Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Submission to Royal Commission into Victoria's Mental Health System from the Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Preventing maternal deaths from suicide in Victoria

WHO IS CCOPMM

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) is a Ministerial advisory body established in 1962 and functions under the *Public Health and Wellbeing Act 2008*. It reviews all cases of maternal, perinatal and paediatric (< 18 years) mortality and severe acute maternal morbidity (SAMM).

CCOPMM considers, investigates and reports on obstetric and paediatric mortality and morbidity, as well as related matters referred by the Minister for Health or the Department of Health and Human Services (DHHS). It collects health and personal information so that it can conduct study, research and analysis into the incidence and causes of maternal deaths, stillbirths, and the deaths of children under 18 in Victoria.

CCOPMM makes recommendations to help health services and medical practitioners improve clinical practice and systems of care, using its annual report to detail the council's research and activities. CCOPMM directly advises Safer Care Victoria (SCV) to improve clinical performance

CCOPMM also directly advises the Minister for Health on strategies to avoid preventable deaths in the community, as well as within health care services.

SUMMARY OF CCOPMM RECOMMENDATIONS TO MENTAL HEALTH ROYAL COMMISSION

1. System level reform that addresses gender inequity and clinical response.
2. Early identification and intervention for women with mental disorders who are or are about to become mothers.
3. Financially and geographically accessible mental health treatment plans and service delivery.
4. State-wide review of mother baby psychiatric units investigating availability and accessibility.
5. Integration of perinatal and infant mental health services.
6. System level reform to deliver culturally relevant and responsive maternal mental services.

THE CCOPMM SUBMISSION

This submission is based on the review of 58 cases of maternal deaths in Victoria the 5-year period, 2014 to 2018.

Maternal deaths are generally classified in one of three defined categories:

- **Direct maternal death –** the death is considered to be due to a complication of the pregnancy itself, for example, haemorrhage from placenta praevia.
- **Indirect maternal death –** the death is considered to be due to a pre-existing condition aggravated by the physiological changes of pregnancy, for example, heart disease or diabetes.
- **Incidental death –** the death is considered unrelated to pregnancy, for example, a motor vehicle accident.

CCOPMM FINDINGS RELATED TO MATERNAL DEATHS

In the five years from 2013 to 2017:

- There were 56 maternal deaths in Victoria

- Of the 56 maternal deaths, 16 were direct maternal deaths, 31 indirect maternal deaths and 9 were incidental maternal deaths.

- Four direct maternal deaths and six indirect maternal deaths were from suicide.

- Maternal suicide remains the most common cause of direct and indirect maternal mortality in Victoria.

The contributing factors for suicide in women included poor or limited screening to identify those at risk; lack of continuity of care meaning they are more likely to fall through the gaps between and within services; a lack of community-based support, especially mother-baby units; and poor follow-up, particularly if the baby is removed from the mother due to child protection concerns.

PERINATAL MATERNAL MENTAL HEALTH

Introduction

Research shows that the burden of mental illness, including depression and anxiety in the perinatal period, is not only a source of significant distress to women, but also complicates their transition into parenthood with associated poor outcomes for both fetal and neonatal development. There is now robust evidence supporting early identification of women at risk of mental illness and offering interventions to prevent long term harm to women and infants. [1] Risk factors such as a mental health disorder, experiences of child abuse and neglect, and current stress relating to family violence, can all increase rates of perinatal mental health issues. It is imperative that the maternity service system has the capability to identify and refer women for mental health care as early as possible.

Victorian women and their health care providers need timely and appropriate access to mental health expertise that is skilled in recognising and responding to perinatal mental health. It is imperative that the Victorian Government provide policy and funding support for the development and implementation of a strategy and services that addresses the spectrum of need from acute inpatient services to step down care in the community and home-based supports.

Antenatal screening

Perinatal depression impacts up to 20 per cent of women and is frequently associated with high levels of anxiety; psychotic illness (for example puerperal psychosis) occurs 1 in 1000 births. Significant numbers of women with pre-existing mental health disorders, including schizophrenia and bipolar disorder, will have difficulties during pregnancy. The rate of relapse of their illness in the post delivery period is up to 40 per cent.

Identifying women at high risk of depression and anxiety due to underlying vulnerabilities, engaging with them during pregnancy to support the psychological transition to parenthood, and actively dealing with mental health issues is an important component of reducing risks when offering the integrated approach to producing the best possible start to life. It is particularly important for women with backgrounds of early trauma, current exposure to conflict and violence in relationships, and a poor understanding of the requirements of parenting. Interventions in the perinatal period are a significant strategy for improving safety, health and wellbeing for mothers and infants.

The National Pregnancy Care Guidelines[2] recommends screening for depression using a well-recognised tool, the Edinburgh Postnatal Depression Scale, early in pregnancy and again later. While this is a national recommendation, it is not universal in Victoria.

Whilst screening may be undertaken, lack of resources for referral and timely and appropriate clinical care can inhibit some organisations from implementing this widely.

Psychology services

Enhancement of psychology services within the public hospital sector could improve management of the high levels of depression and anxiety among women that impact on their recovery from illness or as part of the maternity episode of care. Coupling this with better integration between hospital and community services, women would have continuity of care closer to home. Currently, the cost of accessing private psychological care is prohibitive for many women but is often the only way women can continue their care with a specialised provider skilled in women's mental health. The Better Access initiative[3] has not necessarily facilitated access to psychology services in the community and work should be undertaken to improve this initiative.

Consideration should be given for state-wide training to enhance skills of community-based psychologists in specialized areas of women's mental health including depression and anxiety, perinatal issues and health problems such as cancer.

INTEGRATING MENTAL HEALTH INTO MATERNITY SERVICES

The integration of mental health services into maternity services throughout pregnancy and the period following birth enables health professionals to:

- support a mother's mental health and adjustment during pregnancy and identify risk factors for adjustment difficulties
- actively treat women with serious mental disorders to optimise their mental health through the perinatal period
- support positive interactions with the infant and attachment relationships that optimise infant development.

To facilitate this integration requires the provision of specialist care, the introduction or continuation of early intervention programs and adequate training for health professionals.

Access to specialist care

Women needing high level mental health care during the perinatal period (when the needs of women with major mental illness are increased) require expert psychiatric and psychological supports. In addition, it is important for women with limited English language proficiency that these supports are culturally responsive and facilitate access to language support and interpreters. Expert psychiatric and psychological supports are essential to monitor the progress of women's conditions during this time, due to the high risk of relapse.

Training for health professionals

On-going training of students, doctors, nurses and midwives, mental health professionals and generalists is required to identify women who:

- have symptoms of mental health disorders, such as depression and, or anxiety
- have a history of serious mental illness who need specialist perinatal psychiatric care
- are socially or geographically isolated or lack social support
- are experiencing trauma and domestic violence and, or have experienced past trauma and abuse
- have received care across multiple rural or regional sites
- will need support to make the adjustment to parenting and infant care.

Training should be made available to all doctors, nurses and midwives, mental health professionals, psychologists, psychiatrists, paramedics, Koori Maternity Service clinicians, and generalists including maternal and child health nurses, social workers and family support workers. Clinicians and support workers should be educated on infant communication, including how they express their social and emotional needs, as well as how to use specific mental health assessment tools in standing clinical practice for maternal assessment.

Inpatient care

There is critical need for a targeted state-wide review of the capacity to increased level of care for women with significant mental illness and risk, such as psychosis and severe trauma related disorders.

There are limited options for women needing better integration of maternity and mental health treatment. A co-location model is an approach recommended to improve care planning and coordination. We recommend developing mental health units, within maternity services, with appropriate mental health-trained staff.

This would provide capacity for a longer stay in a maternity hospital, with mental health support in an "acute step down" focusing on providing specialist maternal and infant mental health treatment in the early postnatal period. This provides an opportunity for clinical mental health observation, support and education with the opportunity to provide timely treatment and linkages to ongoing community services such as maternal child health nurses, family support services and primary health. Unfortunately, these services are limited in some areas and enhancement in capacity for home-based outreach in regional and non-metropolitan areas is recommended. Engaging vulnerable families in this process will lead to harm minimisation giving at risk families the best possible start to their parenting journey.

This will help to improve the transition to home when vulnerability is high and promote integrated care aimed at both relapse prevention and monitoring of parental mental health and support for parenting and infant development.

Enhancing the role of maternal child health nurses is an important strategy already supported by the MERTIL (My Early Trauma Informed Learning) as a state-wide training program on early infant trauma and risk. This has been well received and important opportunity to enhance these critical and well-placed staff to recognise and respond to early developmental trauma and risk in vulnerable families.

We recommend a state-wide review of the role of Mother Baby Psychiatric facilities to consider access and roles. As well as a review of maternity hospital capacity for mental health admissions of women needing extended stays.

Prevention of suicide

In the area of women's mental health, an approach to prevention of suicide and self-harm needs to focus on the specific risk factors associated with these issues including long term impact of child abuse and trauma including the role of family violence and abuse and the prevalence of perinatal mood disorder.

There is also a clear need across mental health services and emergency departments to improve intervention and response to women with complex trauma related disorders who may present with self-harming behaviors and suicidal ideation often in the context of lack of social support and interpersonal crisis. These presentations are frequently poorly managed due to a lack of alternatives to acute hospitalization. There is limited visibility to trauma focused interventions for women's complex needs resulting in frequent unproductive hospitalization and repeated presentations. An integrated approach to women survivors of trauma and abuse should include better collaboration and care planning across

mental health and sexual assault services. A focus on raising skills in evidence-based interventions of mental health staff to better manage women with these issues if admitted is required.

WOMEN AT INCREASED RISK

There are a number of cohorts of women who are at greatest risk of acute and ongoing mental health disorders and of specific problems in the perinatal period. The Commission should consider and improve the mental health care of women from the following communities:

Recent migrants, asylum seekers and refugees

Recent migrants, in particular women with limited English language proficiency, asylum seekers and refugees are at higher risk of experiencing poor mental health outcomes than the general population.

Recent migrant women are often living in precarious home situations separated from their family networks. Even when spousal relatives are present, disconnection from their own family supports can lead to social isolation and reduced mental health.

Asylum seekers and refugees are a group of women who experience:

- Higher rates of pre-existing trauma and sexual assault
- Specific issues when they become parents in a new country
- Limited access to culturally appropriate mental health services with specialist expertise in trauma recovery.

There is a significant need to improve the system wide understanding of the mental health needs of traumatised asylum seekers that includes the impact of culture and gender norms on mental health and wellbeing. This information should then be used to develop programs to meet these needs.

Alcohol and drug abuse

Alcohol and drug dependency are common factors in maternal mental health and needs to be addressed. Demand for services addressing these issues is growing and further resources and models of care are critical to meet the needs of very vulnerable women.

Currently, there are three services offering alcohol and drug specialist clinical services in Victoria: The Royal Women's Hospital (the Women's) Alcohol and Drug Service, Monash Health's Alcohol, Drug, Adolescent and Psychosocial Team, and Transitions Clinic at Mercy Hospital for Women.

The Women's Alcohol and Drug Service provides specialist clinical services to pregnant women with complex substance use dependence. The service uses a multidisciplinary team to advance women and their infants' health and wellbeing by providing medical care, counselling and support, and integrated clinical mental healthcare. The service also offers training targeted to acute and primary health services and the community sector to increase the capacity of the Victorian drug and alcohol workforce to appropriately respond to the complex and diverse needs of pregnant women and their infants.

Monash Health's Alcohol, Drug, Adolescent and Psychosocial Team provides specialist clinical services for complex substance abuse as well as care for women with severe mental health difficulties. It links with the addictions medicine unit which includes a consultant and two nurse consultants. Inpatient psychiatric registrar-led team reviews occur, however outpatient services for mental health are severely lacking. At present, women are linked to GP's to ensure a mental health plan is put in place to access care externally. For severe cases, referrals can be made to community psychiatric care teams and Intake, Assessment, Consultation, and Brief Treatment Team (iACT) has a triage service.

A recent audit of women accessing care within Adolescent Drug and Psychiatric Pregnancy Team (ADaPPT) highlighted that 60 per cent met both the alcohol and drug and mental health diagnosis. Which came first is not identified. Women with bonding and attachment disorders can be referred to perinatal mental health team (PIMIT) as an inpatient or outpatient care, the waiting list is currently six weeks. Six weeks is too long.

The Transitions Clinic at Mercy Hospital for Women provides multidisciplinary care to pregnant women with substance use issues. The team contains specialist midwives, an obstetrician, a psychiatrist and social workers. Physician input and other allied health practitioners are involved as required. All patients attending the clinic are offered review with our consultant psychiatrist who is available on an outpatient basis through the pregnancy and in the early post-partum period. Psychiatric care inpatient care is provided to women admitted for obstetric indications by a consultation-liaison psychiatric service. This service has a close working relationship with ReGen drug and alcohol services who provide specialised drug and alcohol counselling as well as inpatient detoxification services for pregnant and post-partum women.

Aboriginal and Torres Strait Islander women

In recent years in Victoria, there has been excellent work undertaken to provide Aboriginal and Torres Strait Islander women with midwifery continuity of care as a way to provide social and emotional support. However, more resources are needed to expand these services to meet the demand.

There is also a significant need to improve access to culturally responsive services for Aboriginal and Torres Strait Islander women experiencing poor perinatal mental health. This requires enhanced linkage between existing Koori maternity services (KMS) in Victoria. KMS provide flexible, holistic and culturally safe pregnancy and postnatal care for Indigenous women, women having Indigenous babies, and their families. KMS are provided by Aboriginal community-controlled organisations (ACCOs) and public health services. With 14 sites across Victoria, KMS are an integral component of Victoria's maternity service system.

Indigenous women may have a greater level of anxiety when faced with traversing the health care system. This can mean a delay in seeking antenatal care due to fear from health care organisations. Institutional racism and stereotyping of Aboriginal and Torres Strait Islander women can mean women are reluctant to disclose feelings of anxiety and depression. For Indigenous women, being diagnosed with a mental health problem attaches a greater stigma. The importance of a continuity of care provider cannot be overstressed. Access to this is limited and may not be provided by a woman which leads to further disengagement from seeking help. Traditionally this care is seen as women's business.

Given there is more out of home care of Aboriginal and Torres Strait Islander children than other nationalities, intergenerational trauma has a significant impact on the mother's ability to parent and therefore affects the mental health of the infant.

Resources are needed to increase availability of culturally appropriate care for depression and anxiety as well as provision of continuity of care.

Women survivors of violence and sexual abuse

Women with a history of sexual assault have significantly higher probabilities of clinically significant depressive symptoms, anxiety, and poor sleep than women without this history. As reported by VicHealth, in Australia, two in every five women (41%) have experienced violence since the age of 15 years. Around one in three (34%) has experienced physical violence and almost one in five (19%) has experienced sexual violence.[4] The negative impacts of violence on women's health includes poor mental health, anxiety and depression, as well as alcohol and illicit drug use and suicide.

CCOPMM RECOMMENDATIONS

1. Address gender inequality in mental health

A Victorian mental health system that is fit for purpose in the 21st century, requires system level reform that integrates a gender analysis and clinical response and is tailored to the different and diverse needs of women and young children.

This includes the specific challenges women experience compared to men over their lifespan through childhood, adolescence, their reproductive years and in mid-to-later life that include:

- More women experience depression and anxiety that impacts on their health and wellbeing and also on their roles as parents and carers;
- Women with mental illness are more likely to experience violence, abuse and harassment;
- Women's biology impacts on their treatment needs such, as drug use and response;
- Women experience higher rates of abuse and trauma and as such, have significant rates of trauma related mental health disorders;
- Women experience specific developmental challenges that impact mental health, including adolescent development, pregnancy and the perinatal period, ageing and menopause;
- Women experience mental health issues relating to women's cancer and gynaecological issues.

2. Early identification and intervention for mental health disorders

Improved support for women with mental disorders who are or are about to become mothers is a current service gap in the Victorian mental health system. This includes the need for greater access to early intervention and prevention programs for women in early parenting that builds capacity to support child development and improve child outcomes. Interventions in the perinatal period are a significant strategy for effectively preventing mental illness and supporting recovery early in life and early in illness.

3. Accessible and timely treatment

A review of the mental health treatment plan scheme is required to support accessibility for those most in need. The rising cost of private psychologists results in many consumers having to pay significant costs despite the rebate, or simply not accessing services due to the cost.

Community access is further hindered by limited clinical mental health positions funded in the primary care sector, which forces practitioners into private practice. This problem is further exacerbated in rural and regional Victoria, where there are fewer accessible clinical mental health practitioners. Increased funding is required to provide equal access to clinical mental health practitioners within community hospitals and primary care settings.

4. Review of mother-baby psychiatric units

A key strategy to improve access to the Victorian mental health system is to undertake a state-wide review of access and availability of mother baby psychiatric units that includes ensuring that there are adequate bed numbers. This needs to consider how to build service coordination pathways with community programs and general acute psychiatric services for the management of pregnant and postnatal women. There is a need for dedicated women's mental health beds for women needing a higher level of mental health care. There are limited options for women needing better integration of maternity and mental health treatment and a model of co-location is recommended as an approach to improved care planning and coordination. We recommend the development of mental health units within maternity services with appropriate mental health trained staff.

This would provide capacity for a longer stay in a maternity hospital, with mental health support in an "acute step down" focusing on providing specialist maternal and infant mental health treatment in the early post-natal period. This provides an opportunity for clinical mental health observation, support and education with the opportunity to provide timely treatment and linkages to ongoing community services. Engaging vulnerable families in this process will lead to harm minimisation giving at risk families the best possible start to their parenting journey.

5. Integration of perinatal and infant mental health services

The establishment of integrated perinatal and infant mental health service hubs aligns with the Victorian Parliamentary Inquiry into Perinatal Services and the need for more community-based services and day programs to avoid women's and newborns' hospitalisation. Services and models of care should be developed in coordination with child protection, maternal and child health nurses, early childhood services, mental health and primary care. These hubs could also integrate with other important reform initiatives such as the Orange Doors.

6. Delivery of culturally relevant maternal mental health supports

There is a significant need to improve the system wide understanding of the mental health needs of recent migrants, asylum seekers and refugees in a culturally relevant context. This includes mitigating the mental health and wellbeing impacts of westernised culture and gender norms. This information should then be used to develop new and enhance existing programs and systems to address these needs, including:

- ensuring women are aware of the cultural and linguistic supports available to them
- providing access to interpreters
- providing resources and supports for clinical and mental health staff to help deliver culturally responsive services

References

[1] Newman L, Mares S, Warren B (eds) (2005) *Clinical Skills in Infant Mental Health: The first Three Years.* Acer Press, Sydney

[2] Australian Government, Department of Health (2018) *Pregnancy Care Guidelines: 27 Screening for depressive and anxiety disorders* https://beta.health.gov.au/resources/pregnancy-care-guidelines/part-e-social-and-emotional-screening/screening-for-depressive-and-anxiety-disorders

[3] Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative. https://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba

[4]Violence against women in Australia (2017) *An overview of research and approaches to primary prevention.* Victorian Health Promotion Foundation, Melbourne, Australia. https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/PVAW/Violence-Against-Women-Research-Overview.pdf?la=en&hash=FE35B4870E2DAD8FFC92C2ADBD49CE6D9C94CC9C

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Submission to Royal Commission into Victoria's Mental Health System from the Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Preventing death from intentional self-harm (including suicide) in children and adolescents in Victoria

WHO IS CCOPMM

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THE CCOPMM SUBMISSION

This submission is based on the review of 173 cases of children and adolescents aged less than 18 years who died from intentional self-harm (including suicide) in the 10-year period 2008 to 2017. In further supporting this submission the experience and expertise of CCOPMM members and members of the Child and Adolescent Sub-committee alongside recent reports both in Victoria and nationally have informed and strengthen our submission.

The overarching themes of the CCOPMM recommendations are:

1. **Timely and appropriate service delivery for those identified with mental health issues**
2. **Early identification and support for at-risk children and adolescents**
3. **Strengthened policy and legislation for mental health – targeting the whole population**
4. **Investment in research into media, its use and impact on suicide in children and adolescents**

Definition: Death from intentional self-harm (including suicide). Cases where CCOPMM (through its Child and Adolescent subcommittee) considers that the cause of death is attributable to an intentional act of the deceased to cause self-injury and / or death, and where death has been the eventual outcome.

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

CCOPMM FINDINGS

Number of deaths due to intentional self-harm (including suicide)

In the 10 years 2008 -17 at least 173 children and adolescents in Victoria aged 10 years to 17 years 11 months died as a result of deliberately taking their own lives (deaths due to intentional self-harm [including suicide]).

Age range

15 y to 17 y 11m 145 deaths
10 y to 14 y 28 deaths

The youngest child to die from intentional self-harm (including suicide) in this 10-year period was 12 years of age. Subsequently, there is at least one child younger than 10 years of age who died from intentional self-harm.

Numbers are likely to be an under-estimate

The above figures are likely to be an underestimate of the real number of deaths due to intentional self-harm (including suicide). In situations where:

- Children or adolescents driving motor vehicles have crashed and died
- Children or adolescents have died from of an overdose of recreational or illicit drugs where intent is not known; these deaths are categorized as accidental deaths.

Mechanisms of death

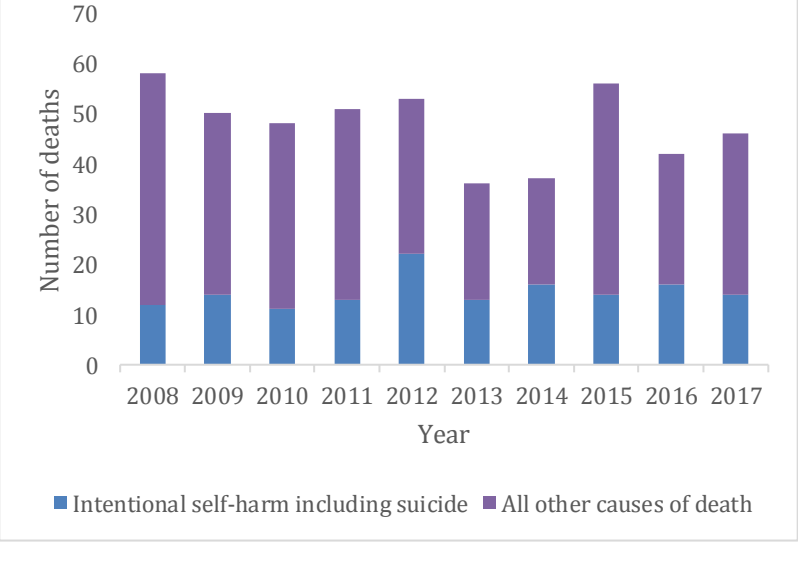
By far the most common cause of death by intentional self-harm (including suicide) is death by hanging or strangulation (61.3 % of child and adolescent suicide). Other causes of death include: death by train, jumping from a height, asphyxiation, gun shot, overdose with medication or other substance.

Intentional self-harm (including suicide) is the most common cause of death in children and adolescents between the ages of 15 and 18 years

In 8 of the 10 years 2008 to 2017, death from intentional self-harm (including suicide) was the single most common cause of death in adolescents aged between 15 and 18 years. In 2008, death from international self-harm (including suicide) was ranked the equal most common cause of death along with motor vehicle accidents; in 2015 it was ranked second most common cause of death after motor vehicle accidents.

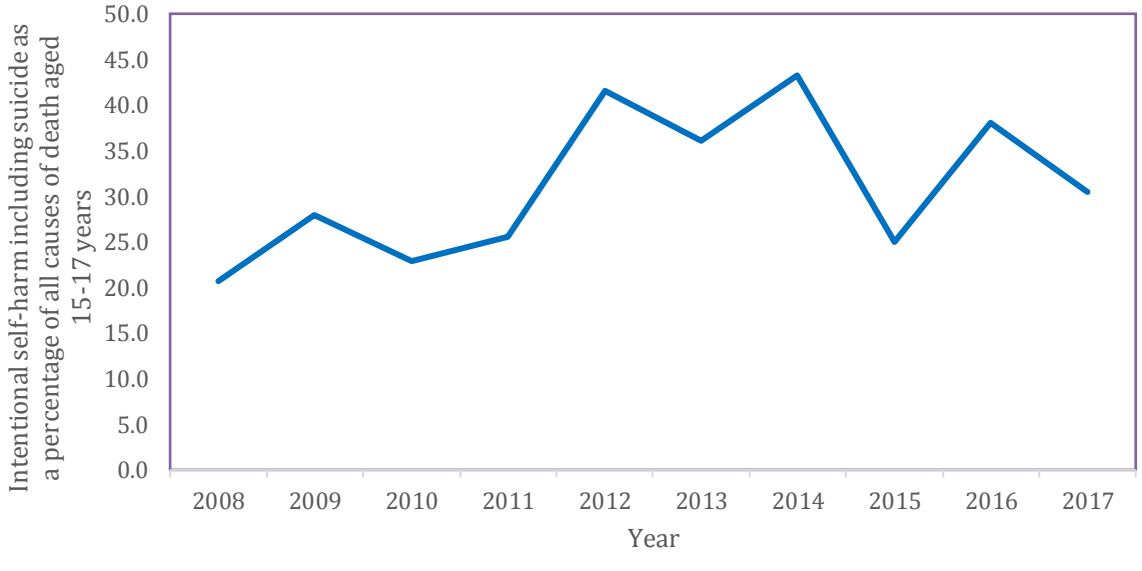
Number of Deaths in Adolescents aged 15y to 17y 11m: 2008 to 2017

While there has been a downward trend in the total number of deaths in adolescents aged 15 and 18 years over the 10 years 2008 to 2017, the number of deaths due to intentional self-harm (including suicide) has not deceased.



Proportion of all deaths in adolescents aged 15y -17y 11m due to intentional self-harm (including suicide) : 2008 to 2017

Correspondingly, the proportion of deaths in adolescents aged between 15 and 18 years due to intentional self-harm (including suicide) has increased over the last 10 years and in the 6 years from 2012 to 2017 deaths accounted for 30-40% of deaths in this age group.



Consultative Council on Obstetric and Paediatric Mortality and Morbidity

CASE STUDY

The following is a common case description of a child who has died from intentional self-harm (including suicide) reviewed by CCOPMM. It is fictional but constructed to highlight the issues commonly faced by vulnerable young people who die as a result of intentional self-harm.

Typical case study:

John is a 16-year-old boy. His parents separated at when he was 2 years of age. He usually lives with his mother, who struggles with her own mental health issues and at times has had difficulty caring for John.

When John was at primary school, there were a number of reports to Child Protection when John came to school without food or with dirty clothes. John spent some time in foster care when his mother was in hospital.

Over the last two years, John's school attendance decreased. His school was worried about John's mood and linked him with the school counselor. The counselor thought John may need medication and suggested he attend his local doctor, but he did not attend.

John was brought in to an emergency department by ambulance one night after his mother found he had taken an overdose. John was admitted to a hospital mental health ward for three days and discharged to a local CAMHS for follow up.

John attended one CAMHS session but did not go back after that. His CAMHS worker contacted John's mother several times by phone, and scheduled three follow-up appointments, but John did not attend. When contacted by phone again, John's mother said he was doing "OK" and that John was going to school on and off. As John did not engage with CAMHS and his mother said he was "OK", the CAMHS service closed the case.

John's mother became unwell again, and John spent more time in foster care. His Child Protection worker suggested to John that he re-engage with CAMHS, but John refused.

John was found dead last week having hanged himself.

RECURRENT THEMES AMONGST DEATHS DUE TO INTENTIONAL SELF-HARM REVIEWED BY CCOPMM

- Children and adolescents who have had contact with the Child Protection and/or the Youth Justice systems are over-represented amongst those children and adolescents who die from intentional self-harm (including suicide). In 2017, at least 7 of the 17 children and adolescents who died from intentional self-harm (including suicide) were, or previously were, known to the Child Protection and / or the Youth Justice systems. Family violence, child abuse, parental mental illness and parental drug and alcohol issues all place children at risk of entering the Child Protection system and increase a child's risk of intentional self-harm (including suicide).
- Disengagement from school is common amongst children and adolescents who die from intentional self-harm (including suicide)**.**
- Close contact with someone who has died from intentional self-harm, increases the risk of intentional self-harm (including suicide).
- Even when the need for care and treatment for children and adolescents with mental health issues is identified, significant barriers exist in referring children and adolescents to appropriate practitioners and services.
    - There is a critical lack of access to psychologists and psychiatrists working at community level who will see children and adolescents
    - Even if local psychologists and other mental health providers with expertise in managing children and adolescents do exist, referrers such as General Practitioners, are often not aware of their expertise.
    - Waiting lists are long for initial assessment
    - Out of pocket expenses are significant
    - Headspace sessions are limited in number each year
    - Referral processes to public Child and Adolescent Mental Health Services (CAMHS)/ Child and Youth Mental Health Services (CYMHS) are difficult to negotiate, for families and health practitioners
    - Those living in rural areas generally have less access to services There is little clinical support for General Practitioners caring for young people.
- Many children and adolescents who died from intentional self-harm (including suicide) also had significant drug and alcohol issues. However, they were not linked to appropriate services largely due to the lack of specific and specialist child and adolescent drug and alcohol services, at community and residential level.
- Many children and adolescents who die from intentional self-harm (including suicide) have had contact with the mental health system but have disengaged from mental health services at the time they die from intentional self-harm (including suicide).
- Health and mental health information was often not readily available to all respective providers responsible for providing health and mental health care to children. Therefore, delivery of health and mental health services was at times not integrated, with services at times being provided in isolation from each other.

The most vulnerable often have the least access to services

These recurrent themes, drawn from the deaths of 173 children and adolescents who have died from intentional self-harm (including suicide) over a 10-year period, highlight the tragic irony that the most vulnerable children and adolescents in Victoria, those in the greatest need of support from the mental health system, often have the greatest difficulty in accessing services.

OTHER RELEVANT REPORTS RELATING TO YOUTH MENTAL HEALTH IN VICTORIA: VAGO REPORT

Victorian Auditor-General's Office report on Child and Youth Mental Health

The Victorian Auditor-General's Office report on Child and Youth Mental Health in Victoria was tabled in the Legislative Council, Parliament House, Melbourne on June 5, 2019. Available at: https://www.audit.vic.gov.au/report/child-and-youth-mental-health?section

The VAGO report found:

- One in 50 Australian children and adolescents has a severe mental health problem.
- Three-quarters of all mental health problems manifest in people under the age of 25.
- The likelihood of mental health problems increases exponentially where there are other indicators of **vulnerability** such as unstable housing and poverty, neglect and abuse, intergenerational trauma or developmental disabilities.
- Specialist child, adolescent and youth mental health services do not meet service demand or operate as a coordinated system. This can lead to significant deterioration in the health and wellbeing of some of Victoria's most vulnerable citizens.
- DHHS has not identified priority populations for CYMHS nor enabled health services to prioritise access at the local level. DHHS advises that individual health services in Victoria's devolved health system are responsible for managing access and any priority populations at the local level.
- Only one of the five audited health services have implemented the Chief Psychiatrist's 2011 guideline to prioritise children in **out-of-home care**.

In regard to vulnerable children, the VAGO report recommended:

- Consider establishing a High-Risk Complex Care Child and Youth Panel, with executive representation from out-of-home care, disability services, and mental health areas of the Department of Health and Human Services, with remit to:
    - allow health services to rapidly escalate cases to the panel when a local service response is not meeting a young person's needs, to prevent a clinically unnecessary inpatient stay that may cause deterioration of the young person's health and wellbeing
    - identify and address service gaps and service coordination challenges that are contributing to clinically unnecessary inpatient stays
    - liaise with the National Disability Insurance Agency, as required
- Ensure the registration forms that the Department of Health and Human Services issues to health services can record a child, adolescent or young person's legal status with regards to guardianship, out-of-home care

The VAGO Report notes DHHS response to the report:

- DHHS accepted each of the 20 recommendations, noting that implementation of the recommendations will be informed by the outcomes of the Royal Commission into Mental Health, particularly recommendations relating to system design.

CCOPMM supports the full implementation of all recommendations in the Victorian Auditor General's Offices report in regard to vulnerable children.

EXPERIENCE FROM OTHER JURISDICTIONS: W.A. CORONIAL INQUEST

The 2017 Coronial "Inquest into the deaths of thirteen children and young persons in the Kimberly region, Western Australia" reviewed the deaths of 13 Aboriginal children and young people aged between 10 and 24 years of age who died as a result of hanging between 2013 -2016.

The Coroner's Report graphically documents the negative impacts of adverse social determinants, abuse, neglect, trauma, disconnection from family and community, untreated chronic illness and lack of access to culturally appropriate mental health services for the children and young people who died because of deliberate self-harm.

https://www.coronerscourt.wa.gov.au/_files/inquest-2019/13-Children-and-Young-Persons-in-the-Kimberley-Region-Finding.pdf

The narrative of the W.A. Coroner's Report paints a similar picture to our experience in Victoria: the most vulnerable and at-risk children and adolescents do not have equitable access to appropriate mental health services.

EVIDENCE-BASED EFFECTIVE PUBLIC HEALTH INTERVENTIONS TO PREVENT SUICIDE

The World Health Organization provides a framework for the prevention of suicide in its publication "Public Health Action for the Prevention of Suicide: A Framework". The Framework documents evidence-based effective interventions at three population levels:

Individual: Targeting individuals who are already known to be vulnerable to suicide or who have attempted suicide.

Vulnerable: Targeting sub-populations that are known to have an elevated risk and can be employed on the basis of socio-demographic characteristics, geographical distribution, or prevalence of mental and substance use disorders

General: Targeting the general population irrespective of the level of risk

INDIVIDUAL (Service Delivery)	○ Identify and treat those with mental illness ○ Appropriate management for those who have attempted suicide or who are at risk
VULNERABLE (Early Identification and Support)	○ Train and support "Gatekeepers" who may come in contact with those in the community who may be at risk ○ Support those who have lost a friend or relative that has died due to intentional self-harm or suicide
GENERAL (Policy and Legislation)	○ Restrict access to means of self-harm /suicide ○ Develop policies to reduce harmful use of alcohol as a component of suicide ○ Assist media to follow responsible reporting practices of suicides

https://apps.who.int/iris/bitstream/handle/10665/75166/9789241503570_eng.pdf?sequence=1

DISCUSSION AND RECOMMENDATIONS

Adapting the concepts of Indicated, Selective and Universal interventions as outlined in World Health Organization Framework and applying these to the themes and issues identified by CCOPMM, we provide the following in our discussion and formulation of recommendations.

1. Timely and appropriate service delivery for those identified with mental health issues

Provision of care to those identified with mental health issues.
This is, without doubt, the area with the largest need for reform. As outlined above, the strong and recurrent story arising from the review of the cases of 173 children and adolescents who died as a result in intentional self-harm (including suicide), was that even when the need for mental health support and care was clearly identified, children and adolescents often did not get access to appropriate services.

Improving access to the most vulnerable should be a priority, as evidenced by the over-representation of those within the Child Protection system amongst those who die from intentional self-harm (including suicide). At present, access to specialist psychiatric referral is limited for children and adolescents in the Child Protection system, and usually requires a referral to CAMHS/CYMHS. Currently, the majority of the prescribing for those who need medications, falls to community based paediatricians.

Breaking down the barriers to accessing services requires an innovative and multi-faceted approach. While it is an immediate priority to streamline referral processes and increase capacity of existing services, this alone will not address the issue of access for many at-risk children and adolescents.

Embedding mental health capacity in services that at-risk children and adolescents already access.
Key to the provision of mental health services to at-risk children and adolescents will be to address the paucity of **mental health capacity embedded within institutions or other services that at-risk children and adolescents already access,** in particular Child Protection, Community Service Organisations and Schools.

Embedding mental health expertise and services within such services overcomes many of the barriers of referral, having to travel to attend a time-based appointment, and for children and adolescents having to re-tell their story of trauma to yet another service.

Services such as Take Two, Berry Street provide excellent intensive (often weekly) trauma-informed interventions for children in the Child Protection System. However, the capacity of such services is extremely limited and waiting lists are long. As such, for many children and adolescents, the opportunity to provide timely services and intervene early is often missed.

Secondary consult where it is not possible to embed services.
Therapeutic services such as Berry Street, usually do not have a psychiatrist on their team, necessitating referral to CAMHS, or a paediatrician, if diagnostic formulations or medication options need to be explored. This could be addressed though increasing access to secondary consultation to Child and Adolescent Psychiatrists where it is not possible to embed them directly within a service.

Extending the Medicare Rebate beyond 10 sessions per year for high risk children and adolescents.
Where access to intensive mental health support is not immediately available through funded programs, the needs of high-risk children and adolescents could be met by extending the Medicare rebate to beyond the currently available 10 funded individual mental health sessions per calendar year. This is not without precedent. As of 1 November 2019, patients with Anorexia Nervosa will have access to 40 MBS funded mental health sessions per year.

Addressing disengagement from formal services.
Disengagement from formal services can be a sign of worsening mental health. Amongst the 173 cases reviewed by CCOPMM, disengagement from services by a child or adolescent, as well as the formal discharge from a service or lack of follow up by a service or provider when children or adolescents did not attend appointments is a concern.

From a service perspective, the issue of discharge from services, or lack of follow up for those who do not attend can be seen from many angles including:

- **Service capacity:** if a child does not attend a scheduled appointment a number of times it is understandable that a service may wish to allocate that appointment time to another patient on their waiting list
- **Capacity / Model of care:** many services do not have the capacity to provide outreach services as part of their model of care.
- **Financial drivers:** especially relevant for practitioners, dependent on Medicare rebate for income

Specialist Child and Adolescent Drug and Alcohol Services

Many children and adolescents who died from intentional self-harm (including suicide) also had significant drug and alcohol issues. However, they were not linked to appropriate services largely due to the lack of specific and specialist child and adolescent drug and alcohol services, at community and residential level. Currently, while some Child and Adolescent Drug and Alcohol Services are integrated with Mental Health Services (e.g. at some headspaces), most of the existing Child and Adolescent Drug and Alcohol services are not.

Sharing of mental health record

While many children had accessed Mental Health Providers, Paediatricians and /or General Practitioners, services were often delivered in isolation from each other. Information relating to previous assessments, documentation of current diagnoses and other information relevant to a child's health and well-being was not readily available to respective providers. This was particularly relevant for children the Child Protection and Out of Home Care Systems, where they may have many placements across different DHHS Regions and/or Health and Mental Health Services.

CCOPMM recommendations to improve service delivery are:

- **Embed services for children and adolescents at highest risk**
- **Increase access to secondary consultation**
- **Extend Medicare rebate beyond 10 Sessions per year for high-risk children and adolescents**
- **Exploring the issues of service capacity, models of care and financial drivers that impact on engagement and access**
- **Develop assertive outreach models to prevent disengagement**
- **Increase accountability that ensures appropriate follow up for failure to attend appointments**
- **Streamline Referral processes to service providers including CAMHS/CYMHS**
- **Integrate specialist child and adolescent drug and alcohol services**
- **Develop and implement electronic records for children and adolescents**

2. Early identification and support for at risk children and adolescents

Train and support "gatekeepers" who may come in contact with children and adolescents who may be at risk

Children and adolescents with mental health concerns and who are at risk of intentional self-harm have contact with adults in many settings. Those best positioned to identify risk of self-harm include:

- Child Protection workers
- School teachers and other staff
- Primary Health Care providers

Child Protection workers

Workers in the Child Protection System are potentially well placed to detect the signs of mental health issues in children and adolescents. However, they are often overwhelmed with excessive workloads and the

immediate priorities of the accommodation, school needs of children and adolescents and legal reports. As such, the health and mental health needs of children and adolescents in the Child Protection system are at times unmet.

CCOPMM recommends:
All children and adolescents on entering in the child protection system have an assessment of their health and mental health needs as a matter of routine.

Child protection workers have ongoing professional development to support their knowledge around primary health and mental health issues common amongst children and adolescents in the Child Protection System

School staff
Teachers and other staff have regular contact with children and adolescents and are potentially well placed to detect the early signs that they may be struggling with mental health issues, e.g. by noticing that a child is becoming increasingly withdrawn or isolated from peers or exhibiting increasing school absenteeism.

Providing professional development to school staff, in the form of "Mental Health First Aid" courses, may equip staff to better recognise the early signs of mental illness and respond appropriately.

CCOPMM recommends:
The feasibility and effectiveness of providing professional development to school staff to better recognise the early signs of mental illness and respond appropriately be further explored and rolled out as appropriate.

Primary Health Care Providers:
Children and adolescents frequently visit a General Practitioner for a variety of reasons, including symptoms that may be related to mental health issues. General Practitioners are well positioned to assess their social and emotional wellbeing.

General Practitioners could be additionally supported by appropriate education, clinical pathway development, and telehealth support to provide primary level mental health care to children and adolescents with mental health issues, especially when local services are not available. However, longer appointments would be needed in order to manage complex patients and consideration would need to be given to appropriate remuneration.

CCOPMM recommends:
- **Regardless of the reason for going to see a health professional, any young person who consults with a health professional should have their emotional health and wellbeing as well as their drug and alcohol use routinely assessed.**
- **General Practitioners who have done extra training in mental health of children and adolescent are able to access a higher Medicare rebate for providing mental health care to children and adolescents**

A database of psychologists and other mental health workers with expertise in child and adolescent mental health be developed and maintained to be accessible to General Practitioners.

3. Strengthened policy and legislation in mental health – targeting the whole population

Restricting access to means of self-harm
Restricting access to means of self-harm /suicide though means of bridge barriers and gun laws has been a successful public health intervention to reducing suicide.

Further restricting access to means of self-harm / suicide in childhood deaths reviewed by CCOPMM is likely to have minimal impact as most deaths are due to hanging.

Suicide by **train** could possibly be reduced by erecting barriers in selected / high risk locations.

At least one death has been due to **inhalation of inert gases** (helium from party packs) and consideration of restricting the sale of this to children and adolescents could be considered.

4. Investment in research into media, its use and impact on suicide for children and young people

Responsible media
Assist media to follow responsible reporting practices of suicides
It is not possible for CCOPMM to quantify the effect of media on youth suicide.

CCOPMM has concerns regarding the potential impact of the increasing use of **social media** by children and adolescents and any links there may be between the use of social media and self-harm (including suicide).

CCOPMM recommends
Further research be conducted into links between the social media postings and self-harm behaviour and the consideration of bans on the posting of suicide related content on social media.

CCOPMM also has concerns relating to access by children and adolescents to content which graphically portrays suicide and self-harm behaviour **on on-line streaming services**. In 2018/19 there have been reports of a spike of deaths due to intentional self-harm (including suicide) in the USA coinciding with the screening on Netflix of the series "13 Reasons Why", which graphically portrayed suicide and self-harm behaviour. CCOPMM has reviewed an adolescent death which was linked to watching this program. In response to similar concerns New Zealand's Office of Film and Literature Classification has created a new rating for such content.

CCOPMM recommends
Further research be conducted into the impact of on-line media content depicting suicide and self-harm behaviour and the consideration of bans on the posting of suicide related content on on-line media platforms.