

The portals can be found at:

Central Coast HealthPathways

[redacted]

HNE Healthpathways

[redacted]

The ATSISPEP report refers to the role of Primary Health Networks (PHNs) in identifying Indigenous communities within their region that may be at high risk of suicide, and to work with local organisations to help plan and fund these services. In what ways do PHNs generally, and the Hunter New England Central Coast PHN, work with local Aboriginal mental health services? Are there opportunities for further collaboration?

The PHN have been working with local Aboriginal communities to determine the needs of various communities within the PHN footprint. Currently the PHN have CE group that have regular meetings to ensure that we are obtaining advice of communities throughout the PHN footprint.

The PHN works hard to ensure that we work with local organisations that service the local Aboriginal communities, the PHN are currently undertaking a cultural audit this will be rolled out to all the services that are commissioned by the PHN this will include ensuring that services are collaborating with the Local Aboriginal services in their local area.

The ATSISPEP report suggests that the Access to Allied Psychological Services (ATAPS) scheme, which normally funded up to 12 visits with a psychologist, had a high uptake by Aboriginal people. The report indicates that the funding for this scheme is now pooled for the commissioning of primary mental health services by the PHN. What are the advantages and disadvantages of the changes to the funding arrangements? Could you comment generally on the success of the ATAPS scheme?

What are the advantages?

PHNs have the remit of introducing a Stepped Care Framework for mental health across the region. Having a flexible funding pool allows the PHN to identify the unique needs of the community and commission services that best meet these needs. This should result in improved access for consumers as a spectrum of services will be commissioned that are designed to be flexible, responsive to need and wrap around the consumer.

What are the disadvantages?

There are no significant disadvantages envisaged due to this change. There may be a broader reduction in ATAPS sessions, but this will be offset by the introduction of service models that are flexible to local conditions. This includes a commitment to rural health,

addressing of unmet needs, workforce considerations and acknowledgement of existing services and resources.

Could you comment generally on the success of the ATAPS scheme?

ATAPS was initially intended to be a safety net for those most vulnerable in the community unable to access clinical services through Medicare better access or private providers either through lack of services available locally or lack of affordable services. It was intended to be a service of last resort when other options to access mental health clinical services were not available. Targeted populations and entry criteria are currently based on national modelling and do not take into account local needs analysis and service mapping. Despite the limitations of the model, the service is generally meeting a need, albeit in isolation from other state and federally funded mental health services. Reports submitted to the national Minimum Data Set indicate consistent positive Patient Reported Outcome Measures.

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