7. Intervention Services

As in the case for early intervention, the appropriate intervention response requires assessing and managing individuals with suicidal behaviours. This chapter proposes strategies to provide effective support to those who have attempted suicide, or who are at ongoing and serious risk of suicide.

The Task Force recognises the same services are often responsible for support and treatment regardless of the level of suicide risk. Distinctions between early intervention and intervention activities can be very arbitrary. Nowhere is this more apparent than in the vital role played by GPs at all stages of the intervention continuum, and it is therefore acknowledged that services provided by GPs and others might just as appropriately be included in this chapter as in the previous one.

Intervention support and treatment services are critically involved in dealing with suicide prevention at the point of crisis as they act as 'first responders' to suicide threat. Individuals and agencies such as police, ambulance services, hospital emergency departments and mental health services provide the key focus for intervention.

The Task Force is conscious that many suicide attempters never present to hospitals or other clinical staff. Many of those who do present to hospitals are released without receiving psychiatric assessment or treatment. Improving crisis response, support and treatment (especially from first responders), and improving access to emergency departments and mental health services are critical for people with suicidal behaviours. The Task Force recognises the importance of intervention services and sees reform in this area as a major challenge.

7.1 Victoria Police

The police play a significant role in providing intervention services through several of their functions and agencies.

Each police district maintains a Community Policing Squad (CPS) whose role is to investigate criminal matters related to family violence, child abuse and sexual assaults. CPS staff are specifically trained to care for people in crisis, including young people, and are available on rotating duty 24 hours a day. They are able to make referrals to appropriate community-based agencies for those people requiring ongoing assistance.

The Task Force heard there may be a need for additional multidisciplinary support to assist police in responding to suicidal individuals and making appropriate referrals.

A member of a rural CPS told the Task Force:

> We are the poor cousins for services because we have a minority of people. We get funding for people to operate services from 8.00 to 4.00, whereas in Melbourne, the services are open all hours. I do not think we get looked after as well as our city cousins.

This is an area requiring further investigation.

The Victoria Police perform an integral role in investigating reportable deaths on behalf of the Coroner's Office. Such deaths include those that 'appear to have been unexpected, unnatural or violent, or to have resulted, directly or indirectly, from accident or injury'. The police provide a report to the Coroner's Court to notify it of such a death. Once reported, the police officer, as part of the investigative process, tenders a statement and/or a brief with regard to the death.

The Victoria Police advised the Task Force of its principal role in suicide and attempted suicide by persons in police custody. Internal procedures have been designed to reduce the incidence of such suicide and attempted suicide.

The Task Force heard police lack the capacity to intervene in potential suicides where the person is not in custody or cannot be taken into custody. Police cannot 'force' a suicide attempter to seek professional help. For these reasons, they are increasingly required to rely on the services of Crisis Assessment and Treatment teams. Unfortunately, in many cases the CAT team is not prepared to intervene because it has assessed the person in crisis as not suffering from a serious mental illness.

I am aware of numerous incidents where individuals have been assessed by a Crisis Assessment Team and found not to be suffering from serious mental illness. This means that a majority of individuals who are mentally unstable have no professional crisis intervention other than police to turn to after hours. I believe that the police, working with Department of Human Services or a private agency, could provide intervention at these times of crisis and so prevent some of the repeated behaviour. (Community consultation)

In some crisis situations, police are the only after-hours response available. Although there is a necessity to intervene in such cases, particularly involving young, homeless persons late at night, there are frequently no other referral or service options for the police but to take the young person to a police cell. This was particularly found to be the case in rural areas.

Often in rural areas there is a lack of a 24-hour, seven-day-a-week service to deal with crises. Often the police end up dealing with issues in an area in which they are not highly trained. (Community consultation)

Police are able and willing to link suicide attempters directly to other services, but have found the service is not available after hours, or they do not know what services are available. One police officer indicated that what was most needed after hours was accommodation, food and travel vouchers.

A member of a CPS in a non-metropolitan region stated at a Task Force community consultation meeting:

…there are many groups out there that can provide help to many people for so many different reasons, but people do not know. I do not know them all and I have been in the police force for 15 years.

Police are currently investigating the possibility of linking all police offices to on-line community service information for local and statewide services.

The Task Force recommends that:
7.1 The Minister for Police and Emergency Services investigate the need for access to multidisciplinary support for police in responding to depressed or suicidal individuals.

7.2 Ambulance Services

Ambulance officers are often the first responders to incidents of suicide attempt. The Task Force met with representatives of ambulance services to identify their role in suicide intervention. Ambulance officers advised the Task Force of current difficulties in identifying appropriate services for suicide attempters. In most cases, hospital emergency departments were the only option. In some instances, ambulance officers felt adequately skilled to deal with cases without the need for further care. However, concern was expressed about inadequate services responses, particularly for individuals who were repeated attempters.

Officers called for a formal referral system that provides better links between health services such as ambulance services, hospitals and doctors in responding to cases of suicide attempt.

7.3 Emergency Departments

The Task Force received numerous submissions from individuals and professionals highlighting the critical role that emergency departments play in supporting, assisting and treating individuals who have attempted suicide. It was unfortunate that by far the majority of these submissions considered the care less than adequate.

As one person commented at a community consultation meeting:

Suicidal people who have mental [health] problems and people who have attempted suicide often do not have easy times in emergency departments.

It is acknowledged that emergency departments are very busy places that need to prioritise care for those with urgent medical needs. While suicide attempts by overdose and serious self harm are considered in need of urgent medical care, the vast majority of people attending emergency departments with suicidal behaviours will be required to wait for considerable periods of time. For people who are suicidal, lengthy waiting periods, often without supervision, may exacerbate their feelings of failure following an attempt, and increase the likelihood that they will leave prior to treatment. It is essential that they receive timely medical treatment and psychiatric assessment.

Attitudes of medical and nursing staff will influence the way the individual and family manage the immediate crisis and how they recover.

A common complaint was that emergency departments rarely provided psychiatric assessment for suicide attempters, and they were frequently discharged without follow-up being arranged. Families often received little, if any, information from the hospital about how to manage the attempter or to whom they could refer for further help.

> Suicidal kids…leave the hospital, there is no support set up and often their families are not even told that they are going to be discharged. Families are not even told how they should approach their children when they come home. (Community consultation)

> In the last admission to [hospital] where he was kept for 12 hours and where he was sedated by injection, they said they had observed him overnight and released him. I wondered how they could say they observed someone who was asleep as a result of sedation. (Community consultation)

> Less than 48 hours before [name deleted] succeeded in suiciding, she was admitted to a major Melbourne hospital after being carried into the hospital by police in an attempt to protect her from herself. She was released from that hospital on day leave about 40 hours later, but within four hours of leaving that hospital she was dead…The key areas that present opportunities for improvement…[are]…communication with family and community carers…discharge or day leave planning…understanding and application of care in individual circumstances. (Community consultation)

In an attempt to overcome some of these problems, a psychiatric nurse was placed in the emergency department of two major Melbourne hospitals. The evaluation found an improvement in the responsiveness to, and treatment of, people presenting with suicidal behaviours. They received timely medical treatment and an immediate psychiatric assessment that then allowed an appropriate management plan to be established. The psychiatric nurse was also involved in educating other emergency staff on mental health issues. The evaluation also discovered that having the psychiatric nurse in emergency enabled the department to develop better relationships and improved communication with community agencies.

Several emergency departments have guidelines or protocols for treating suicide attempters. These may or may not be written, and they vary in their detail and implementation. Even where such protocols exist, they are rarely part of the regular staff induction procedures, and therefore do not become embedded in emergency department practices because of the high staff turnover in this area. Consequently, there is considerable variation between hospitals in their approach to admissions following a suicide attempt, and these variations may also depend on the personal attitudes of staff on duty.

In this context, it is vital that Health Care Networks ensure continuity of service within their agencies for suicide attempters, and keep standard statistics on suicides and suicide attempts to assist program development and research. Targets could be set for reducing readmission of suicide attempters to hospital through providing appropriate support services.

The Task Force considers that the following are important elements of a high-quality intervention service with respect to attempted suicide:
- Multidisciplinary staff who are adequately trained and supervised.
- Proper facilities where patients can be interviewed in privacy.
- Availability of prompt assessment.
- A thorough risk assessment procedure, including interviews with relatives and other key individuals.
- Provision of aftercare from the same service whenever possible.
- Maintenance of appropriate records in a uniform way across all emergency departments.

The Department of Human Services has provided funding for a demonstration project to develop and implement guidelines relating to admission and management of suicidal and self-harming young people to hospitals. The project will impact on the management of violent and impulsive behaviours, self harm and attempted suicide, and provide a model for wider implementation.

The Task Force recommends that:
7.2 The Minister for Health require that Health Care Networks and regional and rural hospitals and health services establish and widely disseminate guidelines to public hospitals, ambulance services, health professionals, community support agencies and police to ensure suicide attempters gain access to care, appropriate referral and follow-up.

7.3 The Victorian Government support the Department of Human Services to appoint a psychiatric nurse or other appropriate mental health professional to emergency departments in public hospitals to:

- **Assist with assessment and management of suicide attempters who present to emergency departments and are not admitted or are only admitted overnight.**
- **Develop referral plans.**
- **Establish and monitor follow-up procedures.**
- **Educate other emergency staff in dealing with persons who are suicidal.**

7.4 The Minister for Health require Health Care Networks and regional and rural hospitals to implement procedures that ensure:

- **A follow-up management plan for suicide attempters is established and communicated to all relevant health professionals involved prior to the person being discharged from hospital.**
- **Significant family members or carers are consulted in developing the management plan and that the plan is clearly communicated to them.**

7.4 Mental Health Services

There is considerable evidence linking suicide with a number of forms of mental illness, particularly depression, schizophrenia, bipolar disorder, conduct and personality disorders and eating disorders.

As indicated in chapter 4, Victoria has been a leader in providing mental health services. Nevertheless, written and oral submissions to the Task Force have expressed the view that mental health services are inadequate, unresponsive or inaccessible when dealing with distressed and suicidal people. Of particular concern are the differences in the nature of the interventions provided by Child and Adolescent Mental Health Services and Adult Mental Health Services, and problems of continuity of care for young people moving from the former to the latter system.

The Task Force believes there is a lack of awareness among professionals and, more generally, about the prevalence of mental illness in adolescence, especially depression. There has been a tendency to consider adolescent experiences such as emotional distress, depression, excessive dieting, binge drinking and drug abuse as 'normal' adolescent behaviour. This is usually far from the case and can result in troubled adolescents not gaining professional help when needed. American research shows that up to 90 per cent of mental illnesses have their onset in adolescence or early adolescence.

There is also a lack of evidence regarding the most effective methods of treatment of adolescents who are depressed.

> An issue of primary concern…is the non-detection of depression in the early stages. Often this is dismissed as being just normal adolescent behaviour. It is not until at-risk behaviours become evident, self mutilation and overdoses being the most obvious, that referrals are made to this service…However, after assessment, young people who present initially with eating disorders, aggressive behaviours and/or family difficulties are often found to have underlying depressive features. (Community consultation)

At the same time, many professionals are sometimes reluctant to label young people as having psychiatric disorders. This can be interpreted by the family and young person as meaning there is no problem and no need for treatment. The parent of a young woman who died by suicide informed the Task Force:

> A psychiatrist…assessed her and said she did not have a personality disorder and no psychiatric illness and was not certifiable. I asked them what I was to do with [her] to keep her safe in the light of her overdosing, cutting her wrists and so on and the psychiatrist replied that it was not his responsibility and not to lay a guilt trip on him. (Community consultation)

Emotionally distressed adolescents may be reluctant to seek help from professionals. They may also lack knowledge of what help is available and how to access it.

> Providing flexible and responsive mental health services that can be more easily accessed by young people is important. The issues of stigma and accessibility arise again. Young people feel threatened by suits and by going into formal offices or, in the local case, the psychiatric service, which is still housed in the former [psychiatric] hospital, about which there is a perception in the community. Often people who are in need of services will not access them. We need assertive outreach-focused services for at-risk young people. (Community consultation)

Outreach approaches are more suited to many young people and older adults in need of mental health services.

Where referrals do occur, the pathways into and between services and case management procedures sometimes work against therapeutic outcomes. The Task Force heard much about the importance of early identification of risk and appropriate referrals by GPs. However, several speakers at public consultations drew attention to shortcomings of mental health services when such referrals were indeed made.

> As a general practitioner, several things concern me about dealing with young people who are at risk of suicide, and they relate to the psychiatric mental health area. One is that I do not think there are enough adolescent psychiatrists. That is a problem in itself. Another is that I do not think there are enough adolescent psychiatric beds. (Community consultation)

> I speak tonight from the point of view of the average general practitioner and, in particular, about the lack of accessible services for youth who are psychiatrically disturbed…The process by which an urgent referral needs to be made is extremely tedious. One has to go through an admitting officer who takes the story, consults with her consultant, and gets back to you but sometimes not for six hours. In the meantime you have an urgent crisis on your hands. (Community consultation)

> Another issue is that after psychiatric referral, we often do not hear back from psychiatrists or mental health services. Because GPs are as involved as they are with young people at the ground level, there should be some networking and feedback. That has been a big problem and needs to be addressed. (Community consultation)

In speaking at a public consultation meeting on the suicide of an adolescent girl, the parent stated:

> With sick or difficult teenage children, parents often have to rely on other people to assist and guide them. In seeking help from public medical areas, we expect to receive professional direction, but are often let down. Some psychiatrists and nurses were overcaring, some undercaring, some very damaging to our objectives. (Community consultation)

There appears to be a significant service gap for those people who do not meet current criteria for assistance from the mental health system yet are not adequately assessed or treated by GPs for their psychiatric disorders. Therefore, the Task Force has considered the need for additional services for people who do not have a severe mental illness but require treatment for their mental condition.

The Task Force was informed of a recent study of the 730 suicides occurring between 1989 and 1994 of persons who had previously been treated in the Victorian public mental health sector. The study showed that of the 220 suicides where the last treatment setting was an inpatient service, 45 per cent of these deaths occurred within four weeks, 56 per cent within three months, and 71 per cent within a year of discharge (Burgess, briefing to Task Force).

The suicide rate was higher for those patients where there had been no community follow-up after discharge from inpatient care, for those who had schizophrenia, and for women in the 20 to 40 age group. Therefore, there is a need for active community follow-up of all patients post-discharge from inpatient care, particularly those patients known to be at highest risk of suicide.

Prior to discharge from hospital, a comprehensive case plan must be developed in conjunction with appropriate community service providers, including GPs and carers, to assist smooth re-entry into the community and provide continuity of care.

In this context, the Task Force is concerned at recent changes to the Medicare system that limit, with some qualifications, the number of rebatable psychiatric consultations to 50 per year, as many people with mental illness, and who are at risk of suicide, need frequent and extended psychiatric consultations.

The Task Force recommends that:
7.5 The Minister for Health initiate pilot research into innovative depression treatment approaches for adolescents.

7.6 The Minister for Health request that the Commonwealth review Medicare guidelines with a view to extending the qualification for Item 319 to those patients with a psychiatric illness who have reached or exceeded 50 attendances in a 12-month period but who continue to be, or who become, suicidal.

7.4.1 Access to Inpatient Services

Several submissions highlighted the difficulty of access to adolescent inpatient beds, and the inappropriate placement of young people in adult inpatient facilities that are generally not responsive to the developmental needs of adolescents.

> Two different hospitals recommended [she] be treated at [a psychiatric hospital], but it refused to take her but did not offer an alternative. Another two hospitals said she was ineligible because she did not live in their zone. Once again [she] was not their responsibility…Where were we to go? How could we get emergency help when the system ran like this? (Community consultation)

Problems in accessing mental health services in rural regions was a theme raised by several speakers at the non-metropolitan community consultations.

A representative of a rural CAMHS stated:

> An issue the unit finds disturbing lately is the lack of inpatient beds, particularly in Melbourne. In a lot of cases, we are seen as a last port of call but, in effect, we are still an outpatient unit and so still require inpatient beds in Melbourne. Obviously, we do not have any child and adolescent beds up here because we are in a rural area. It depends on the level of disturbance, but some young people are placed in the adult unit alongside severely depressed or psychotic adults, in some cases up to several days, which is highly inappropriate. (Community consultation)

Another rural CAMHS clinician commented:

> I have also found that when we refer young people down to Melbourne-based hospitals, which we tend to use when they have attempted suicide, there are often no beds and they cannot be admitted, even though we still think they are at risk. Often I have received phone calls from people who have said, 'We would like to admit the person but we haven't got beds, so just keep doing what you're doing' which is less than reassuring for those involved with that young person. (Community consultation)

In this regard, it should be noted the Government provided an additional $8 million in the 1996–97 budget for enhancements to CAMHS community and inpatient services. Developments are currently under way to establish a statewide child inpatient service to be located at the Austin and Repatriation Medical Centre (A&RMC) and operational by 1 July 1997. In addition, adolescent beds have also been commissioned at Maroondah Hospital, and there are increases to current adolescent bed numbers at the Royal Children's Hospital and A&RMC. Moreover, CAMHS policy provides for the establishment of two adolescent beds in each of the five non-metropolitan Human Services regions. In concert with these developments, and the additional mental health services funding initiatives announced in the 1997–98 State Budget, pressure on inpatient facilities will be further reduced if community services are enhanced in ways recommended in this report.

7.4.2 Services in Rural Areas

There is a need for flexible and innovative counselling services for small communities in rural and remote areas. Such counselling services should have a particular focus on areas with significant Aboriginal populations without access to counselling, and where there is a need for interventions with rural males with high-risk factors, including psychiatric disorders.

One proposal for improving mental health services in rural areas came from the Australian Nurses Federation. The federation suggested using appropriately trained, community nurses available on-call to deal with an immediate crisis, followed by links into more specialised services.

Another model was the suicidal youth referral structure developed by the Health Department of Western Australia. The model proposes that a small group of carefully recruited and specifically trained volunteers be attached to psychiatric and child health centres to provide practical support to designated clients who are receiving clinical treatment, such as linking clients to other agencies. In this way, volunteers can assist clients, thereby reducing the pressures on scarce clinicians who are able to focus on their other professional duties.

The Task Force recommends that:
7.7 The Minister for Health develop rural and regional counselling services that focus on the needs of Koori people and males in small and isolated communities.

7.8 The Minister for Health investigate the potential for improving mental health services in rural areas through use of community nurses, appropriately trained, and adoption of the West Australian suicidal youth referral structure.

7.4.3 Brief Intervention Program

The Task Force received information regarding the Brief Intervention Program (BIP) provided by the A&RMC, CAMHS and considered this an example of best practice. This is an outpatient, group-based day program that is full time over 10 weeks. It provides intensive support for an estimated 30 young people each year. It targets adolescents aged 13 to 18 years with emotional, behavioural, social and/or psychiatric difficulties. Program components include a cognitive-behavioural skills group, psychotherapy group, wilderness-adventure therapy, arts/media/creative therapy, drama therapy, work education, living skills, sex education and relationship groups. The precise program structure and content varies according to the needs of individuals. Staff include CAMHS clinicians and Department of Education special education teachers.

Several speakers at the public consultation meetings spoke in support of such programs as a valuable therapeutic adjunct for at-risk young people.

> That mode of work has been proved to be quite successful, particularly by the Austin hospital, which has a strong wilderness therapy program. We would support any endeavours to get such a program up and running with other agencies, because obviously we cannot do it on our own and need collaboration. (Community consultation)

The Task Force recommends that:
7.9 The Victorian Government support the Department of Human Services and the Department of Education to establish and evaluate a program in each Department of Human Services region along the lines of the Brief Intervention Program (BIP), linked to a Child and Adolescent Mental Health Services and/or Adult Mental Health Services and other appropriate services.

7.4.4 Provision of Youth Sensitive Mental Health Services

Currently, young people move from being the responsibility of CAMHS to AMHS at around the age of 18, or when they leave their parental home, and this can lead to a break in the continuity of care.

> While the age limit for referrals to child and adolescent mental health services is 18 years, it is of concern that there are few referrals of those over the age of 16 years. It is understood that some young people over 16 are presenting neither at the adult mental health service nor at child and adolescent mental health services. The reasons for this are diverse, ranging from the reluctance of young people to access psychiatric services, to the interpretation placed on the intervention by psychiatric services for those over the age of 16 years. It is also understood that some patients of the 12 to 25 year target age group that present at the…hospital after suicide attempts where follow-up is offered by psychiatric services either do not accept, or follow through is not continued. (Community consultation)

> …there is a grey area about whether people between 16 and 18 years of age who are living independently and not attending school are adolescents or adults. (Community consultation)

In many cases, the CAMHS is well placed and able to deal with young people up to the age of 18, particularly where the young person is still at school. However, the scarcity of secure facilities for suicidal, potentially violent, mentally disturbed adolescent males leads to fairly frequent boundary disputes between CAMHS and adult inpatient and community support teams. Although the combination of suicidal behaviour, mental disorder and youth will always create difficulties and boundary disputes no matter where the line is drawn, evidence presented to the Task Force suggests the current situation can be improved.

Reference was made earlier in this report to the work of EPPIC within the Centre for Young People's Mental Health. This is a model of good practice, particularly in relation to the out-of-hours outreach and crisis services to the young adult population, and its support for families through counselling and peer support groups. The Task Force is aware that CAMHS inpatient adolescent units also provide services along similar lines for first onset psychosis, though for a younger age group.

De-institutionalisation and the development of CAMHS makes this an opportune time to consider establishing a youth program by AMHS to better meet the needs of older adolescents and young adults. The operation of CAT teams and MST could then be extended to ensure the delivery of mental health services to these young people.

The Task Force heard that the 'culture' of the AMHS is still dominated by institutional practices. There is a need for an improved approach to the treatment of young people that would include a greater emphasis on the importance of the family and non-medical systems.

> I came down to Melbourne from the country by myself…and I was admitted to the…hospital, which was a frightening experience in itself…They then decided to put me into the adult unit. I was told to pack my bags and go for a morning walk and when I came back I would be moved to the adolescent ward. I did that and when I came back my bed had been taken in the adult ward. I went up to the adolescent ward and my bed had been taken there in the past half an hour…The hospital staff had to ring my parents who lived hours away to come and get me. I spent three weeks back home very ill and I refused to see anyone else after that. (Community consultation)

The Task Force recommends that:
7.10 The Minister for Health require that existing Adult Mental Health services place greater emphasis on the care of young people aged 16 to 24 years who are mentally ill and/or at risk of suicide.

7.11 The Minister for Health establish guidelines and appropriate training for clinical staff to ensure smooth transition of clients from Child and Adolescent Mental Health Services into Adult Mental Health Services.

A frequently cited criticism was the exclusion of families from therapeutic interventions and appropriate follow-up.

> The mental health system should not treat the person in a vacuum but in a family and community context. It should cooperate with the families and social supports of the patient rather than pushing them away. The cultural and ethnic background of the patient should be taken into account when decisions relating to treatment are taken. (Written submission to Task Force)

Evidence was provided to the Task Force that patient confidentiality is often used as the rationale for lack of comprehensive care. The Task Force believes professionals should work cooperatively with families in the interests of the client, and not use confidentiality as an excuse for fragmented and ineffective care. Confidentiality protocols can be developed with client support.

> Many professionals ignore parents and family as a source of information and as a source of support for the patient. At one large meeting of doctors, nurses and social workers, I wanted to show [the] stockpile of pills and the notes she was keeping regarding her plans to suicide so that we could all make a responsible decision about [her] future. The doctor refused to allow me to speak, he was adamant in not wanting to hurt [her] feelings. I believe parents have an important role to play in meetings of this type when their teenagers are suicidal. They should be regarded as an important resource rather than dismissed as irrelevant, which was more often the case for us. (Community consultation)

> Confidentiality laws also meant [she], at 16, could forbid hospital staff from telling us, her parents, anything. When we phoned to see how she was, we were always told she was settled, when in actual fact she had run away from the locked ward and they did not know where she was, and that she was actually in intensive care and near death as a result of an overdose. Do we have to accept this totally unacceptable denial of our rights as parents? Confidentiality that forbids us to be told that our child is extremely ill and near death! (Community consultation)

The parent of an adolescent, who was diagnosed with schizophrenia, stated at a public consultation meeting:

> …if mental institutions were prepared to take him on and to take care of him, why did they not communicate better to his parents…

> One of the biggest problems is that they not only cannot stay in hospital, but when they are discharged early, there is very little communication with family and friends and there is almost no networking. (Community consultation)

> There is not much communication between the family, the school and the friends, and so when that young person goes out, everybody is walking on eggshells and nobody quite knows what to do because they have not been organised to be an effective support. (Community consultation)

7.4.5 Services for People with Personality Disorders

Of particular concern to several speakers at public consultation meetings were the difficulties experienced in gaining access to, or adequate treatment from, mental health services for individuals diagnosed as having personality disorders.

Victoria's Mental Health Service: The Framework for Service Delivery (1994) explicitly acknowledges the complex needs of specific client groups, including people with a severe personality disorder who are at risk of self harm. It states that the provision of mental health services must take into account the specific needs of these clients so that access is facilitated and services provided in ways that are most effective.

It is argued in the literature that successful treatment of personality disorders is more likely to occur in the context of a model of service provision in which there is a demonstrated motivation for, and cooperation with, treatment rather than by involuntary or coercive methods. Consequently, most services to people with a severe personality disorder are provided in the community or on a voluntary basis.

Case Study

At one of the consultation meetings, the parents of a 21-year-old daughter who died by suicide shared their story. Near the time of her death, she was diagnosed as having borderline personality disorder. During the final 10 months of her life, she made 12 attempts to suicide.

'Please imagine an attractive but sad young lady running away from a hospital mental health ward, being caught by a youth minister from her church who hugged and held her for two hours while she waited for a CAT team to arrive to assess her, and then being told that neither the police nor the CAT team could accept responsibility because it was not its jurisdiction. Then imagine that same sad girl being carried back to the hospital in a police van and being admitted to hospital but allowed to leave only 40 hours later. Then imagine the same girl four hours later dying because the system had failed,' said her father.

'In the 40 hours between the time [our daughter] was admitted to hospital and let out on day leave, six messages were left from people who were caring for her in the community and who wanted to say how serious this particular situation was. Not one call was returned by doctors in the hospital.

'I point out that with the value of hindsight it is easy to say that [our daughter] should have been restrained. Is someone who is 21 years of age really adult or more adolescent? Is that person capable of making those decisions?

'Does it have to be only a dream that our hospitals and doctors work together with the family, friends and community carers so that attractive and courageous young people can live to experience the joys of life?'

The parents believed their daughter's story raised four key areas requiring improvement:
- Failures or weaknesses in communication with family and community carers.
- Weaknesses in discharge or day leave planning, particularly for continued care from family and community carers.
- How to provide protective care for patients who may be reluctant to be there but who are not certified as involuntary patients.
- Understanding and applying what care is appropriate in individual circumstances.

However, there is a small group of people who sometimes require involuntary treatment. Comments by the coroner highlighted the need for continuity of treatment for people who cause significant and severe harm to themselves. Recent amendments to the *Mental Health Act 1986* have taken the needs of this group into account. New sections of the Act enable continued detention of an involuntary patient in circumstances where the person may no longer be considered to be 'mentally ill', but has a 'mental disorder' that causes them to inflict significant and severe physical harm on themselves.

Nevertheless, evidence presented to the Task Force suggests when confronted with an individual with a personality disorder, the service response is often crisis driven and ad hoc.

> Mainly we found it was very hard to get our children into hospitals and it was very hard to keep them there. One of the impediments to keeping them there seemed to be the Mental Health Act which seemed to suggest, for example, that people who were diagnosed as having borderline personality disorders only received crisis care and subsequently were not given full care. (Community consultation)

> In 1995, they refused my admission to hospital because they were sick of me and had rediagnosed me as having a borderline personality disorder. For those who do not know, that is the trendy label to give somebody, and it is convenient that the treatment for borderline personality disorder is to withdraw treatment. After I was refused admission to hospital, I nearly died. (Community consultation)

> The youngest of my children died several years ago. He was 18. He died on the seventh attempt on his life…He saw many professional people…We used to describe his behaviour to them and they started off telling us that he had a personality disorder. At the end, we were told that it was a borderline personality disorder and because of the word 'borderline' we thought he was getting better when in fact it was a lot worse… The doctors at the inquest said that [he] was not suicidal and that he only had suicidal ideation. When was he suicidal? On his last attempt when he died! (Community consultation)

The Task Force recommends that:

7.12 The Minister for Health implement procedures so that any person with suicidal ideation or who has attempted suicide, seeking admission to a psychiatric facility, who does not meet the Mental Health Act requirements and where a voluntary admission is inappropriate, should be immediately and directly linked to community mental health outpatient and follow-up services.

7.13 The Minister for Health expedite the establishment of a specialist statewide service for people with personality disorders to provide a range of options including hospital treatment, and to broker relevant community services prior to discharge.

7.14 The Minister for Health require mental health services to develop guidelines for mental health clinicians regarding provision of information on treating mental illness and supporting families and carers to assist them to manage the situation in the home.

7.4.6 Crisis Intervention

The most passionate criticism of mental health services heard by the Task Force at the public consultations was in respect of the limitations of services provided by the CAT teams.

Chapter 4 of this report has outlined the Victorian government policy that defines the CAT service target group as:

- Individuals in acute phase of a mental illness, or immediate risk of an acute episode, who require intensive treatment and support and are being considered for an inpatient admission.
- Individuals in psychiatric crisis whose community living arrangements are deteriorating as a result of their mental illness, and who require intensive out-of-hours intervention to prevent inpatient admission.

The policy states that the CAT service is intended to provide:

- Acute and crisis assessment.
- Screening of admissions to public adult acute psychiatric inpatient services.
- Inpatient liaison
- Help on discharge from inpatient services.
- Crisis intervention.
- Intensive community-based treatment and support.
- Supplementary out-of-hours treatment and support.

Submissions received suggest that CAT services are not addressing all these service objectives but are mainly focusing on inpatient 'gatekeeping' and people presenting with psychosis.

Criticisms of the service have included lack of sensitivity and responsiveness to adolescent risk-taking behaviours; failure to provide timely, after-hours crisis assessment to young people; and leaving a 'crisis' without taking any further action or making an appropriate referral to any another agency.

> As a general practitioner, I deal with crisis intervention; the support services are simply not available. The [local psychiatric centre] has a crisis assessment team but the response time can be up to 24 hours. (Community consultation)

> I have read…[about] crisis assessment treatment services, the CAT team, the famous CAT team. I don't want to can them, but all I can say is, we tried from 6.00 p.m. till 3.00 am. 'We provide a rapid 24-hour response to people in crisis'. The first night they said, 'We only deal with 18 to 25 year olds'. Okay. We tried the police, everything. Eventually we got her to hospital. They agreed she was suicidal, but wouldn't admit her. We took her back home. The second night, same thing. The CAT team, after our complaints the next day about the treatment plan, had said they would respond. The second night, the response was, 'We don't visit people's homes. Take her to hospital, and we might come there'. There she is, not agreeing to come to hospital, cutting her wrists and arms, suicidal. Your psych registrar said she is suicidal, and no-one would come. Thank God for the Ambulance Service, who came, got her to hospital, and after negotiations, she spent an overnight stay there. (Community consultation)

The Task Force is of the view that CAT teams must be required to make alternative referrals if a client is assessed as not needing hospital treatment, and ensure that follow-up mental health services are provided.

A CAMHS clinician stated:

> We need better protocols with the CAT team, so they are a bit more aware of adolescent issues and treatment and a bit more sensitive.

Youth Forum participants consulted by the Task Force argued that:
- Services should adopt an informal and human, rather than clinical, approach.
- Psychiatric and other health services in institutional settings should make serious attempts to overcome their insularity and develop outreach services to establish connections with young people and agencies.

On the whole, workers with youth argued that mental health services are often insensitive to the specific needs of youth and other special needs groups, and that outreach services best meet these needs. In this context, the CAT and MST services, with some minor changes in role, are best placed to provide the outreach treatment and support services needed by suicidal young people. The increased funding provided to these services in the 1997–98 State Budget should greatly assist this development.

The Task Force recommends that:
7.15 The Victorian Government support the Department of Human Services to expand the role and number of Crisis Assessment Team and Mobile Support and Treatment teams to deal with attempted suicide and other behavioural and psychiatric illnesses that do not require hospital care. This should include additional team members with expertise in providing mental health services to young adults aged 16 to 24 years. Priority should be given to improved effectiveness of Crisis Assessment Team and Mobile Support and Treatment teams in rural areas.

7.4.7 Residential and Respite Care

Victoria's Child & Adolescent Mental Health Service: The Framework for Service Delivery (1996) states that 'access to respite care for behaviourally disturbed children and adolescents will be required'.

The Task Force heard evidence of the desperation experienced by members of the community in being unable to find a place of safety, or access to an appropriate professional for family members who appeared to be at imminent risk. Many people exiting hospital emergency departments following suicide attempts remained in a precarious emotional state and in danger of self harm. Homeless people exiting mental health services with only sketchy discharge plans often have nowhere to go.

The Task Force believes, for some young people in crisis, there may be a need for residential support on a short- to medium-term basis.

Currently, there are no dedicated CAMHS-supported housing or other residential rehabilitation options for those young people with a mental illness whose families are unable to support them at home. Some support is provided to young people with psychosis; for example, a limited number of clients of EPPIC, specifically in the Western Metropolitan Region, can receive long-term supported housing through the Schizophrenia Fellowship Victoria, Housing and Support Program. Richmond Fellowship Victoria also provides transitional residential rehabilitation to young people in a number of settings.

Several CAMHS have experienced difficulties in discharging clients from inpatient to home-based care once acute treatment and stabilisation have been concluded but recovery is incomplete.

Therefore, there is a need to establish alternative support to:
- Ensure appropriate utilisation of inpatient beds.
- Avoid prolonged inpatient stay.
- Provide a lesser intensity of supervised care where there is risk of suicidal behaviour but not a serious mental illness.

Such services would support a range of at risk clients. They would need to be available on a 24 hours basis and linked to a 24-hour suicide prevention telephone counselling line, which would refer people at imminent risk of suicide to face-to-face counselling.

Staff teams of such facilities should be multidisciplinary and include clinical and human service worker support. The staff should have a role in developing a plan and brokering ongoing care and support for clients who have experienced difficulty in accessing the service system.

To ensure that this service was not overwhelmed, it would be necessary to give priority to specifically identified at-risk clients, while still allowing some access to young people who may come up as a first presentation in situations where the young person requires basic care and support that is unavailable at home.

Models for such a service include:

- Residential rehabilitation along the lines of Richmond Fellowship Victoria and Denham House, Hawthorn. These facilities provide accommodation from six to 24 months, and rehabilitation programs to facilitate a return to home or independent living.
- Home-based outreach support where the young person is living in a group home, private rental flat, with parents or foster parents.
- Residential respite care, such as that provided by Schizophrenia Fellowship Victoria. For child and adolescent outpatients with chronic difficulties, and where families and carers are unable to cope, residential respite of one to three weeks duration would assist management at home.
- Activities respite care, such as that offered by Outdoors in Northern Metropolitan Region, which provides outdoor adventure-type experiences for up to a week.
- Day respite care to provide daytime outings and educational services for clients and give carers a brief break.

The Task Force recommends that:
7.16 The Victorian Government support the Department of Human Services to establish, in each of its administrative regions, community residential support services and day programs, linked to Child and Adolescent Mental Health Services and the young adult program within the Adult Mental Health Services, for young suicide attempters who are discharged from hospital and/or not considered in need of hospital care, to provide short- to medium-term care and outreach support services.