Inquiry into the Prevention of Youth Suicide - Questions on Notice and Supplementary Questions from the Singleton Hearing on 27 November 2017

Question on Notice for Michael DiRienzo

1.1

Mr DAMIEN TUDEHOPE:

Q) How many bodies in your local area or district provide suicide prevention or self-harm prevention programs?

Hunter New England Local Health District's Child and Adolescent Mental Health Service (CAMHS) is a specialist mental health service that provides assessment, stabilisation and treatment and works in strong partnership with other providers to support best practice outcomes for children, young people (0 to 18 years) and their families/carers who are living in the District.

CAMHS has three School-Link Coordinators located at Tamworth, Taree and Newcastle. These staff work with schools to provide advice and implementation of evidence-informed mental health and wellbeing programs, guidance in collaborative care planning, psycho-education for staff, links to local services and support in implementing suicide postvention programs.

Everymind (formerly the Hunter Institute of Mental Health) is a leading national Institute dedicated to reducing mental ill-health, reducing suicide and improving wellbeing. It has an excellent reputation for delivering world-leading prevention programs and high-quality translational research.

Under the NSW Government NSW Suicide Prevention Fund, three mental health non-government organisations in the District are delivering community based suicide prevention activities. These are:

- HealthWISE New England North West - providing clinical mental health aftercare support for those at risk or affected by suicide
- Hunter Primary Care - providing case management for up to three months for people who had a recent suicide attempt and presented to Calvary Mater Newcastle Hospital
- Compass Housing Services - delivering activities to social housing tenants and staff across the region. This includes mental health first aid training, and an awareness campaign to better identify and respond to mental health issues.

LifeSpan is a new evidence-based model for integrated, regional suicide prevention in Australia. It involves the simultaneous implementation of nine key strategies to reduce suicide. LifeSpan aims to support people to live full and contributing lives by bringing together healthcare, community services, and those with lived experience within a region, to work collaboratively to implement the multiple strategies within their community. Strong evidence points to the benefits of combining effective strategies into an integrated approach to suicide prevention.

The LifeSpan Newcastle pilot is being led by the Hunter Alliance, a partnership between the Hunter New England Local Health District (including **Everymind**), Hunter New England Central Coast Primary Health Network, Hunter Primary Care and Calvary Mater Newcastle. The pilot builds on collaborative work already occurring in Newcastle between these organisations

In addition to these services, CAMHS has both formal and informal partnerships with a number of organisations. Formal partnerships through Health Funded Programs are with:

Flourish Australia

- HASI (Health Accommodation Support Initiative),

- Supported Discharge Program,
- CLS (Community Living Supports)
- Tamworth Homeless Men's Transition Program
- Aboriginal Social and Emotional Wellbeing Traineeships

Parramatta Mission
- HASI (Health Accommodation Support Initiative),

ARAFMI
- Mental Health Carer Support

Billabong Clubhouse
- Mental Health psychosocial support

Samaritans
- Kaiyu Konnect Program

Life without Barriers
- Social and Recreational Program

One Door
- Carer Support program

CAMHS also has Memoranda of Understanding with **MaiWel, Job Centre Australia, Castle Personnel, Best Employment** and **OCTEC** for Vocational Partnership arrangements across the Districts.

Informal partnerships exist with other organisations through the Community Advisory Group and Hunter Interagency meetings.

Supplementary Questions for Wiyiliin Ta

2.1

Q: Does the Hunter region have a lower rate of Aboriginal youth suicide compared to other areas of NSW? If so, what might be the reasons for this?

Local data concerning rates of suicide for Aboriginal and Torres Strait Islander people and generally across the Hunter region and NSW is limited.

HealthStats NSW has released data concerning the rates and trend for suicide data by Local Health District and by Aboriginality. However a report combining these variables is currently not publicly available.

The Lifespan program is working with local partners to better collect and report on this data. Some of the early indications of this data, which is currently limited to National Coronial Information System (NCIS) data, in at least one Local Government Area in the Hunter region reported zero deaths by suicide recorded for Aboriginal and Torres Strait Islander people aged zero to 24 years.

In the area covered by this LGA the Aboriginal and Torres Strait Islander community has an existing network of Local Health District and community partners who work collaboratively to prevent suicide in Aboriginal children and young people at all levels from promotion/prevention, early intervention, secondary specialist care and tertiary services.

Services working in this collaborative network include:

- the Wiyiliin Ta Aboriginal Child and Young Person's Counselling Services
- mainstream CAMHS services
- Awabakal Primary Health Care Services
- Local Aboriginal Land Councils
- Department of Education and
- A network of Aboriginal and non-Aboriginal non-Government organisations.

2.2

Q: Where are the gaps in current mental health services available to Aboriginal and Torres Strait Islander young people in the Hunter region? What practical improvements should be prioritised?

There is limited availability of Aboriginal-specific or culturally appropriate mainstream mental health services across areas of the Hunter region, particularly in the Upper Hunter and parts of the Lower Hunter.

From a CAMHS secondary care perspective, service capacity in these areas has been recently enhanced with existing generalist CAMHS positions reallocated to these areas to begin to address any gaps in services.

There are limited Aboriginal-specific services for primary health care available in the Lower Hunter and Upper Hunter areas. Awabakal Medical Service is located in Hamilton and has outreach services to Karuah, Toronto and Mindaribba.

In other areas of the Hunter region, Headspace services and Hunter Primary Care services contribute greatly to facilitating access to primary care services for Aboriginal and non-Aboriginal people.

One practical improvement that should be prioritised in these areas is enhancement of these services in the Upper Hunter region. This could be delivered as a visiting service from Headspace services offered in Maitland or an application to fund the creation of a specific Headspace centre for this area. Expansion of the existing service in Maitland is likely to have

maximum benefit due challenges recruiting general Allied Health clinical staff in the Upper Hunter region.

2.3

Q: The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) report notes that Aboriginal Community Controlled Health Services are in a position to provide 'indicated responses' but only about 40% offer onsite access to psychiatrists and 58% onsite access to psychologists. Could you comment on the availability of psychiatrists and psychologists at Aboriginal medical services generally and in the Hunter region?

The Wiyiliin Ta model supports the unique role that Aboriginal Community Controlled Health Services play by providing responses to the prevention, treatment and management of mental health concerns and suicide.

Across the Hunter region CAMHS has a formal partnership with the Awabakal Primary Health Care Centre and Mindaribba Medical Service (Mindaribba Local Aboriginal land Council- currently in review).

This partnership ensures the service provides access to Aboriginal and non-Aboriginal Allied Health clinical staff, including:

- An Aboriginal Senior Clinical Counsellor
- Aboriginal Senior Psychologist
- Aboriginal Senior Social Worker
- Two Senior Clinical Psychologists
- A Dietician and
- A visiting Child and Adolescent Psychiatrist.

In addition Rural Doctors' Network (RDN)-funded Allied Health Services currently visit Mindaribba Medical Service, with the support of the Awabakal Primary Health Care Centre and also Ungooroo Aboriginal Corporation.

No psychologists or psychiatrists are currently available through Ungooroo Aboriginal Corporation.

2.4

Q: Could you explain the Wiyiliin Ta model and what makes it unique? Has the model been independently evaluated?

The Wiyiliin Ta model operates as a specialist CAMHS service for Aboriginal children and young people aged two to 18 years across the Hunter region.

The Wiyiliin Ta team operates within a network of CAMHS services delivered in specific geographic locations across the Hunter.

The Wiyiliin Ta model is a long-term collaborative partnership of the Local Health District, the Aboriginal community, Aboriginal community controlled services and Aboriginal and non-Aboriginal Allied Health clinical staff.

The partnership is built on a common goal - to improve the social and emotional wellbeing of Aboriginal children and young people and ultimately to prevent deaths by suicide. Through these partnerships the Wiyiliin Ta model facilitates access to and delivers mental health services across all levels from prevention, treatment and management.

Wiyilin Ta delivers components of the care pathway independently, or in partnership with partner organisations.

The Wiyiliin Ta model has not been independently evaluated because it is delivered within the context of normal clinical care. However due to growing interest in the model the feasibility of conducting an evaluation is currently being considered.

2.5

Q: How do suicide prevention services available to Aboriginal young people in the Hunter region work together? What are the opportunities to collaborate further?

Suicide prevention services for Aboriginal people work collaboratively with non-Aboriginal cliniciansacross the Hunter region to deliver services. .

There is a formal network established to support their introduction into the area. From time to time an Aboriginal suicide advisory group has been established to support discrete pieces of work across the Hunter.

With the recent commencement of the Lifespan program in the Newcastle area this committee has been reconvened. This committee has members from a number of Wiyiliin Ta's key partners. This may represent an opportunity to continue to formalise the network across the Hunter and to expand the membership to include services in the Upper Hunter.

Everymind is the current convenor of this group in the Newcastle area.

2.6

Q: The ATSISPEP report refers to a variety of 'selective interventions', including peer-to-peer mentoring and diversionary programs such as sport. Can you comment on the effectiveness of such programs?

Wiyiliin Ta supports the potential benefits of selective interventions, including peer-to-peer interventions and diversionary programs such as sport to prevent the onset of mental health concerns and to assist with the treatment and management of mental health concerns.

In the absence of any local data, practice-based information supports the many benefits that these activities could have for Aboriginal children and young people from a mental health perspective and in also addressing a number of risk and protective factors for the onset of mental health concerns.

2.7

Q: 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 working partnership between the PHN and Aboriginal Mental Health services is growing with work underway in the Hunter region to increase communication between these services. The introduction of Aboriginal specialist positions within the PHN is supporting this process.

In addition, LifeSpan is contributing to increased communication between the PHN and Aboriginal Mental Health Services through its participation in the local Aboriginal Advisory Group.

There is great potential for the PHN to partner with Aboriginal Mental Health Services to identify the needs of the local community and to ensure that commissioned supports within these communities are likely to have benefit in preventing suicide and improving the social and emotional wellbeing of Aboriginal children and young people.

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2.8

Q: 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?

Wiyiliin Ta has no specific comment on this. However one of the potential risks of this change is the chance that these dedicated clinical supports could be commissioned in areas that do not address and meet the same outcomes as direct clinical care.

2.9

Q: The Fifth National Mental Health and Suicide Prevention Plan identifies improving Aboriginal mental health and suicide prevention as a priority area, and highlights the role of culture in mental health and wellbeing. Can you comment on the role of culture in preventing youth suicide in Aboriginal and Torres Strait Islander young people?

Connection with culture, family and community is a significant protective factor for preventing the onset of mental health concerns in Aboriginal children and young people.

This also needs to be understood alongside the impact of risk factors, including:

- transgenerational trauma
- complex loss and grief
- experiences of psychological distress and racism.

2.10

Q: The ATSISPEP report notes that researchers estimate that men who drink at risky levels have a 6 times increased risk of suicide, and similar drinking levels for women result in an even higher risk of suicide. From your experience, can you comment on the role of alcohol and drugs in increasing suicide risk in Aboriginal young people? What programs and strategies are in place in the area to combat this? If appropriate, are there further opportunities to reduce the consumption of alcohol and drugs?

The inter-relation between alcohol and drug use with mental health concerns is well published. Consistent with this evidence, Aboriginal young people who experience addiction concerns with alcohol and drugs are at an increased risk of impulsive and at times lethal behaviours.

In the Hunter region we are fortunate to have access to mental health and substance use services. However these services have traditionally been targeted at the adult population and their acceptability for Aboriginal young people is currently being looked at by HNE LHD Drug and Alcohol Services.

Given that these services are generally mainstream services, HNE LHD is fortunate to have access to an Aboriginal Drug and Alcohol Team. The role of this team is to support access to drug and alcohol services for Aboriginal people and to build the capacity of mainstream services to meet the needs of Aboriginal people.

Continued focus on improving the cultural appropriateness and youth friendliness of mainstream drug and alcohol services is one of HNE LHD's current goals.

As part of the 2016 Drug Package budget enhancement HNE LHD will receive additional funding to enhance youth alcohol and other drug treatment services for both the public sector and non-government service sectors

Supplementary Questions for Hunter New England Child and Adolescent Mental Health Service (CAMHS)

3.1

Q - A few submissions, including one from the NSW Mental Health Commission, state that rates of self-harm in children and adolescents are increasing. Is this reflected in your own clinical experience? Are there particular groups that have increased rates of self-harm? What are the possible reasons for this?

In our experience as CAMHS clinicians, we have noticed there has been an increase in:

- Admissions to the Nexus Child and Adolescent Mental Health Inpatient Unit, with 157 admissions over the period Jul 17 to Oct 17.
- Referrals to the CAMHS community teams, especially in the Hunter Valley. Between January 2016 and December 2016 there were 490 accepted referrals. Between January 2017 and October 2017 there were 611 accepted referrals.

In terms of particular groups, as stated previously, there has been a pronounced increase in the number of referrals for young people from the Hunter Valley area, as well as an increased level of acuity, complexity and overall risk. Adolescents in particular are the biggest group that presents with self-harm and suicidal ideation. However, anecdotally the average age is decreasing.

The reason for the dramatic increase in referrals for the Hunter area is probably multifactorial.

3.2

Q - The 2016 Orygen report Looking the Other Way: Young People and Self-Harm noted that women aged 15 – 19 years account for a significant proportion of those hospitalised for self-harm. What are the possible reasons for this?

The statistics for admissions to the Nexus unit show that in the period from 2014/2015 to the present, approximately two thirds of all admissions were for females. These would not all have been for self-harm reasons, however, it gives an indication of the ratio of female to male admissions.

CAMHS provides services for children and adolescents aged zero to 18 years.

Possible reasons include:

- Females tend to have more internalising disorders such as depression and anxiety, which can often manifest via self-harm or suicidal ideation, especially in severe cases..
- Males tend to have more externalising behaviours, such as aggression to others.

3.3

Q - In your experience, what are the most common forms of self-harm and have they changed over time?

[redacted]

3.4

Q - What kind of follow-up is provided to patients following discharge? Are there policies or procedures governing the follow-up that should occur?

Upon discharge from the Nexus Unit, the vast majority of young people are referred to the local CAMHS community teams for follow up. However, there are some who may be referred back to a private provider or other Community Managed Organisation (CMO), where appropriate, and in line with the family's wishes.

There are a number of policies and procedures governing follow-up. For example:

- A written discharge summary for the family and General Practitioner (GP)
- A follow-up telephone call within 24 hours from the inpatient unit
- Direct clinical contact from the community CAMHS team within seven days of discharge
- A formal handover process from inpatient to community, all of which are part of local policies and procedures on transfer of care.

In addition, CAMHS is working on enhancing communication between Emergency Departments and Community Mental Health services by establishing formalised follow-up processes.

The CAMHS' Community Mental Health Teams have also become more responsive. An example of this is the ability to offer an appointment within 48 hours. If a child or a young person were to present with their family or carers to Emergency Department after-hours and they were deemed as requiring an urgent appointment with the community team within two business days, the Psychiatry Registrar assessing the young person can call the Mental Health Line following the assessment and obtain the date, time and place of appointment with Community CAMHS team within two business days. This can then be offered to the family or carers.

CAMHS is developing information that can be provided to families and carers by the assessing clinician to help them understand the process. It is hoped that this would alleviate the young person and family/carer's anxiety about ongoing care in the community post-discharge.

3.5

Q - How does CAMHS work with other relevant services in the region to improve outcomes for children and young people experiencing mental distress? Where are the gaps?

The CAMHS model of care specifically addresses the issue of partnering with other relevant agencies.

CAMHS has developed close working relationships with a number of agencies (for example, Headspace) where there is regular discussion and often co-management of young people.

There has been a specific focus during the past 12 months on partnering with the Department of Education and non-government school sector to offer training and consultation to build the capacity of the education system to support young people to stay at school even when they are experiencing difficult times.

The focus in the next 12 months for CAMHS will be on building and improving partnerships with GPs.

3.6

Q - We understand that CAMHS services vary between regions. How do these services vary?

CAMHS services are mainly located within population centres. That is, the greatest number of staff are located in Newcastle, Lake Macquarie and the Lower Hunter areas.

CAMHS staff are based in multi-disciplinary teams in these areas. In more rural areas, the teams are spread out over larger distances, with individual clinicians in the smaller rural towns.

However, CAMHS has been implementing a new model of care in the past couple of years that aims to offer a more consistent level of service across its very large District. For example, CAMHS has recently moved resources to the Upper Hunter area to create equity of access in areas of high need.

3.7

Q - 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?

There has been opportunity recently for CAMHS to be involved in the planning of some services that the PHN is trying to establish in priority areas. There is a recognition that CAMHS is servicing the most acute end of the spectrum of referrals whilst Headspace services the mild to moderate referrals.

The PHN has identified “Youth Complex” – the referrals that are moderate to severe that are increasingly finding it difficult to get a service, as a potential new service in the Hunter region, and CAMHS has been part of the planning process.