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Informing youth suicide prevention for Western Australia



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Disclosure

Some people may find the content of this report distressing. If you start to feel distressed during or after reading the report, or you have been thinking about suicide, please talk to someone you trust or call the services listed below.

- **Kids Helpline 1800 55 1800** (Webchat between 8am and midnight at kidshelpline.com.au) – confidential 24/7 phone counselling service for young people aged 5-25
- **Lifeline 13 11 14** (Webchat between 7pm and 4am at lifeline.org) – confidential 24/7 phone counselling service
- **Suicide Call Back Service 1300 659 467** – confidential phone counselling for people aged over 15 years

If you or someone you know is in immediate danger, call 000 for an ambulance or go to your nearest Emergency Department.

Where to find more information:

Young people:

- kidshelpline.com.au
- ReachOut.com
- Youthbeyondblue.com

Adults:

- kidshelpline.com.au.
- beyondblue.org.au
- ReachOut.com
- Conversationsmatter.com.au

Foreword

The Youth Mental Health Sub Network is proud to present this report to inform the youth suicide prevention strategy for Western Australia.

This project was made possible through collaboration between young people, their families and friends, youth mental health workers and researchers. The project steering group included representatives from the Western Australian Government, the Western Australian Primary Health Alliance, the Commission for Children and Young People, the Telethon Kids Institute and community organisations working actively with young people across the State.


It is well recognised, and sadly real, that in Western Australia suicide is the leading cause of death for young people aged 15 to 24 years. This age range is a critical period in development, in which young people transition from childhood to adult life. Based on the voices of young people, this report provides critical insights into their experience of current services, and makes key recommendations for system change aimed at bringing support to those when they need it, and reducing the incidence of youth suicide.

A joined up and flexible system across the continuum of care is urgently needed. A coordinated, comprehensive and whole of government approach that listens to young people is a priority. Providing a full spectrum of services that are responsive to young people, and delivering them in the places that young people live, learn and work will be required.

Reducing youth suicide in Western Australia will require an integrated and coordinated approach. Young people, their families and their local communities will need to work with support services, researchers and both the federal and state governments to plan for a future where the number of young people committing suicide is reduced.



Lyn Millett



Warwick Smith



Co-Chairs
Youth Mental Health Sub Network
Mental Health Network

Thank you

The authors would like to extend their thanks to the 55 young people who participated in this project and shared their personal stories. Their willingness to share personal information about their life circumstances proved humbling. Many of the young people had experienced much adversity and their willingness to share their stories and experiences is a testament to their resilience, bravery and desire to see changes that will benefit others and reduce the number of young people ending their life by suicide. This project would not have been possible without their engagement, and for this we are grateful.

We would also like to thank the community stakeholders who provided assistance with the recruitment of young people. In particular, headspace Albany and Joondalup, Albany Youth Support Association, Youth Affairs Council of Western Australia, Freedom Centre, Mission Australia, Mercy Care, Ebenezer Aboriginal Organisation and Youth Focus. Your support, insights, experience, guidance and contribution were invaluable to this Project. The authors also thank the suicide prevention and youth mental health professionals in Western Australia who completed the online survey.

Acknowledgement of funding

This collaborative endeavour emerged from a meeting of the Youth Mental Health Subcommittee (co-chaired by Lyn Millett and Warwick Smith) in recognition of the urgent need for an improved understanding of youth suicide prevention in WA. The project was funded by the Telethon Kids Institute, Mercy Care, Mission Australia, Youth Focus, the WA Commissioner for Children and Young People, Western Australia Primary Health Alliance and the Youth Mental Health, North Metropolitan Mental Health Service.

Many of the young people had experienced much adversity and their willingness to share their stories and experiences is a testament to their resilience, bravery and desire to see changes that will benefit others and reduce the number of young people ending their life by suicide.

Project Steering Group

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All should be recognised for their commitment to the Project, improving young peoples' mental health and reducing youth suicide rates more broadly. The Project Steering Group would like to thank Nicole Smith for her support during the project.

Acknowledgement of Country

We acknowledge Aboriginal and Torres Strait Islander people as the Traditional Custodians of the land and waters of Australia. We also acknowledge the Nyoongar Wadjuk, Yawuru, Kariyarra, Mineng and Kurna Elders, their people and their land upon which the Project team is located and seek their wisdom in our work to improve the health and development of all children.

Executive Summary

In Western Australia (WA), more young people aged 15 to 24 years died by suicide than by any other means in 2018. Nationally, suicide accounts for a third of all deaths in this age group. Despite significant investment in funding for suicide prevention, in 2018, WA recorded its highest suicide rate in more than 20 years, with a 10% increase in the number of people who took their own lives between 2016 and 2017. Areas in regional WA have the highest rates of suicide for Aboriginal people, with young people aged 15 to 19 years being the worst affected.

There has been a range of inquiries and reports investigating youth suicide in Western Australia, including the 2019 findings of the Coroner's Court of WA on the 12 suicides by Aboriginal young people in the Kimberley region. However, despite these inquiries and their recommendations, WA does not currently have an overarching youth-specific suicide prevention strategy and the current approach to youth suicide prevention in WA has been described as fragmented and lacking coordination. Taking action to reduce youth suicide clearly needs to be prioritised by the WA Government and the WA Mental Health Commission, and requires a whole of government approach.

The aim of this project was to provide a report that would inform a youth suicide prevention framework for WA. Views on how youth suicide prevention can be improved from both young people aged 16 to 25 years and professionals with experience in youth mental health and/or suicide prevention living in WA are presented in this report. In total, 55 young people from diverse backgrounds and with experiences of marginalisation (such as justice involvement, homelessness, refugee and child protection systems) participated in the focus group discussions conducted in the Perth metropolitan area and the regional city of Albany. Previous to the focus groups, 192 professionals with experience in youth mental health and/or suicide prevention also completed an online survey that explored how youth suicide prevention in WA can be improved.

Young people were asked to describe how they find support for their mental health concerns, including suicidal thoughts, and to identify who in the community they felt should be able to support them when presenting with suicidal-related behaviour. They were also given the opportunity to discuss the barriers and challenges for seeking mental health support. In particular, the Emergency Department (ED) was perceived by many of the young people as a service that required significant improvements for young people presenting with suicidal-related behaviour. The majority also felt that increasing mental health education and suicide prevention training for young people themselves was required to improve youth suicide prevention in WA. Overwhelmingly, young people reported that every young person's needs are different and that it is imperative that individual circumstances should be a focus for all youth suicide prevention strategies.

Responses from professionals largely supported the views of the young people participating in the focus group discussions. Many of the mental health professionals had similar concerns regarding the ED and reported that they would prefer to see the overall management of young people with suicide-related behaviour in the community rather than a hospital setting. They also acknowledged that to achieve this end, they would require further training and ongoing support from their organisations. Another factor identified by professionals was that while there may be many suicide prevention programs and activities being delivered, not all of these are evidence-based or appropriate for young people. As such, they suggested that it is critical that both state and federally-funded suicide prevention strategies and activities are developmental and age appropriate and that they are based upon evidence.

Overall, it is recognised in the report that one government department can not be solely responsible for youth suicide prevention in WA. A coordinated, comprehensive and whole of government approach is required if the state will make significant in-roads into reducing the number of young people dying by suicide in WA.

A set of recommendations for informing youth suicide prevention in WA is presented next, followed up the full report of the findings in detail.

Despite significant investment in funding for suicide prevention, in 2018, WA recorded its highest suicide rate in more than 20 years, with a 10% increase in the number of people who took their own lives between 2016 and 2017.

Recommendations

1 The Mental Health Commission needs to develop a specific youth suicide prevention strategy for Western Australia.

2 Develop a comprehensive youth suicide prevention model for Western Australia.

3 Involve young people in the conversation about youth suicide by:

- Empowering young people by listening to them and including them in the conversation about suicide.
 - Including representation from a diverse range of young people from different regions, different vulnerabilities, and different cultures and backgrounds.
 - Including young people in the design, delivery and evaluation of youth suicide prevention and intervention strategies and initiatives in this state.
 - Including young people in the decisions about their own care and support.
-

4 Ensure that there is comprehensive and coordinated planning, modelling and resourcing of evidence-based youth suicide prevention and intervention initiatives that is aligned with need including:

- Across the full spectrum of services.
 - Across the full suite of services including, early intervention, prevention strategies and postvention support.
 - Targeted at vulnerable groups of young people.
 - Joint planning, sustainable funding and coordination to avoid duplication and fragmentation.
-

5 Implement the recommendations as outlined in the, *Learnings from the message stick, the report of the Inquiry into Aboriginal youth suicide in remote areas and the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP)*.

6 Build capacity and increase suicide prevention training in the community to identify and respond to young people at risk of suicide.

This must include:

- Evidence-based, developmentally appropriate suicide prevention training.
 - Training for parents, primary care givers, foster parents and kinship carers.
 - Training for all professionals who work with young people, including non-mental health professionals.
 - Building competency to support diverse groups of young people.
-

7 Improving service responses for young people at risk of suicide.

This following is required to aid this.

- Ensuring all services are adhering to the Western Australia Youth Policy 2018-2023.
 - The consistent determination of thresholds for risk of suicide for young people.
 - Increasing outreach support for young people.
 - Increasing inclusion of lived expertise and peer support.
 - Recognition of the use of digital technology as a conduit and compliment to face-to-face service provision.
-

8 Enhance the role of schools in suicide prevention by:

- Embedding universal suicide prevention training for students at a developmentally appropriate level.
 - Providing developmentally appropriate mental health education and positive coping strategies for students in schools.
 - Increasing confidence of staff to have conversations about suicide risk.
 - Reviewing resource allocation and service models for student support within Western Australian schools.
-

9 Improve responses to young people with acute risk or who have attempted suicide by:

- Educating and training emergency department staff and first responders in the assessment and management of young people who present with acute emotional distress and suicide.
 - Providing a crisis response alternative to the emergency department for young people with suicidal ideation and behaviours, such as Youth Crisis Assessment Team.
 - Upon discharge, providing a coordinated and integrated approach to follow up for all young people presenting to the ED with suicidal-related behaviour.
 - Increasing resources around post ED and discharge.
-

10 Improve oversight and evaluation of youth suicide prevention activities

This includes:

- Developing an outcome measurement framework for State funded suicide prevention strategies and activities.
 - Improving data collection of youth suicide and attempted suicide including better ED data and police and ambulance responses for suicidal behaviour, as well as data from outside of Health, such as child protection and justice systems.
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**Project
Background**

Introduction

This report, 'Informing youth suicide prevention in Western Australia', is the outcome of a project initiated in response to systemic issues in the Western Australian (WA) mental health sector relating to youth suicide prevention.

WA does not currently have an overarching plan for implementing youth-specific suicide prevention strategies. Stakeholder consultation undertaken in preparation to complete this project identified fragmentation and a lack of coordination in current approaches to youth suicide prevention being undertaken in the state. The report presents the views of young people aged 16 to 25 years and professionals with experience in youth mental health and/or suicide prevention living in WA on how youth suicide prevention can be improved. The primary aim of the project and subsequent report is to inform a youth suicide prevention framework for WA.

According to the Australian Bureau of Statistics in 2018, suicide was the leading cause of death among young people aged 15-24 years, and nationally, suicide accounted for more than one third of deaths among young people in that age bracket. The number of young people who have died by suicide continues to increase and many more young people have thought about or attempted suicide [1].

WA also has the highest rate of suicide deaths for Aboriginal people in Australia, with the worst affected being Aboriginal young people between the ages of 15 and 19 years [2]. Aboriginal people hold a holistic view of health and wellbeing, incorporating physical, social, emotional and cultural wellbeing [3]. Adverse experiences of disadvantage, grief and loss, life stressors, disruption or loss of connection to family or Elders not only impact on the wellbeing of Aboriginal people, but also create a vulnerability to suicide [4]. The recent WA Coroner's Report (2019) investigated the deaths of 13 Aboriginal children and young people in the Kimberly region and highlighted the complex circumstances, life events, developmental experiences and behaviours that may have contributed to making these young people vulnerable to suicide. Twelve of these deaths were reported as suicide, with most of these young people not having had any contact with mental health service providers [5].

An increased risk for suicide is seen for adolescents aged 12 and 17 years, with between 50 and 100 suicide attempts made for each suicide death; each year more and more young children are suiciding [1, 6-8]. Suicide attempts can be linked to developmental risks, including bullying, relationship breakdowns, and a lack of maturity to cope with some of the major changes that occur during adolescents and young adulthood. Suicidal behaviours represent a significant burden of disease among young people, and the development and provision of effective suicide prevention initiatives are required. Adolescence and early adulthood are also the peak risk periods for the onset of, and required care for, mental disorders [9, 10]. It is important to acknowledge that while many young people may describe suicidal behaviour as symptoms of mental health disorders, others may not describe or present with any signs and symptoms of mental health disorders prior to their suicidal behaviour or death by suicide.

While this project focussed on young people, there is a need to address suicide prevention in younger cohorts given the age of some children who have suicided in WA. Early intervention in childhood, may improve outcomes as compared to waiting until adolescence or when symptoms are severe.

Within WA, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of WA. No disrespect is intended to our Torres Strait Islander colleagues and community.

The WA mental health system is complicated, with multiple providers at a Federal, State and local level. The current system has been described as, ‘funding-centred’ rather than ‘people-centred’, which has led to the needs of individuals becoming lost or overlooked [11]. There are a range of gaps in mental health services to address children and young people’s mental health in WA, including, but not limited to, gaps for children and young people under 12 (who potentially need intervention for early onset of mental health problems), a lack of community mental health treatment services for young people with severe mental health issues, gaps in service availability in regional and remote Western Australia, and a lack of culturally appropriate services for Aboriginal people [12]. In order to effectively address mental health issues, and prevent suicide, the infrastructure, the systems, and coordinated action needs to be, implemented and in some circumstances changed.

Effective mental health care in WA, as in other states, requires collaboration between multiple parties. The recent Review of Safety and Quality in the WA health system observed that “the plethora of organisations [in mental health] and their overlapping roles has led to confusion and concern” [13]. Additionally, it is important to draw a distinction between those services which are predominantly focused on improving mental health outcomes for the community, and those which specifically address suicide prevention.

Currently WA has two principle suicide prevention programs in place, the nationally funded Suicide Prevention Trial Sites and the State-funded strategy “Suicide Prevention 2020: Together We Can Save Lives”. The current WA suicide prevention strategy aims to improve youth mental health outcomes and reduce youth suicide but there are no specific strategies outlined to achieve this. The suicide prevention trial sites are a regional approach to suicide prevention in Australia.

There are currently three nationally funded sites in WA targeting specific priority populations:

- Aboriginal and Torres Strait Islander peoples in the Kimberley;
- Males aged 25 to 54 years, in particular fishermen, farmers and fly-in fly-out workers in the Mid-west; and
- Young people in the Southern corridor of Perth.

There are currently 10 Suicide Prevention Coordinators across WA who are funded by the Mental Health Commission (MHC) to deliver the suicide prevention strategy (Suicide Prevention 2020: Together We Can Save Lives). These positions work with local communities and stakeholders to develop local suicide prevention action plans. The action plans are designed to provide education and harm reduction strategies to local communities to ensure they are well equipped to manage and deal with suicide in their local context. The action plans ensure that suicide prevention is everyone’s business rather than the notion of service providers holding all of the responsibility. Suicide prevention coordinators are hosted by not-for-profit organisations, the WA Department of Health (WADoH) and Aboriginal Community Controlled Health Organisations (ACCHOs) across the state.

According to the Australian Bureau of Statistics in 2018, suicide was the leading cause of death among young people aged 15-24 years, and nationally, suicide accounted for more than one third of deaths among young people in that age bracket.

The findings of this report have been informed by:

- Focus group discussions with young people aged 16 to 25 years including those accessing mental health services, crisis and transitional supported accommodation, a lesbian, gay, bisexual, transgender, inter-sex and queer/questioning (LGBTIQ+) support agency, alcohol and other drug detoxification and withdrawal programs and advocates for youth mental health (referred to as young people throughout), (see Appendix one). All quotes in the documents are by young people unless otherwise specified;
- An online survey for mental health professionals who engage with young people, or other professionals who work alongside young people supporting their mental health (referred to as 'professionals' throughout) (see Appendix two);
- A critical analysis of literature published about vulnerable young people in WA, and literature published in a non-commercial form (i.e., government reports, policy statements) specific to youth suicide prevention in WA (available as an appendix to this report).
- A review of Western Australian data on youth suicide; and
- A survey of current suicide prevention service, undertaken through a desktop search.

Project scope

The Project aimed to:

- Describe current understandings of youth suicide in WA;
- Describe what is known to be effective in reducing youth suicide;
- Identify what is working well and gaps in the current youth suicide prevention approach; and
- Recommend strategies for reducing the rate of youth suicide in WA.

The project team fully acknowledged the diversity of experiences of the young people participating in the consultation, as well as the diversity of young people's experiences and needs across WA. As such, the views and opinions provided by consultation participants should not be considered or reflective of the views of opinions of other young people across the State. Further work may be required to understand the distinct needs and experiences of specific groups of young people to ensure that suicide prevention activities are appropriate, particularly for those living in regional or remote WA, and Aboriginal young people.

Approval to conduct the project was provided by the University of Western Australia Human Ethics Research Committee (RA/4/20/4850).



How do young people find support?

How do young people find support?

The peak period of vulnerability for the onset of mental health problems is during adolescence and young adulthood [9]. In addition to this young people are known to be particularly poor help-seekers [10, 14]. According to an Australian survey, only 13% of young men aged 16–24 years who were experiencing clinically significant symptoms had sought professional help, compared to one-third of the young women [15].

Not all young people who participated in the project had experienced suicidal thoughts and therefore the focus groups were asked how they initially found support for their mental health concerns, including suicidal thoughts. The two most common responses were dependent upon their help-seeking behaviour. If a young person was help-seeking, their first place of support was usually online (e.g., Google). When young people didn't seek help, they were generally referred to services at point of crisis.

The following sources of support for mental health concerns and suicide-related behaviour of young people outline below were the most prominently represented in the focus group discussions.

Finding support online

'Online' was the most common response in the focus groups when young people were asked where they sought information about support for mental health issues. Young people reported Googling terms such as 'suicide', 'depression' or 'killing myself', which resulted in them being directed to crisis helplines. They also found information through Facebook, Tumblr, Instagram, applications, and other social media. Young people reported trigger words used while accessing these sites often resulted in pop-up ads for crisis services. They reported using the primary mental health services providers online chat platforms including Beyond Blue Chat online, Lifeline Crisis Support Chat online, Kids helpline Webchat and e-headspace.



I use Beyond Blue, the chat online. I found that's very comfortable as well because it's very easy to sit behind the computer and just type or even on Lifeline as well.



Even on Facebook, they have helpline numbers. That's where I see mine, they come up on Facebook, people share stuff as well through suicidal stuff and saying like, you know, share this and that. So the word gets out, so that's kind of helpful, when your friends do that.

General Practitioner

General Practitioners (GP) were identified as a source of support for mental health issues by most young people. GPs were identified as the entry point into seeking help for their mental health concerns and the health professional who assisted in accessing a mental health care plan. Young people stated that their parents, school psychologists, teachers or online crisis chat lines referred them to a GP in the first instance if they identified concerns about the young person's mental health.

Young people described their experience with finding a GP to support their mental health and help them with the referral pathways as challenging. Nearly all young people were referred to other services by a GP, but only a few young people felt fully supported by a GP for their mental health concerns.



I think some GPs could do with training, would be a nice way to say it.



...the GP that I see, took a while to find a good one, that I, that I connect with and that seemed to genuinely care about my health.

In most circumstances, if a young person continued to see their GP for mental health care, it was because they were on prescribed medication. However, few young people thought that the medication they were prescribed improved their well-being.



I went to my GP about my mental health and they put me straight onto anti-depressants and it just – it didn't help, like, I don't know.

Professional survey respondents also identified the GP as the first health professional that young people should seek assistance for their mental health concerns and for accessing a mental health care plan.

GPs are well-placed to identify and provide an assessment of suicidal risk and manage suicidality in young people in the community. Research has found that, GP's perceive communicating with young people to be challenging and the majority of them identify the need for further training on assessing and managing young people at risk of suicide [16].

According to an Australian survey, only 13% of young men aged 16–24 years who were experiencing clinically significant symptoms had sought professional help, compared to one-third of the young women.

School

School was commonly reported to be a place where young people found support. Some young people spoke about being offered support for their mental health concerns, with most referrals coming from a teacher.

Young people stated that teachers suggested accessing the school counsellor or school psychologist after they broke down in class crying, or when the teacher observed a change in their mood or behaviour. The young people who accessed a school counsellor or school psychologist stated that the referral to a GP or other youth mental health organisation was provided by the school's mental health staff.



I started crying in the class, and then I got taken down to the psychologist and then they were like, "Okay, well, come back and see us," and so I did and then they said, "I think it's best if you go to headspace or somewhere else."



I was quite young when I presented to a teacher with suicidal ideation, I think it was. And then, and then I got referred to a school psych which then referred me to CAMHS.

Even though most teachers believe it is part of their role to recognise students at risk for suicide, it has been reported that only 9% of teachers have the ability to recognise the risk factors for suicide or respond effectively when a student presents as at risk [17].

Family and friends

Family and friends were identified as primary sources of support for mental health concerns by most young people. Young people who had experienced anxiety and depression from an early age had a parent that had been responsible for their care and continued to assist them with seeking professional support.



I usually don't know where to find help. I guess my mum is usually the one that, you know, goes out there and fights as hard as she can to find somewhere.

Young people stated that family members had suggested they seek support after observing changes in their mood and/or behaviour. Some family members were able to suggest mental health organisations, but mostly the GP was suggested as the starting point for mental health support.

Friends were also a source of support for young people, especially if the friend had used services for their own mental health concerns.



...it's mostly been through word-of-mouth, finding out some friends that have been in counselling services or family members.

Using crisis help lines for support

When young people searched online for support, the most common source of support reported was what they generally referred to as 'crisis help lines'. They also became aware of 'crisis help lines' through advertisements on television, pop-up advertisements online or through Google searches.



'Crisis help lines' was an umbrella term used to describe the organisations most commonly identified with mental health support over the phone including Lifeline, Beyond Blue, emergency numbers, Kids Helpline, the Mental Health Emergency Response Line, or was used to simply describe the suicide help-line numbers. Young people only named, or stated a preference for, individual organisations that provided online or phone assistance if they had used the service on multiple occasions, or if they had a negative experience.



I just looked up on Google, "Oh, I feel depressed or I feel like I wanna kill myself," and it just popped up with Kids helpline and Lifeline. Just like every time I felt depressed or anything, I just called them.

Hospital

A number of young people reported that they only received support after their suicide attempt resulted in a hospital admission. Young people described their first point of contact with a mental health organisation, or with a mental health professional, as being organised by a hospital-based staff member upon discharge.



Yeah, and that first connection happened when I was in Royal Perth Hospital through the social worker.



Uhm, so we just kind of get set up with it when we, uhm, cry for help basically.

Young people stated that teachers suggested accessing the school counsellor or school psychologist after they broke down in class crying, or when the teacher observed a change in their mood or behaviour.



Who should be able to support young people?

Young people were asked who they most wanted to support them when they were feeling overwhelmed, during periods of crisis or when experiencing suicidal thoughts. Young people were encouraged to identify any supporting person, including individuals who currently supported them, individuals who young people wanted to be supportive but were currently not, professionals that did not currently provide services, and non-professional people in the community

Professionals were asked to select one or more community members from a list provided in response to the question, “Who should be able to support young people when life is overwhelming, during periods of crisis or when they are feeling suicidal?”. Professionals were also asked to describe other community members not listed that should be receiving suicide prevention training.

Family and friends

Young people most commonly identified family and friends as the source of support they wanted the most. This is consistent with the findings from Mission Australia’s 2018 Youth Survey where young people in WA reported they value family relationships and friendships (81.1% and 77.7%, respectively) as extremely or very important [18]. For issues of concern, friends or parents (82.3% and 72.9%) were the two most commonly cited sources of support.

Studies show that family is a crucial source of support and safety for adolescents who are vulnerable for suicide [19]. Compared to peer relationships, parents have been found to be the most consistent protective factor for adolescent suicide and if a young person is to disclose suicidal risk to an adult, it is most likely to be a parent [19]. Gatekeeper suicide prevention training involves teaching individuals who have regular contact with others in their community to recognise and respond to people at risk of suicide and to support those who are bereaved by suicide or those who have lived experience. Research shows that gatekeeper training is a safe strategy for increasing awareness and knowledge in parents, and that teaching parents how to respond and provide support to young people could have a protective function against youth suicide [20].

Compared to peer relationships, parents have been found to be the most consistent protective factor for adolescent suicide and if a young person is to disclose suicidal risk to an adult, it is most likely to be a parent.

Challenges in parental support

For just over half of the young people in the focus groups, parental support during crisis or when feeling suicidal was not an option as they described their parent as having a mental illness. By asking for support from their parents, some young people feared they may exacerbate their parents' mental illness, while others acknowledged that this simply was not an option for them because they themselves often played the parenting role in the family. However, they stated that, if possible, they would have wanted their parent to be a source of support for their own mental health issues.



Kinda my mum but, yeah, I can't really like do that because she's got quite bad metal health problems. I'm trying to keep it off her a bit. I wish I could go to her more.



Both of my parents have mental health so they understand mental health, but when it comes to suicide they just don't wanna know about it.



I know that personally, like my parents have their own mental health struggles and for me it's like, okay, well if I'm talking to them, "Am I just aggravating their own issues more?"



Sometimes I, I find that I end up supporting my mum more than she supports me and I'd like that role to be reversed if I could.

There is a significant amount of research on children of a parent with a mental illness (COPMI), but limited research focussed on adolescents and young people. Young people who are COPMI are known to be at a greater risk for mental illness themselves. Because adolescence is the peak onset of mental illness, additional efforts to support COPMI young people should be considered by health care service providers [21, 22].

Some young people also described other factors which made parents unavailable to provide mental health support. These included: experiences of homelessness, incarceration of parents, being in care, deceased parents, parents having their own drug and alcohol issues, and cultural conflicts.



I've been through a lot, like domestic violence between my mum and dad growing up as a kid and like, you know, them being on drugs, of course having nowhere to stay and, you know...



I wish my parents were able to support me. Like mental health is just not discussed in my – especially my current community, like they just – because like, you know, my dad believes just even like talking about suicide can make you suicidal, so they avoid the conversation all together.



I don't really have anyone so...

Other identified sources of support

Young people identified a range of other people in the community who could play a role in mental health support and suicide prevention at a universal level. These were not mental health professionals, but people who were in contact with young people, who played a significant part in young peoples' lives, or played a part in the young person's help-seeking experience. They included teachers, sports coaches/mentors, workplace managers and first responders (police and ambulance officers).

Teachers

Young people reported that staff in schools should be able to provide support or at least receive training to be able to support young people with mental health concerns. Some young people accessed support during secondary school through a supportive teacher who had suggested they seek assistance either from the school counsellor/psychologist or a GP.



Yeah, people that you're gonna be around and you spend a lot of time at school. So it makes sense for them to be aware of things that they can help you with.



I think from the school, we hear about the school stuff that all teachers should have some level of training, or at least awareness in mental health because I know some teachers are definitely not very accommodating, especially going through my school, mental health was not even a subject that was touched on at all.

Over 90% of professionals who completed the survey reported that teachers should receive suicide prevention training. Currently mental health first aid or any form of suicide prevention training is undertaken at an individual level by teacher's dependent upon their level of interest. As many young people identified the teacher as the first school staff member to recognise signs and symptoms of poor mental health, it is important that teachers have a strong understanding of suicide prevention.

According to the Department of Education WA (2018, p.2), 'children and young people spend a significant amount of time at school, teachers and support staff are able to observe and identify changes in behaviour and notice other signs that may indicate concerns for student mental health and wellbeing. They play an important role in identifying as well as supporting individual students who are distressed and may be at risk of suicidal behaviour and/or non-suicidal self-injury.'

Some young people accessed support during secondary school through a supportive teacher who had suggested they seek assistance either from the school counsellor/psychologist or a GP.

Sports coaches/mentors

Young people identified sports coaches and/or mentors as community members who should receive suicide prevention training because of their involvement with young people. They reported that sports coaches should have the skills to identify when a young person might be struggling with their mental health problems or know what to do if a young person discloses feeling mentally unwell or suicidal. Over three quarters (78%) of professionals identified sports coaches or recreational instructors as key community members who should receive suicide prevention training.



I think it would be really beneficial and important for like people like sports coaches or mentors in like the lives of young people to have some sort of training so that they know how to handle when someone speaks forward.

Workplace managers

Some young people with mental health concerns suggested support in their work environment, in particular from managers would be helpful. They wanted managers to have a better understanding of their mental health issues and how it might impact their ability to work. Seventy seven percent (77%) of professionals selected 'workplace managers' as community members who should undertake suicide prevention training, especially those who employ young people.



If anything, I feel a lot of guilt, uhm, when I feel like I'm not being helpful, I feel like I'm being unreliable, uhm, and – I don't know – it almost sets off a chain occasionally, uhm, of me going a bit downhill, but I think if, you know, if they were supportive, they're like, "That's okay," like you know, that positive vibe, "I can do this," and then you've get over and you'd pass that.



If they're were aware, like how serious it can be for people and that they're not faking it and it's a serious thing to come to them.

Young people stated that they were unlikely to disclose they had a mental illness to an employer, or during a job interview, for fear of discrimination.



...a certain type of person, in a certain type of position that I find uncomfortable and like scary to approach especially if I'm having a hard time is, uhm, like head managers and bosses in jobs, that is really scary, especially when you're doing your resumes or something, and they say, "Do you have any like disabilities? I'm afraid to say I've got anxiety and think that, "Oh, they seemed nice, they're gonna be like, 'That's okay,' we understand," and so I always hesitate to write anything.

First responders (police and ambulance officers)

When young people described their encounters with first responders (police, ambulance officers, paramedics), the majority of these experiences were negative. Police were often called at crisis point and some young people felt their suicidal thoughts were exacerbated by police presence.



And they (police) like to use the – yeah, under arrest under the Mental Health Act a lot and you don't – like, sometimes you don't need to go to a hospital. You're just having a moment in public and, yeah, they still to take you to hospital.

The facilitators asked the young people, 'If you could change the situation, what you would like to happen instead, what would your ideal situation be?'

Responses from young people included:



Like them (police and ambulance) getting more training in the mental health field.



And so maybe sitting and like having a chat to you and -? Yeah, instead of just going "You're under arrest under the mental health act. We're taking you to hospital." They handcuff you and legit throw you in the paddy wagon and that's it....



...we don't know where to go and there's a huge stigma around calling an ambulance...

Community members

Professionals identified other community members including public transport officers, chaplains, staff employed at public amenities, staff employed at tertiary institutions, security guards and youth justice staff. Professionals stated that suicide prevention training or mental health first aid training should be taught in the same manner as physical first aid training, especially those who engage with young people.



Everyone can benefit from greater awareness and varying levels of training appropriate to their role – all training increases community capacity to respond to the threat of suicide. (youth worker)



Every person in the community should have skills to act competently and appropriately to assist others considering suicide. (youth worker)



All community groups. It is everyone's business. (nurse)

A young man with a light beard, wearing a blue hoodie, is shown in profile, looking out of a window. The window is covered in raindrops, creating a blurred, atmospheric effect. The background outside the window is dark and indistinct. A blue banner with white text is overlaid on the right side of the image.

**What are some of the barriers
and challenges for young
people seeking support?**

Young people often experience a range of barriers and challenges in their access to health services [23]. These include internal barriers, such as fear of judgement and stigma around mental health and seeking help, as well as barriers related to the service characteristics or service models themselves (e.g., accessibility and availability). A failure to seek, or inability to access help, early in the course of mental health difficulties can lead to symptom exacerbation.

Not being ready

A common theme that emerged in the focus groups was the ‘readiness’ to seek help or acknowledgement that what young people were experiencing wasn’t ‘normal’. For some, a friend or family member suggested they might need professional support because they didn’t recognise the symptoms in themselves. Other young people ended up at crisis point before they acknowledged they required help.



I referred myself to headspace, I attempted suicide myself and, and it was a big, a big turning point but that was really scary that I’d done that. I didn’t think about things properly, at the time, but I – that was scary enough for me to seek help myself, so – yeah.



I didn’t feel like I was – I didn’t think I needed it at the time, and I didn’t- I was a little bit naive.



I think it’s because, uhm, I was ready to, to get better, that’s why I found that easier to talk to, but when you’re not really ready to get better and people kind of force you to, to see these people, you-you’re gonna rebel and not wanna go, so that’s, that’s like a lot of why, I guess, people around our age don’t like counsellors and stuff.

Fear of being judged

The most overwhelming challenge perceived by young people who are seeking support during periods of poor mental health or in crisis was judgmental attitudes. Fear of being judged was clearly identified by many young people as a key barrier to engagement with services. They described feeling unfairly judged by service providers and this discouraged them from further help-seeking.

Being judged by Emergency Department (ED) staff in response to presenting with suicide-related behaviour, was reported as feeling like they were ‘being treated like a bad person.’



...because it’s just – you get judged...



You know, she, she looked down on you instead of just talking to you, it all seemed kind of ridiculous.



You feel like you can talk to them and not be like completely judged on absolutely every minute thing you say, if that makes sense, yeah.

These responses are highly consistent with the current literature, and other studies conducted with young people in WA [23, 24]. Feelings of judgement and disengagement from services were demonstrated in a study of homeless young people with mental health problems. They identified a lack of judgement as important for the continuation of their treatment or consultation [25]. Being understood, and importantly, not being judged is a significant factor in young people seeking support for suicidal behaviour and the decision to continue with counselling [26, 27]

Shame/Stigma

The stigma of having mental health issues can impact the help-seeking behaviour for many young people. Young people described how they and their friends were able to mask their mental health issues because they feared the associated stigma.



...cause I know like mental health was like a bit of a taboo subject but like talking about it is like one of the ways to like bring it up more and make it like – well, not normalised but as like more accessible in talking about it if that makes sense. But yeah, that’s definitely like some people I wouldn’t tell but like with a couple of my close friends that they already know and – yeah, and it’s good to like when they see them like they have a quick chat about it with me and then we just talk about other stuff.



So I went to a Catholic high school and there’s a big stigma around suicidal thoughts, suicidal attempts and just generally like the, you know, the bad side of mental health.

Young people from culturally and linguistically diverse (CALD) communities reported concerns about their own community’s lack of mental health literacy. They described conflict between a desire to express their own feelings and cultural expectations. They also reported a lack of understanding from services providers (or service providers failing to consider their cultural obligations), including underestimating the role of family and community. Young people from a refugee background reported that service providers either didn’t consider their trauma or they brought it up very early in the conversation and weren’t focussed on the current needs of the young person. Similar barriers for refugee youth accessing and maintaining mental health services were identified in a study conducted in Victoria [28].



I’m talking about like the multicultural communities here, with the parents and the, the literacy and everything is a bit of a challenge to get the message across and talk about mental health because that is really a taboo topic in our community and trying to find the wordings and everything, just that – if you don’t have the right wording and you can’t really express your feelings, there’s no need to explain, go to your family members and start having a conversation because then it’s just may lead to something that you wouldn’t be happy with so –yeah. (young person)

Some of the Aboriginal young people in the focus groups discussed their shame around seeking help, particularly in relation to confidentiality concerns, which is discussed in further detail later in this document. Aboriginal children and young people may experience shame as a result of talking about their mental health, sharing sensitive personal information, particularly with a person of the opposite gender, or shame at the thought that their personal information may be revealed to others [29, 30].

Fear of outcomes when using online or phone support services

Young people were asked if they would utilise telephone or online services if they were feeling suicidal. The responses varied, and often mirrored the issues raised when attending face-to-face services, such as fear of being unanswered, distrust and negative experiences. Young people also expressed the challenges in talking to a stranger during these crisis periods and their fear of first responders becoming involved.



I'll be too scared to, like, especially if I'm suicidal, like, I don't want, like, the cops around or ambulances.



I guess, in my experience, I just never really wanted to, like, call (emergency numbers such as Beyond Blue or Lifeline etc.) someone I didn't know and I didn't know what to say, I didn't know what to talk about, so I just kind of avoided it and – yeah.

Only 4% of Aboriginal young people participating in a youth suicide prevention program reported using help lines when having a problem, issue or crisis [31]. Importantly, over 60% of young Aboriginal people who responded to the survey did not use crisis help lines [31]. Similarly, only 2% of young Aboriginal and/or Torres Strait Islander young people in WA call Kids Helpline [32]. In 2017, 59% phone calls and web chats to Kids Helpline were unanswered, highlighting that the demand is far outweighing the service and the fear of your call not being responded to is justified [33].

Aboriginal children and young people may experience shame as a result of talking about their mental health, sharing sensitive personal information, particularly with a person of the opposite gender, or shame at the thought that their personal information may be revealed to others.

Lengthy waitlists and lack of availability

There were multiple references to lengthy wait time periods to access support, lengthy periods between clinical visits and the lack of available support during periods of escalating mental health difficulties by young people. This lack of availability of support prior to crisis point often resulted in a hospital presentation, seeking assistance elsewhere or left unsupported. The ability to make an appointment within a reasonable period was important to young people who are engaged with mental health services.



Probably also just the lack of availability, so like if you need an appointment soon, you have to have made it primarily like a long time beforehand. Yeah, if you need like more urgently then it's more difficult, especially with the current counsellor that we see, it's harder to ring them and make a sooner appointment.



The availability I think, to be able to call up, with a weeks' notice and go, "Hey can I actually get my appointment, please?"



There's always a waitlist, like a six-month waitlist, for like services these days. So when I was at CAMHS, they were trying to send me to the place I'm at now and I had to wait about four months even though it was a crisis problem.

Young people were concerned with the lack of support in between appointments and were required to seek additional support that involved 'retelling their story' which they reported they did not like doing because it was often distressing.

Professionals highlighted the need for additional funding and resources to reduce wait lists for youth mental health services. They also identified long wait lists and lengthy waiting periods as an area that requires improvement to reduce youth suicide across WA. Professionals wanted to see young people earlier before the young person's mental health deteriorated or escalated to suicide-related behaviour.



Less wait times getting into services for young people. (youth worker)



...they are left on waiting lists for alternate services for sometimes up to 3-6 months... (nurse)



...the biggest problem with all services in Geraldton is that there are more clients than professionals and waiting lists are often over full. (professional)

Intake criteria as a barrier

Young people discussed restrictions and criteria for service entry as a barrier to help-seeking or remaining engaged with mental health service providers. These included age restrictions, area of residence, diagnostic criteria and the numbers of visits or sessions.



My worker I have for like twelve months. And I wanted to have longer but basically you only get a set amount of time and I was turning 19 as well so there was an age limit.

Place of residence was identified as a potential barrier to seeking help by both young people and professionals. Young people described seeking mental health services that were outside of their community because they did not want other community members knowing they were seeking help. Mental health professionals felt they were restricted in who they provided services to based upon the young person's postcode.



I also reckon some services have like too strict criteria for like referrals, 'cause sometimes – like the service I've been referred to, like it actually creates a barrier with how strict they are with the criteria, like where you live, what catchment area, how old you are, etcetera, you have to fit so much and it actually limits the services that are available to you rather than expand them because you have to be so specific in one and then not in the other, that it doesn't help at all. It actually limits what you can access.

Professionals felt restricted by their service provision with specific criteria required to assess, treat and care for young people.



A lot of us are very specific and have criteria that people need to fit into, not the other way around (where the service fits the person). (occupational therapist)



The current services are postcode specific. More focus on the needs of young people and less focus on gate-keeping. (physician)



CASE STUDY

A young person presents to headspace seeking help for their mental health concerns. They are assessed and referred to a psychologist. They receive counselling from the same psychologist three weeks in a row but their symptoms exacerbate and as they are now outside the organisation's criteria (based upon a risk assessment) they are referred to CAMHS. CAMHS conduct a lengthy (3 hour assessment) of the young person and the young person does not meet their criteria for their services. They are too well for CAMHS and too unwell for headspace. They are then referred back to headspace and see the same psychologist who then has to refer them to another high risk service based at headspace. The family and the young person are uncertain if they will pursue further mental health support.

Limited number of sessions

A Mental Health Care Plan provides 10 free or subsidised counselling sessions in a calendar year (six sessions followed by potentially four more as needed). Young people reported challenges with this model and, for many reasons discussed in this report (e.g., building trust, establishing a relationship, therapeutic fit), young people felt that in some circumstances, 10 sessions was insufficient. The timing of becoming eligible for a Plan also affected the support a young person received. For example, a young person is mentally unwell at the commencement of the year and receives a Mental Health Care Plan from their GP. When the young person has used the 10 sessions early in the year, they will either have to remain mentally well for the remainder of the year, pay for psychological support, or wait until the following year to commence another Plan.



And also kind of with the criteria and things like that is similar on the line is that usually when you get referred to a place, you can only stay with them for like, six sessions or you can only, you know, spend, you know, six months with them or whatever. But like, you know, six sessions, like an hour, that's six hours within over a few months, how is that supposed to help you, you know?



So the mental health plan with Medicare is pretty good but once it does run out, you're sort of stuck because I'm seeing a psychologist so often I used most of my mental health plan like Medicare rebate things, and then so about halfway through the year, I was dry and like – you know, I was sort of floundering a bit, so my doctor, my GP, did manage to put in that application for four more extra ones during that year, so instead of six, I had ten and then I just had to try and pace myself throughout the year and keep myself in a good headspace.'

Professionals had similar views on the limited number of psychological sessions available through a Mental Health Care Plan or the number of allocated sessions through a provider. They reported that longer treatment times were required, especially if they were working with vulnerable young people with complex issues.



Many people need more than the 10 Medicare rebate sessions offered by the government and this causes young people in particular to cease treatment due to finances. ...most young people can access 6 sessions with a Youth Access Worker or 10 sessions with a contracted psychologist. From there, they are left on waiting lists for alternate services for sometimes up to 3-6 months, forced to pay for a private psychologist if they are able, or simply left and have to wait until the next calendar year for additional sessions. (nurse)

Professionals felt restricted by their service provision with specific criteria required to assess, treat and care for young people.

The 'clinical approach'

When seeking assistance for mental health concerns, young people who perceived service providers as working from a textbook and/or demonstrating a lack of genuine care was described as a barrier to remaining engaged with that service. Young people described experiencing a 'clinical approach' when a mental health professional just asked questions and ticked the boxes without really listening to their concerns or the reasons they were accessing support. Being asked to reveal everything at that first presentation was very confronting and discouraging for some of the young people. Those with a diagnosed mental illness reported that they felt like they were being treated as a mental health condition rather than as a young person with mental health concerns.



I guess attentiveness. I know that people are actually listening and not just going, "Uh-huh, uh- 'huh."



You know is listening, you know is listening to you and you know is trying to help you instead of just – instead of just looking, looking at you with a notepad and going, "How does that make you feel?" you know –'



And at the actual issues and not what's in the book cause what's in the book, cause doesn't all fit everyone and I don't think it'll fit 95% of the population, and it's just – and also be able to kind of express, express it without feeling like you have to unravel everything and then the hour is up.



I just don't really like talking. And they'll ask me questions I really don't wanna answer and – yeah, that's why –. you telling them about yourself, not them asking you is better.

Youth mental health services that are attached to hospitals were not favoured by the young people – many who had had a negative experience with attending hospitals reported that they felt uncomfortable and were less likely to either access the service or remain engaged with ongoing support.

Young people reported that individual services require their own mental health assessments, so that if a young person goes to headspace and then to CAMHS, they fall into the situation of being assessed twice before they even get to see a counsellor or psychologist. And as previously mentioned in this report, having to continually repeat their history or story can often be very distressing for the young person.



Like if you've been through some real tough shit and it's always been happening throughout your life, whatever, or even if it's just a little bit, you know, you find it difficult to explain things, like they only give you a certain amount of time, like, "Oh, sorry, you know, you have to move on to a different service. Here's another service," and then you have to start all over again from like when you're fucking born and – But, yeah, you have to start all over again from like, you know, when the stuff started, and then by the time your six sessions are up, or you six months, or whatever, then you have to move on to a next person, and you haven't actually gotten the time to deal with anything. (young person)

Perceived issues with the Emergency Department (ED)

Presenting to the ED

Many young people in the focus groups had a personal experience of attending hospitals (in particular the ED) with suicidal behaviour or after a suicide attempt. They were asked how young people could be better supported when presenting to the ED with suicidal ideation, post-suicide attempt, and after leaving the hospital. The questions explored in relation to experience with the ED included where young people go for help, knowing how to receive help, if they were supported and what young people did after leaving the ED. Of interest, questions about the ED were intended to be asked towards the end of the focus groups, but in almost every focus group, the experience of the ED was initiated by the young people early in the discussion, highlighting it as a priority concern for young people. It was reiterated by the facilitators that the young people did not have to share their personal experience. However, the participants who had attended an ED readily shared their experiences in detail despite most having had a negative experience.

ED's were identified as a place to go or a place to be taken to be kept safe during periods of strong suicidal ideation or post-suicide attempt. Presentations to ED's were usually made outside of normal working hours. ED's were also identified by young people as a place that police took them to under the Mental Health Act when they were actively suicidal. Young people described ambulances being called by police, case workers calling for an ambulance, or support staff or family taking them to an ED. Some young people also mentioned that they themselves had requested to go to an ED when they were actively suicidal or post-suicide attempt. ED's were the most commonly cited service for young people in acute crisis.



That's a really bad system for like when you're in crisis, the only option is ED, which is like the most – which isn't really a helpful place for someone in crisis. It's like the opposite of what they mean and then – but there's no other option, so it's like when you reach that point or something hasn't been noticed earlier, it's like that is the only option And then you often wait around for hours to speak to someone and there's never ever any beds. Once you're in that position, there's like a constant need for beds for people who have, who have got to that point and then it's relying on the family to then take the responsibility of their safety 'cause they just don't have beds, you either sat there or you're just waiting and it's not helpful.



I did take myself to accident and emergency in the Perth hill area, and I don't think the hospital was very equipped for mental health emergencies. So I got there and it seemed like the staff didn't know what to do and I didn't know what to do so it was a little iffy off but I didn't end up staying at the hospital. My parents came and picked me up but after that, I was sort of cut free because the hospital didn't have the resources or the contacts to give me, so I just ended up going to my GP again and he referred me to another psychologist and more mental health plans but yeah.



Like if I go to ED, it's either you help me now or I leave and I go kill myself. So in the end, I'm already dead on the inside, I have nothing to live for. So it's either help me now, send me to, you know, a mental ward and, you know, figure something out or I'm just gonna leave here even more angry because I've just taken a step forward, I've tried to get help, you've knocked me back, so I might as well just end it because, you know, it's gonna be easier.

Young people had strong and consistently negative views about their experience with EDs and this was often dependent upon how they arrived at the ED. If they arrived via an ambulance or with the police, they reported their presentation was usually taken more seriously. If they brought themselves to the ED (or a friend or family member brought them in), their suicide ideation was not taken as seriously. Young people also described feeling that staff reacted differently based upon the mode of the suicide attempt (e.g., consuming drugs as compared to self-harming). Young people who had attended ED multiple times with suicidal-related behaviour reported negative experiences from the first point of contact with the triage staff member through to receiving treatment and being discharged.



Yeah, and, like, if you come in by police, they take you more seriously. If you get taken in by ambulance, they take you more seriously.



And ED is horrible as well anyway. I had the worst experience with that.

Young people stated that one of the most significant barriers to seeking assistance from EDs when feeling suicidal was having to publicly announce that they were suicidal. This is particularly difficult in the ED context because patients seeking mental health care are treated in the main area of the ED; which is not ideal for managing people experiencing mental health issues. Considerable distress is caused to the help-seeker because the triage nurse is in full view and earshot of other patients and staff, and at worst, pose a safety risk.



Uhm, like when I did go in the emergency, I found it was, was really scary having to talk through that thin slit, you know, without shouting and then telling everybody else in the emergency why, why I was there, so like, you know...

Many young people described feeling like an inconvenience and that a physical injury was considered more important or life threatening than a mental health problem. They described extensively long waiting periods (waiting up to 20 hours in the ED with no attention), waiting in the main area of EDs with other patients and members of the general public (greatly increasing their levels of anxiety). They also reported long periods of time where they were left alone while waiting for many hours to see a mental health qualified staff member (psychiatric liaison nurse, a psychologist or a psychiatrist).

These findings are consistent with those from the Australian College of Emergency Medicine (2015) which showed that 90% of people attending an ED for acute mental health care in WA waited for up to 15 hours before progressing to a suitable care environment. This is 3.5 hours above the national average for appropriate mental health care, and well above the WA's emergency access target of 4 hours [34, 35].



It's like you're like an inconvenience, like sort of like, you know, just an annoyance and it's like you're always waiting hours just to be even seen. And to them it's not really a crisis 'cause they've people come in like dying or whatever but it's not helpful to sit in the waiting room with no one to come in to see you or even really notice that you're there, and then you wait – I've waited one time over 20 hours just to speak to the psych 'cause some hospitals don't have a 24-hour psych liaison nurse, so then you wait all night, morning to be seen for like 20 minutes, and then given a crisis numbers on your way and it's like, "What have you helped me with at all?"

Young people described some ED staff as judgemental, dismissive and rude. They encountered staff who referred to them as ‘attention seeking’ and staff who informed them that the hospital was not a hotel for them to utilise.

It has been well established that factors such as negative staff attitudes and stigma can impact patient engagement in follow-up services, as well as future help-seeking behaviour [36-39].

Young people reported that they were well aware of the shortage of mental health beds available in hospitals and were also often unnecessarily reminded of this fact by staff.



Now they call, “Well, you know, we can’t find a bed for you. I’m sorry, you’re gonna have to go because this isn’t a hotel”.

If young people were admitted to hospital, they still felt that staff didn’t treat them with respect. They felt they were talked about (rather than spoken to), with staff talking about them and their situation in their presence but not interacting directly with them. Some young people even received a diagnosis at the hospital and a brochure on the purported condition upon discharge from the ED without being admitted to the hospital.



...one of the times I remember having two nurses talk to each other. One of them was saying, “Just chuck him in the, uhm, psych ward,” and then like another nurse was just saying, “Just leave him there,” and like the nurse that said, “Chuck him in the psych ward,” she just kept saying, “But he’s a danger to himself,” like, “He just tried committing suicide. He should be in there with like 24-hour watch.” And like I could just continue hearing her and she just kept saying “it”. So that’s what she was talking to me as, “it”. By the end of it, I yelled at her and said I have a name and I am a person. So, then she finally started calling me by my name, but that’s all she wanted to do was just brush me off, get me out of the emergency department.



They told me I apparently have a personality disorder. And they didn’t really do no tests, no nothing, they talked to me for a little bit and then they came out with bunch of paperwork and said, “Here, you have borderline personality disorder.” I was like okay and they said, “You can go.”

Professionals identified EDs as a health sector that requires significant improvement in terms of suicide prevention for young people in WA. However, many professionals also acknowledged that the ED was the only service available for young people during phases of acute suicidal ideation. Over 40% of professionals referred young people with strong suicidal thoughts directly to the ED. Professionals described that the current model of acute care for young people with strong suicidal ideation is to funnel youth towards EDs, and the ED was a place where young people ‘bounced in and out of based on extreme symptoms and then apparent symptomatic diminished risk’.

Professionals also identified the need for better emergency responses and supported the young people perceptions of EDs. They reported being aware of poor acceptance and care upon presentation to EDs for young people, and suicide attempts as being derided as ‘attention seeking’. Professionals strongly indicated that ED staff and first responders should receive suicide prevention training.



The current mental health services are failing to provide alternatives to the emergency department for young people in crisis. (social worker)

Professionals were asked where they themselves refer young people with strong suicidal thoughts and behaviours. The most common response was the ED followed by CAMHS. For young people with strong suicidal ideation it seems clear that there are very few options available for professionals, highlighting the need for additional resources including training and education and funding to enable suicidal young people to be managed in the community rather than at ED. This is supported by the results of a recent survey of WA youth mental health workers who identified managing self-harm and suicidal behaviour in young people as the most important training topic for mental health professionals, with over two thirds indicated that this training is very important to their work and over 40% felt they required advanced training [40].



More upskilling on managing suicidal ideation and behaviour in young people rather than just flagging them and referring. (social worker)



Acceptance and care at Emergency Departments within WA need improving as currently a youth is seen in crisis, made to wait extraordinary times and then after calming are advised to go home. Perhaps with a referral to CAMHS but no further follow-up if they do not meet that referral. (first responder)

Professionals identified a gap in services for young people requiring the ED, particularly those aged 16 or older, who are too old for the children's hospital but too young for the adult hospital. They also felt that mental health services often will not deem young people 'ill enough' for their services until they have had to present to ED or are brought to ED by police or ambulance following a suicide attempt. This situation has been identified as a gap in services for young people and described as the 'missing middle'. Generally, the young people are too unwell to be provided services through the primary mental health system, but are not acutely unwell enough to access tertiary based care and end up in the ED.

The key outcome identified by professionals would be to build less reliance on EDs as a place for young people with strong suicidal ideation and behaviour, or after a suicide attempt (unless medically indicated) or during acute phases.

A review of EDs mental health attendances in metropolitan Perth for youth (16 to 24 years) in 2013-2014 and 2014-15 found that the top presenting symptom was suicidality [41]. Those aged 18-24 comprised the second highest proportion of mental health-related ED presentations in Australia (AIHW, 2018).

Most EDs are not equipped and not all staff are trained to support people in need of mental health care. Suicidal presentation at an ED is considered inconsistent and when young people are trying to get help, they may be misunderstood and dismissed, and therefore they find it difficult to access the professional support they require [42].

For young people with strong suicidal ideation it seems clear that there are very few options available for professionals, highlighting the need for additional resources including training and education and funding to enable suicidal young people to be managed in the community rather than at ED.

Support after leaving the Emergency Department or hospital

Support for young people after they have made a suicide attempt needs to be enhanced, and an integrated approach to care is required with improved referral pathways, sharing of information between health care systems and staff attitudinal change. Young people who experienced care after a suicide attempt from ED or who had presented with suicidal thoughts reported they felt unsupported following discharge from hospital. This included all onus and responsibility being placed on the young person to access and seek further support once discharged, despite them still being unwell, or possibly not in a position to access that level of support.



They don't give you follow-up support. They just kind of expect you to go and be fine just because you've had a small like, 24-hour break from something, they expect you to be okay.



There needs to be more follow-ups, they need to make sure you have follow-up appointments, 'cause they don't. They just leave you to your own devices once you've left. They need to make sure you have those follow-up appointments to remain supported in the community once you've left emergency.



...actually when they discharged me after the hospital stay, I didn't follow up or anything and no one followed that up with me, and to my knowledge, to me directly. So I feel like I was probably left in the dark a bit with the whole situation and it's just the thing that I thought of that didn't, didn't work very well.

If young people did receive support after a suicide attempt, it was most likely to be from the Adult Hospital in the Home (AHITH) program, which currently operates out of the North Metropolitan Health Service. AHITH was well-received by the young people while they were receiving the service, but once that service had been completed, the young person was left without other means of support and there were no referrals to other services or additional support from the program.

Professionals confirmed experiences reported by the young people. Additional support and follow-up for young people who were discharged from either the ED or hospital after presentation for suicidal behaviour was identified as an area of suicide prevention that requires improvement. Professionals stated that young people, after waiting long periods in the ED waiting room, were advised to go home once the young person had calmed down with no additional support. They also reported that they were aware of young people who had been discharged with no follow-up one hour after presenting to the ED with suicidal behaviour.



It would be good for the ED to not discharge clients one hour after they present with suicidal ideation (social worker)

Perceived issues in the school environment

Young people described issues in being able to access supports within the school environment, including a lack of education and awareness of mental health, as well as challenges with their school psychologists.

As previously raised in the report, young people saw teachers as playing a vital role in providing students with an awareness and understanding of mental health, as well as playing a role in recognising students at risk for suicide and referring them for help and support. However young people also talked about the lack of any significant attention given to mental health within their schooling experiences.

School psychologists

Young people perceived the primary role of the school psychologist as a staff member of the school responsible for providing counselling services and able to support young people with mental health concerns. The complex work of school psychologists in the WA Education Department is outlined in the Competency Framework for School Psychologists (Department of Education, 2015). “The school psychologist must balance a system of interlocking networks that all have an interest in the life of the student – the school’s values and expectations, teachers’ expectations, concerns of parents and families, the internal psychological life of the student and the ethical standards expected of a practicing psychologist” (Education Department of Education, 2015 p. 5). The student’s perceptions of the role of the school and psychologist may not align with the Framework and therefore school psychologists’ availability for counselling and ongoing therapy is restricted by the competing needs of the school.

Some young people who had experience with the school psychologist described their engagement negatively. Concerns expressed by the young people included:

Confidentiality: The physical location of the school counsellor or psychologist was a barrier to seeking help. Their office is often located in prominent positions in the school, such as opposite the main communal area. If a young person attended the school psychologist, they felt like everyone in the school knew about it and they received negative remarks regarding their mental health. Young people from small schools, especially in regional areas, reported difficulty accessing the school psychologist without other students knowing.



I have problems where I don’t wanna go to the school psych, because my school is so small, everyone could hear it, and I was like, “Whoa, I don’t want to do that”

Young people described issues in being able to access supports within the school environment, including a lack of education and awareness of mental health, as well as challenges with their school psychologists.

Availability: Young people reported a lack of availability of school psychologists because many were employed only on a part-time basis in their schools. They felt that employing a school psychologist part-time was reflective of the school’s limited commitment to youth mental health. Many young people reported that they did not seek support from the school psychologist because the lack of availability meant waiting several weeks until they were able to obtain an appointment, often after a crisis had passed.



I feel like just that even, you know, when the school got part-time psych and you kind of – we ask the questions like, “Why isn’t it full-time?” I mean is it not as important, yeah, if that makes sense? (young person)



We did have a school counsellor and a psych, but they weren’t very accessible because there were just so many people going to see them.

Lack of awareness: Young people reported they were unaware that their school had a school psychologist and only became aware after it was suggested to them by another member of staff or after a crisis event.



I think I first found out about the school psychologist, uhm, through like needing to go see like the nurse and then I linked on to it from that.

Unapproachable: If it was known that a school psychologist was available at the school, then some young people described them as unapproachable and only good for day to day issues such as fighting with friends.



Well, she’s just – she did not look approachable. She looks very standoffish. And in literally in the way she dressed and everything, just everything about her was like, “Do not approach,” which is not good if you’re a school psych.

In 2012, the School Response to Suicide and Self-harm Program was established in response to increased suicide deaths, suicide attempts and self-harm among teenagers in WA. The program provided extra specialist clinicians through the Department of Health Child and Adolescent Mental Health Service, Department of Education School Psychology Services, and non-government youth mental health service, Youth Focus. The integrated program increased access to counselling and suicide prevention education for young people at risk and supported school communities and parents to appropriately prevent and respond to suicidal behaviour, including developing guidelines for managing related social media issues [43]. Although this program no longer exists, guidelines were developed to enable staff to recognise, support and respond to suicidal behaviour in students. The number of school aged children who have died by suicide has increase since 2012, and school staff may require more than guidelines to assist with identifying suicidal behaviour and responding supportively in school aged children (ABS, 2018).

Suicide prevention initiatives

Ideally, suicide prevention should involve evidence-based interventions. Suicide prevention strategies range from universal interventions for the general population through to interventions for high-risk individuals. Not all suicide prevention interventions identified or implemented by the professionals who participated in this study are evidence-based. Integral to delivering successful suicide intervention is the implementation of evidence-based suicide prevention strategies.

Professionals were asked to identify the program/s, model/s or framework/s they use to address suicide prevention in their work environment from a list of 15 different suicide prevention programs. If the program/model or framework was not listed, they were asked to name or describe other suicide prevention strategies they had implemented.

More than 15 additional suicide prevention activities, programs or models were identified by the professional participants. Not all of these additionally identified programs had either been evaluated for young people or were evidence based. The most commonly used suicide prevention programs were:

1. Mental Health First Aid
2. Applied Suicide Intervention Skills Training (ASIST)
3. Gatekeeper Suicide Prevention Training
4. safeTALK

Currently, there is dearth of evidence of effective suicide prevention in vulnerable young people and further research into suicide prevention in these vulnerable youth populations is required. Additionally, further investigation is required to determine the manner or process by which service providers determine what suicide prevention strategies they implement, and whether these are evidence-based.

Whilst well intended, service providers may vary or amend a suicide prevention initiative in the belief that this may better suit their particular region, or the characteristics/demographics of their clients. However, deviations away from the evidence dilutes the integrity and fidelity of suicide prevention programs, models and frameworks, and strategies must encompass evidenced-based intervention if they are to reduce suicide [44].

Currently, there is dearth of evidence of effective suicide prevention in vulnerable young people and further research into suicide prevention in these vulnerable youth populations is required.



What works
well?

Meeting the unique developmental and cultural needs is a requirement of mental health services to reduce the impact of mental disorders on young people [45]. Young people are often reluctant to seek support for their mental health concerns and this reluctance is heightened in vulnerable populations [27].

Young people in the focus groups were asked to describe what has worked well for them when they accessed support for their mental health concerns. The initial engagement with a mental health service was explored by the facilitators and some participants described their first experience with a mental health service as daunting, scary and even terrifying. Subsequent engagement with services providers was very much dependent upon that first experience.



I don't know if anybody else experiences this but like your first session with somebody is terrifying.



Yeah, 'cause like you get to talk to somebody finally about like this thing that's been bothering you, all these multiple things that it's just destroying your life at that point and – but you don't know how's the person's gonna react and it's the most terrifying, anxiety provoking thing you could do.



I was literally shaking on the way. It was a day that I was feeling pretty bad, when I first decide to go to headspace I was literally shaking on the way until walking to the building 'cause it's like there's that level of anxiety that it's just, "How is this going to turn out?"

Young people identified common enablers for accessing mental health support which included: extended opening hours, less 'clinical' approaches, consistency in staff, youth friendly staff, youth friendly environments and financially available services.

Youth friendly

Consistent with other types of work in WA, young people raised a range of factors which made a service youth friendly, and which improved access to their services access and promoted engagement [46].

Youth friendly service

First impressions of an organisation were important to young people in assisting with help-seeking behaviour and remaining engaged. Young people described the characteristics of the services that worked well as safe, positive, warm, welcoming, inviting or calming. Their anxieties around attending a mental health organisation decreased if the first point of contact was a nice, welcoming receptionist. Good services were places where they felt supported, where the service providers were listening to them, where they were treated with respect and were not seen as a problem to be fixed. Most young people preferred face-to-face engagement where possible and used terms such as a 'less clinical approach', 'informal approach' and a 'person-centred approach' in describing positive service provision.



I just like the headspace to, yeah, and I might, I just found out from like Facebook, but like, I don't know, I just really like their advertising and like how they use bright colours and stuff and like their facility is really like welcoming.



I actually get along with the receptionists there pretty well – so from the second walk in, you wanna feel like it's a place of support rather than sorting out your problems. Like when they focus on sorting out your problems, it just kind of pushes you away.



I was actually about to say like walking into a room with positive, warm and welcoming environment, so with like a nice kind of lighting or some plants in the room. Again, like having a nice friendly receptionist, just little things like that that take away how daunting and hyped up it's meant to be because I still think it is made to be quite a big thing to go and speak to someone. So just little things like that really calm me down and get you in the mood to actually speak and open up.



Oh, I wanted to say that, that initially I sought help at headspace. They, they treated me like an adult, like a – a respect was there straight from the start, and it just helped me connect better with who I was talking to and, yeah, the whole process of getting into headspace and getting the help was – I felt like they were treating me with respect and – straightaway.

Youth mental health services that are embedded in organisations that provide allied health services were favoured by some young people because they felt more comfortable in accessing these services as compared to a standalone mental health service.



...you know, it's – when you go there, not everyone knows that you're going there to see a counsellor, 'cause some – I know that sometimes I get a little bit, you know, anxious of, "Everyone knows I'm going here to see a counsellor, so they might think something is wrong," but, yeah, I see that, like people go there when they're generally sick or, you know, just seeing physiotherapy and stuff like that. So no one knows why you're actually there which is a good thing I reckon as well.

Youth friendly staff

The characteristics of service providers that worked well for young people were described in detail by the young people with multiple references to the personal qualities that resonated with them when seeking help.

It is important for young people to have honest, non-judgemental and consistent professionals that they trust and can build a connection with. Most young people stated that having one point of contact, the same professional to assist with ongoing mental health concerns, was a priority in remaining engaged with an organisation. Young people described that it takes time to build a connection with someone they trust enough to share their history, their stories, their problems and their concerns. Maintaining a singular point of contact assists with building trust, especially for vulnerable young people, who find their stories are difficult to disclose.



Just make sure they're all friendly workers and make you feel like they're there to listen and not to judge.'



You know is listening, you know is listening to you and you know is trying to help you instead of just – instead of just looking, looking at you with a notepad and going, "How does that make you feel," you know. They actually try and help you and take those steps to be able to think, instead of just, uh, just listening to you and then, and then saying some stupid advice. They actually, they actually take steps to



try and help you because they actually care, so – yeah.



In my experience, it was a conversation. It wasn't someone with a clipboard taking notes. It wasn't looking at me like I was a wounded animal. It was – you start off with something and you think, “How the hell is this related to what's going on?,” and then you start talking about stuff and, you know, sometimes I'll cry and I'll be sad, and I'll come out of it and just go, “Wow, I just wanna go to bed,,” and sometimes I'll come out and be all bouncy but it's – it never makes you feel worse, it never makes you feel bad, it's just as if you're the actual person.

Young people reported that they understood that it is sometimes outside the mental health organisation's ability to provide consistent staff. Mental health professionals relocate to other organisations, shift professions, change their personal circumstances and this impacts on their ability to provide primary care to a young person. However, if a service provider must be changed (e.g., change of case manager, psychologist, counsellor), then what young people found helpful to assist in remaining engaged was to be introduced to the new staff member while their primary staff member was still employed with the organisation. Changes in primary contact often exacerbated their fears and anxieties.



So definitely making sure like if you can kind of maintain a singular person so you can talk to them as much as possible, 'cause that makes it a bit more – it centralises it, it makes it a lot more like – they know your story from past.



I find it helpful when, often the services, if they have to change, like your case manager or psych cause they've left or whatnot, a lot of the time, these services I've used, they've like slowly introduce you to that new person and like maybe had sessions where they're involved in. So then, you knew, you're not just going from one person to another, and then from barely knowing them to knowing them and then chopping and changing. I think it's helpful when they slowly like get to meet them before they have left. I find that helpful.

Extended opening hours

The provision of services outside of traditional business hours was well supported by young people. Extended opening hours meant that there were options if they were having a difficult time outside of traditional business hours and for young people who didn't want to utilise the school psychologist, they were able to access mental health services confidentially outside of school hours. They reported:



...you can't really schedule your problems around those hours.



Yeah, I'll see the afterhours support which I think is really good 'cause like most services are 8:30 to 4:30 and then no crisis stops, you know what I mean?



There're times when there isn't many services available, especially in the evening when it's not the typical time.

Mental health services that do not require an appointment were favoured by young people. They described how anxious they would become having to make an appointment and possibly describe their reasons for accessing a mental health service to a receptionist.



...especially people with anxiety, you know, I use to have a lot of anxiety back in the past, it was really, really hard to be able to call someone up physically and then ask for help, you know, ask for appointment. And not only is it, is it nerve-wrecking to ask people for these types of services, but when you're depressed and anxious about other things –uh, I thought it was a lot easier for myself if I could just get up and go there when I wanted to, you know what I mean?

Extended opening hours meant that there were options if they were having a difficult time outside of traditional business hours and for young people who didn't want to utilise the school psychologist, they were able to access mental health services confidentially outside of school hours.

Affordability

The financial issue of accessing mental health support was widely discussed in the focus groups. Many young people were either students or unemployed, and their ability to access mental health services was completely dependent on a Mental Health Care Plan, utilising a GP that bulk-billed, or accessing a youth mental health organisation which provided free support. Without either free or heavily subsidised mental health service provision, many young people do not have the financial means to access support.



Uhm, yeah, one of the reason, the main reason I pick headspace is 'cause I know that they bulkbill and when I first referred, I was – well I still am a TAFE student, but I was a TAFE student and, uhm, just living on Centrelink, uhm, so I, I needed something that was affordable and I looked around town for counsellor and they all seemed to be private, so yeah.



I think where I go it's ten free sessions and then they're like, uhm, reassess you and if they think you're, you know, well enough or okay, then that's kind of like the end of it, but I, I've been there twice now, so they let you back in and they don't need to pay, uhm, so which is. which is very good 'cause if I have to pay, I'd not be able to afford it.



I think the other contributing factor with headspace is that you do get the six free sessions if you get a referral so it's financially, like within, within reach, yeah.

Including lived experience and peer support

Young people, especially marginalised young people (such as those who identified as sexually and gender diverse, or those with a diagnosed mental illness) reported positive experiences with mental health professionals who disclosed personal stories that aligned with the young person's experience. Similarly, peer support was viewed as a positive experience. This helped young people feel like individuals rather than 'a clinical presentation'. Improving engagement through those with lived experience may assist with increasing support and engagement with mental health organisations and early intervention.



One thing I would say is having, having counsellors or therapist or whatnot who have gone through the same issues I suffer from gender dysphoria and – well one of the counsellors I was seeing at headspace is – it identifies as non-binary and was assisting me in starting my transition, and so it makes it a lot easier to talk through with any of the issues if there's someone who knows exactly how you're feeling and doesn't just see it from like clinical perspective or anything like that.



I have the same sort of thing at PCH with one of the nurses there, she suffered in the past with an eating disorder so she could relate to me with that on that level and it was really nice to find somebody who you can actually talk to about something really personal and they would completely understand where you're coming from.



Like, uhm, I was going to a borderline personality disorder support group not too long ago that is run by a woman who had borderline personality disorder, and she'd been through the system for ages and that was like one of the most supportive things like – that helps me more than being in Bentley Adolescent Unit and stuff like that, so...



It would be good to have, like those peer support workers come in and be like, “Yeah, I've been through what you're going through, and like I can help you.”

The inclusion of peer support was reported by many of the professionals as an effective means to support marginalised young people and as a strategy to improving youth suicide prevention in WA. Professionals described the importance of having individuals with lived experience of suicide provide mentoring for young people at risk of suicide.

Outreach support

During the focus group discussions it was identified that some young people were receiving outreach care, although the young people did not always use this term to describe the support they were receiving. Support from outreach workers was reported positively in terms of assistance in navigating systems. Young people perceived outreach to be more supportive than accessing mental health professionals such as psychologists and psychiatrists. Young people described outreach as a less ‘clinical’ approach.

Outreach was identified by the young people as an essential service in supporting mental health. Positive outreach was primarily delivered by organisations that provided crisis or transitional accommodation – for homeless young people outreach was an important mechanism to engaging young people with support for their mental health concerns.

In some specific circumstances, outreach was the preferred service mode. This included being homeless or having transient accommodation, symptomatic difficulties while travelling to services and a lack of parental support.

Young people who had an experience of homelessness described outreach as supportive in a range of ways. They were supported to access social services to gain identification, social services payments and obtain a driver's licence. Outreach was identified as key to engaging with marginalised young people who find it difficult to engage with services.



It was so much easier, so much easier. Because it's a pain in the ass to like just getting – like sometimes, you don't even feel like going to go to – like if you're having a shit day or whatever, you don't really feel like going out of your way to go and talk to someone. But if they come to you, you kind of feel – I don't know. It's like they do it to everyone, but I don't know, I felt like, I don't know, just I'd rather they come to me.



Yeah, I prefer outreach. It helps a little more, personally, anyway.)



...cause since about 12 to 13, I was kind of like in and out of home, and then from about 14, I was out on the streets, and I'm almost 17 now, I still haven't had a stable place but I think outreach places a lot – there needs – personally, there needs to be a lot more outreach places, yeah, know, you might be like they're here one day and then, you know, this places here, so it's kind of easy, and then next minute, you are in a completely different place.

A study conducted in WA with young people at risk of mental health difficulties (including young people with an experience of homelessness) found that the ability to meet support staff outside of the office environment was important for engagement [26]. The evaluation of the Innovative Health Services for Homeless Youth in WA found that outreach was a factor contributing to successfully engaging with marginalised young people [47].

Increasing the provision of specialised youth outreach services was also identified by professionals as a strategy for reducing youth suicide in WA, especially for marginalised young people who may struggle with parental support, are homeless, in out of home care, or lack the funds or ability to travel to organisations for scheduled appointments.



Our “normal” Gov MH services need to embrace the idea of assertive outreach-that young people can't just be sent a letter and expected to arrive for an appt... we need to engage these young people differently... we also cannot just close a client because they have not turned up or they have DNA'd.
(Psychologist)



...assertive outreach to prevent hospital admissions. (Professional)

A study conducted in WA with young people at risk of mental health difficulties found that the ability to meet support staff outside of the office environment was important for engagement.

Online support

Online support was identified as helping young people experiencing crisis outside working hours and in-between appointments. It provides anonymity and the opportunity to reflect on their feelings as they typed or texted. Some young people who find it difficult to talk to a stranger about their mental health concerns found the online space provided a more suitable option. Young people also reported they liked having the option to choose between organisations, so some used the phone helpline from one organisation and the online chat from another organisation. Other young people discussed the use of apps as other online tools to calm themselves during periods of high stress or anxiety.



Yeah, compared to like the phone ones – I find– a lot of people would find that easy ‘cause, I don’t know, just most people I’ve spoken to about it find it hard to talk to a stranger about – especially like a crisis point, it – it feels a bit strange speaking, but I think it’s a lot easier like messaging, or texting, whatever, and then you can think about like what you’re gonna say because sometimes it’s like, I don’t know, just stressful ringing a stranger and talking about something difficult to them, yeah.



I think the accessibility online as well as the anonymous side of it was really appealing.



I was also gonna say when I was quite unwell, I found the help lines very good, like just talking to someone over the phone, because I was not dealing with sleep very well at that time. So just having – like I was very lost, so having that connection with someone over the phone made it nice. Like you can’t always ring, you know, headspace or whatever, so you can call afterhours. The people on there are quite helpful.

Young people reported visiting online spaces in order to read about other young people’s mental health experiences. They weren’t seeking help but reported they followed blogs or read what others have written online as a means of feeling less lonely.



Sometimes, like, I find it hard to put things into words. I guess I like to just go online and, like, read what other people are going through if I can, like, resonate with that. And that kinda gives me, – I feel like I’m not alone but – yeah.



What is required to
improve youth suicide
prevention in WA?



Everyone's needs are different, like, it all depends on how severe your mental health is and, like, your circumstances and all that. It's all different. Yeah, it just – yeah, it depends on your circumstance, your experiences and 'cause everyone copes differently, like, someone could be through, like, something so extreme and seem like they're fine and other people can break over smaller things, so it – and everyone needs help even – no matter, like, what their circumstance but everyone needs help differently, I guess, depending on the person.

Despite the number of studies in youth suicide doubling in recent years, there is still only limited evidence of interventions that were designed specifically for young people. Indeed, most interventions conducted with young people are designed for adults with little or no adaption [48]. This lack of well-designed, youth-specific intervention studies is unfortunate as the components of treatment for the reduction of suicidal ideation and behaviour remain largely unknown [49]. There is also little understanding of the suicide prevention strategies required for young people who have experienced care and justice systems and/or traumatic life experiences as identified in the Ombudsman report and the Coroner's report (Ombudsman WA, 2014; Coroner's Court WA, 2019). From the Coroner's Report, it is acknowledged some of young people who died by suicide were known to government agencies such as Department of Communities, Department of Health, Department of Justice and had been enrolled in the educational system. Most of these young people had no contact with a mental health organisation and therefore a whole government approach is required to address youth suicide prevention in WA. Further research is also required to determine effective suicide prevention strategies for these vulnerable cohorts.

Any youth suicide prevention intervention needs to account for individual characteristics, such as developmental stage [8, 50]. For example, a recent study found that there were not only differences in the characteristics between younger and older adolescents who died by suicide but also between male and female adolescents [51]. Thus gender-specific youth suicide prevention strategies may also be needed. Younger children are dying by suicide and consequently there is a need to address suicide prevention in the early years (as compared to adolescence), as well as addressing the factors that contribute to suicide, including social determinants. Young people, including vulnerable young people (i.e. Indigenous populations, low socio-economic cohorts, sexual and gender diverse and CALD young people), need to be involved in the design, delivery and evaluation of suicide prevention strategies [50]. Young people's involvement will ensure that suicide prevention interventions are acceptable, appropriate, relevant and important.

Young people in the focus groups were asked, "What does good suicide prevention look like for you?" Young people struggled to respond to the question.



I don't know. I feel like stigma surrounding it, that would help, and either stop things happening or at least help...



There needs to be so much more, that is my opinion, so much more. I know so many people who have died because there's not enough help.



I personally think that there needs to be more, more youth mental hospitals and things like that 'cause – well, I'm experienced anyway, so there're so many adult places and stuff but there's only a handful for young people.

Primarily, young people suggested that every one of them should be considered as individuals with different backgrounds, experiences, different capabilities, coping strategies and support mechanisms and these should be considered by each service provider. They also stated that education about mental health, including suicide, should be included in the school curriculum and commenced in primary school. Young people also wanted to receive education and training so that they themselves are able to support their peers who are experiencing suicidal behaviour. Young people discussed that support for mental health was not the sole responsibility of mental health professionals. They identified several systems such as education and health and community members who engage with youth that should be able to provide mental health support, as well as among their family and friends.

Prevention

Increasing mental health education and suicide prevention training for young people

Early identification of a young person at risk of suicide is a critical component of delivering timely intervention to mitigate suicide risk. This can occur when community members are aware of the signs and symptoms of risk. As highlighted earlier in the report, all community members that engage with young people should receive suicide prevention training.

Young people were asked if they would like to know how to provide support for someone who was in crisis, felt life is overwhelming or was having suicidal thoughts.

Some of the responses included, 'Yes', 'Absolutely', 'I think I need to know this stuff now', and 'Yeah. I've been in that situation quite a lot of times where I've like needed to and it's like hard to make the right decision like to do stuff'

It was clarified by the facilitators that there is training available for young people that can teach them how to support someone who is suicidal; would they like to learn this? Overwhelmingly, nearly all the young people indicated that they would want to assist someone if they were in crisis, suicidal or needed help accessing mental health support. Young people were also very aware that they needed to protect their own mental health and that this not something they were prepared to risk.



Yeah, that, that would be good. I think that a lot of people that have mental health issues, a lot of the people surrounding them have mental health issues too, so it's like – that would be really good...

Some of the young people had already completed courses, such as Mental Health First Aid, Youth Mental Health First Aid, or safeTALK. Some had attended camps and workshops delivered by Zero to Hero.



I've actually come across a situation at school, and one of my friends, walked in and saw this person is crying in the bathroom and she came out and she actually said, "You know, there's someone in the bathroom. I don't know what's happening. I know that you've got a bit of training which is through the safeTALK program," and when I approached this particular person, I knew the right type of questions to ask her to make sure that she was okay and I was okay.



So we had a friend that we lost to suicide last year and this friend reached out to another friend of mine the day before he passed and she didn't know what to do. She didn't know how to respond and so her immediate response was to just not say anything. It was just kind of this lack of education. She wishes she knew more but she was never in an environment where she could, so I think in that kind of respect, people do wanna know more, they just don't necessarily have the tools that they just need it given to them, whether that's education system or just through programs, because it wouldn't necessarily have saved a life in that instant but it gives you that peace of mind I think to know that you have done everything you possibly could.



I think it would just depend on the sort of person, like you didn't want a widespread teach it, because people wouldn't take it in, and they wouldn't know how to use it when the time came. But if you had like specific people, like people who volunteer to like whatever things like camp Hero, like teaching them more about it when they're willing and able to like do something like that, helping in crisis, but I think that would be helpful just to have more people generally in schools and universities who are actually equipped to deal with that sort of thing.

Professionals reported that young people should be receiving suicide prevention training such as the Applied Suicide Intervention Skills Training (ASIST) or safeTALK as part of their secondary education curriculum in WA. The course was described as a complement to first aid certification, a commonly attained qualification by young people.



safeTALK implemented in secondary schools (this has been done and evaluated in other states within Australia) and ASIST offered to year 12 students, with ongoing and wrap-around support, following the training. (Suicide Prevention Coordinator)



Early intervention education in schools, compulsory! (Youth Worker)



MHC to fund the ongoing rollout of training like ASIST to youth and education sector. (Youth Worker)



Basic mental health first aid and suicide prevention psychoeducation provided in schools. (Psychologist)

Schools are a suitable location for the provision of suicide prevention interventions, and school-based universal education and awareness training programs for students have shown some promise [52, 53]. For young people not engaged with schools or other educational settings, Mental Health First Aid training and suicide prevention training programs should be considered.

safeTALK [54] is a 3 hour workshop that prepares anyone over the age of 15, regardless of prior experience or training, to become a suicide-alert helper. In 2016 safeTALK was delivered to Australian high school students and evaluated to examine its efficiency, acceptability and safety. Overall, participants demonstrated increased knowledge and confidence in issues relating to suicide, a willingness to discuss suicide and increased likelihood of seeking help for suicidal thoughts. There was no evidence that the training induced suicidal thoughts or caused distress and the majority of participants reported it to be worthwhile and that they would recommend it to a friend [55]. Researchers have argued that universal suicide prevention workshops in secondary schools should be incorporated into the curriculum for students aged 15 years and older [14, 56]

Increasing mental health awareness

Many of the young people and professionals suggested that mental health should be addressed early in life and that mental health education in school should commence at a young age, preferably in primary school. Waiting until secondary school to develop strategies to cope with life as it became more complex, overwhelming and challenging was viewed as being too late.



Putting things in place before it reaches that point 'cause it's better to catch them early than let it get to that point then have no real way of solving things.

Young people considered that mental health education should be regarded in the same manner as physical health education. They described having lessons on the importance of physical exercise, eating nutritious meals, the signs and symptoms of puberty and sexual health education but no education on mental health. Young people felt it was just as important to receive education on the signs and symptoms of poor mental health (e.g., what it might feel like to be anxious, overwhelmed or depressed) as it was to have physical health education.



...being made aware of early on about what mental health is and the difference sort of like symptoms and things like that. Cause I remember when I was younger and showing symptoms, I didn't realise what was like going on and I don't know. It's just like that when I was in year seven, they taught us about puberty as well, and I feel like why wouldn't you also teach us about mental health and how it can really – it's really affect your life if it's not, you know.



...maybe more education 'cause it was definitely missing when I went to school.



...like little kids, like in primary school, that's when they need to start talking about mental health. It's not – it shouldn't be held off into high school because by the time you get to high school it's too late...

Professionals stated that early intervention is necessary for improving the prevention of youth suicide in WA. They reported approaches and strategies that build resilience in children and young people that should be delivered in the educational setting. They also described early intervention for known vulnerable families. This included coordinating services for the vulnerable populations to facilitate access to multiple services with a focus on prevention and early intervention.



Early intervention works and is supported by a plethora of evidence-based research... so why aren't we doing anything about it? (nurse)

Young people reported that improvements in youth suicide prevention will require the destigmatisation of seeking help for mental health concerns and suicidal behaviour. Increasing mental health literacy and awareness will assist in this destigmatising and ultimately improve help-seeking.



It's probably like the biggest thing we need to work on in the mental health community as a whole is getting rid of the stigma that comes with any diagnosis that there is.

Public health campaigns and social media also assists with increasing awareness and decreasing the stigma associated with help-seeking for mental health concerns and suicide. Young people suggested using 'young influencers' such as sports people, musicians, artists or celebrities to raise awareness of mental health concerns to reduce stigma.

Intervention

Youth and professional respondents reported that the current model of presenting to the ED with suicidal behaviour does not work. To reduce youth suicide in WA, there must be either an alternative to the ED for young people with suicidal behaviour. Professionals want young people with suicidal behaviour to be managed in the community, but report that this is not feasible currently because there is no alternative to the ED.

Increasing the options for young people experiencing suicidal behaviour

Despite most young people having negative experiences, both professionals and young people identified the ED as the primary service and only option for young people with strong suicidal behaviour.



Yeah, I feel like they should have like a separate unit, like one emergency, like for people that have injuries and, and are gonna die, and like a separate one for like mental health because so everyone has a fair like thing. And there probably won't be as much as a waiting lists and probably maybe prioritise the people that wanna kill themselves, like just a little bit more I mean because it's hard.

The 2019 Sustainable Health Review reported that substantial improvements have been made in various Perth metropolitan EDs with the introduction of Mental Health Observation Areas (MHOAs). The MHOAs allow patients to receive treatment separately from the main waiting room of the ED [11]. None of the young people in the focus groups ever described receiving treatment in a MHOA, even though some of the young people had multiple presentations to EDs.

Improving current ED responses

Follow-up with young people after discharge from hospital is an opportunity for intervention. The period following a first suicide attempt is associated with the highest risk of further suicide attempts and suicide, as well as staff negative attitudes [6, 37, 50].

Professionals proposed the following ED-related recommendations to improve youth suicide prevention in WA:

1. Further education and training for ED staff to increase their knowledge and understanding that youth at suicide risk are not ‘attention seeking’ when they present to the ED.
2. Improved follow-up care for young people who are discharged from either the ED or hospital after presenting with suicidal behaviour or after a suicide attempt.
3. Improved collaboration and information sharing between state mental health services, GPs and community-based support services to transition a young person in and out of acute care. (Professionals currently feel this is ad-hoc and comes down to individuals rather than a commitment at service level).
4. Young people that have attended hospital with suicide related behaviour should not be discharged until a safety plan is signed off by both a guardian and/or a residential worker or case manager.
5. Assessment framework developed to collaborate assessing suicide risk across services so that young people don’t have to tell their suicide risk story multiple times.
6. Increased funding for increased service provision to support young people in suicide and mental health crisis other than only accessing ED.

Other states in Australia have similar concerns regarding people’s experience of presenting to the ED for acute mental health care. Both Victoria and New South Wales are trialling different approaches, but they are not youth specific.

In Victoria, they are currently trialling the Hospital Outreach Post-Suicidal Engagement (HOPE) initiative. This is aimed at improving care following a suicide attempt. Twelve health service sites in Victoria are implementing enhanced support and assertive outreach for people leaving an ED or hospital admissions following a suicide attempt. The HOPE program provides intensive, person-centred support which is tailored to the unique needs and circumstances of the individual. Those eligible for the service will be contacted within 24-hours of hospital discharge, and support will continue for up to three months [57]. St. Vincent’s Hospital in Melbourne have opened the first Safe Haven Café. It is based on a successful model in the UK and has shown to help with de-escalating and preventing crisis as well as acting as an alternative to the ED for adults experiencing mental health issues including suicidality. The Safe Haven Café model in the UK showed a 33% reduction in admissions to acute in-patient psychiatric beds within the catchment area [58].

Additional training for mental health professionals

Professionals were asked if they felt they required additional training or upskilling to effectively manage young people with suicidal behaviour. They were also asked if they thought their organisation required additional training and upskilling to effectively manage young people with suicidal behaviour.

Professionals cited a commitment to continue working with young people at high risk for suicide if adequate support to do so was available. This is because they have already built rapport and trust and would prefer to continue to assist the young person rather than refer them elsewhere.

Over 40% of professionals believed they required additional training, and nearly 50% thought their organisation required additional training, to effectively manage a young person with suicidal behaviour.

The five most commonly identified training professionals would find useful were:

1. Therapies for working with highly traumatised and chaotic families (66%).
2. Professional training in working with young people at risk of suicide (59%).
3. Trauma-informed care (47%).
4. Additional training in conducting risk assessments (44%).
5. Aboriginal and Torres Strait Islander cultural competence (41%).

The five most commonly identified training professional respondents felt would be beneficial for their organisation were:

1. Therapies for working with highly traumatised and chaotic families (70%).
2. Professional training in working with young people at risk of suicide (59%).
3. Trauma-informed care and suicide prevention training (57%).
4. Additional training in conducting risk assessments (53%).
5. Aboriginal and Torres Strait Islander cultural competence and LGBTIQ+ knowledge and competence (42%).

LGBTIQ+ training

LGBTIQ+ young people experience higher levels of anxiety, depression and suicidal ideation than their peers, but there is a lack of evidence for effective suicide prevention for this group of young people [50, 59, 60]. In an Australian study, approximately 23% of LGBTIQ+ young people perceived that health professionals are homophobic, support heterosexuality, lack knowledge and misunderstand this specific population [61]. Thus, mental health professionals require better understanding of LGBTIQ+ young people and the unique issues they face.

More than a third of professionals reported that they would find additional LGBTIQ+ training beneficial to increase their knowledge and competence when working with this population. Over 40% thought their organisation required additional LGBTIQ+ knowledge and competence training.

Aboriginal and Torres Strait Islander cultural competence

Aboriginal young people are less likely to access mental health services, often present in crisis and engage with services for shorter periods of time [62]. Systemic change is required if mainstream youth mental health services are to be relevant and culturally secure for Aboriginal young people [63]. According to the Building Bridges project (WA), engagement with young people in youth mental health services must be expanded to meet the preferences and specific needs of Aboriginal and Torres Strait Islander young people. This will involve mental health organisations partnering with communities, Elders and young people to design, develop and deliver safe, secure and appropriate service responses.



There are few services that really offer a culturally informed model that is embedded in Aboriginal and Torres Strait Islander cultural understanding and practice. (Nurse)

A culturally safe and competent workforce is likely to assist with reducing the number of suicides of young Aboriginal people. There is certainly a need for more Aboriginal mental health services and Aboriginal mental health professionals, in particular Aboriginal psychologists skilled in Indigenous-specific mental health and suicide prevention and intervention programs, but it will take time to develop the number of practitioners required to meet current service need.

Considering this, it is vitally important that non-Aboriginal mental health professionals have the cultural competence and the ability to engage with Aboriginal young people, develop trust, build rapport and deliver psychological interventions that are culturally consistent with Aboriginal worldviews [64]. A culturally aware and safe non-Aboriginal workforce is essential for those who prefer not to attend an Aboriginal service, given some Aboriginal adolescents may experience discomfort at seeking help from Aboriginal health services because of confidentiality concerns and shame [65]. This was reflected in the comments by some Aboriginal young people in the focus groups.



I don't trust Aboriginal services. People talk. They go home to their families and they say things and, you know, that's used against you on social media. (young person)



So I don't go to no Aboriginal services, I go to non-Aboriginal services cause I feel more safe with people I don't even know, that's not my own kind or culture or whatever. (young person)

These experiences demonstrate the importance of having a range of culturally safe and responsive Aboriginal and non-Aboriginal services available for young people which are reflective of their service preference. More than 40% of professionals identified that training in Aboriginal and Torres Strait Islander cultural competence would be personally useful and 42% thought that their organisation would find Aboriginal and Torres Strait Islander cultural competence training useful.



I started counselling when I was like 14 with Anglicare and I had an old lady, she was like, understood a lot and yeah actually she knew a lot about my culture and stuff, so I felt comfortable with her you know. There are some people that can like know and have experienced with Aboriginal people and I know a lot about it that aren't actually Aboriginal, you know, so – yeah.

Coordinated and integrated suicide prevention

Suicide prevention requires a comprehensive strategy that includes, a universal approach (i.e., delivering to the whole population), selective approaches (i.e., cohorts who are considered to be at greater risk of suicide) and indicated responses (i.e., provided to individuals who display suicidal behaviours). Effective youth suicide prevention will require a whole of government approach, including (but not limited to) those departments that are responsible for mental health, health, education, justice, disability, child protection, housing, regional development and multicultural affairs to address youth suicide prevention as a whole of government strategy. Suicide prevention will also require non-government agencies who may be responsible for delivering suicide prevention strategies collaborating with both government and non-government agencies and addressing the social determinants and life experiences of young people which contribute towards the risk of suicide in young people.

A comprehensive and coordinated model and planning for services is required for WA, based on population size and demand, to ensure the provision of services where there is a need and to prevent the duplication of services. This project sought to identify the range of suicide prevention activities and services that were available to support young people, however there were challenges in collating this information, due there not being a single directory of service provision in the suicide prevention space. The project investigation did uncover, however, that current service provision is ad hoc and is not necessarily based where there is need, or in areas where there have been high numbers of youth suicide.

To assist with ensuring that youth mental health services and suicide prevention strategies are being delivered to those areas in need, service providers require access to suicide related data in a timely manner. One of the aims of this project was to collate and make comment on the data regarding youth suicide, however there were challenges in being able to obtain and make use of this data publicly, or draw meaningful interpretations from it. Data that was available provided no understanding to the increasing number of youth suicides in WA, apart from those in the Ombudsman report and the Coroner's report. However, this data rarely included a young person over the age of 17 years. Due to small numbers and the fact that youth suicide is statistically a rare event, other available data (such as police, paramedic and ambulance responses to suicide related behaviour, ED presentation for suicide related behaviour, the Department of Justice and Communities) should be consistently reported and made available to facilitate service provision and additional support.

Suicide prevention needs to be evaluated and the development of an evaluation framework linked to clear outcome measures, rather than service outcomes for government and non-government organisations who receive suicide prevention funding through the State is required.

For young people, there is an opportunity to establish a coordinating function that helps bring together the emergency departments, mental health organisations, first-responders, schools, and other state-funded clinical care providers in a community to support young people overcome suicide. Prioritising the enhancement of communication channels between key stakeholders is required in responding to serious mental health concerns to ensure an integrated care coordination approach occurs across all government settings.

The Central Australian Aboriginal Congress provided this recommendation for Aboriginal and Torres Strait Islander young people:



Strengthening community-led initiatives to reduce the rates of suicide requires recognising the impact of colonisation, intergenerational trauma and loss of control. This includes supporting community control of Aboriginal services and programs, connection to family, community, country, language and culture and support for trauma-informed services, healing programs, culturally secure SEWB programs and, where appropriate, Aboriginal families living on country.

To assist with ensuring that youth mental health services and suicide prevention strategies are being delivered to those areas in need, service providers require access to suicide related data in a timely manner.



Conclusion

This report provides a comprehensive overview of youth suicide prevention in WA as it currently stands. The aim of this report was to provide recommendations that would be beneficial for informing a youth suicide prevention framework for WA. The impetus for this report was the continuously increasing number of youth deaths by suicide in the state, despite significant investment in suicide prevention. It was imperative that youth were consulted to ensure their voice is heard as the State moves forward in tackling this issue.

Both young people and professionals cited areas that need improvement. Specifically, extra training and support are required at schools and emergency departments (ED). Shame/stigma, affordability, accessibility, waitlists and intake criteria were all identified as barriers to effective youth suicide prevention; these require substantial improvement across all services. Overall, key areas identified for reducing youth suicide were prevention, intervention and co-ordination of services. Increased mental health awareness and suicide prevention training for the community, improving ED responses and provision of alternatives to ED are all essential to reducing numbers of young people experiencing suicidality.

It is hoped the results and recommendations contained in this report will be used to guide a comprehensive youth suicide prevention plan for WA. The primary message that was present across focus groups and professional responses was that suicide prevention should be the responsibility of the whole community, not just specific individuals or organisations. As identified through multiple quotes and statements, there is no way to know if or when a member of the community may need to intervene for someone experiencing suicidality, therefore improving the capacity of the whole community to respond is crucial to suicide prevention.

References



1. Australian Bureau of Statistics. *Causes of Death, Australia*. 2018 [cited 2019 12/2/2019]; Available from: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3>.
2. McHugh, C., et al., *Increasing Indigenous self-harm and suicide in the Kimberley: an audit of the 2005-2014 data*. Medical Journal of Australia, 2016. 205(1): p. 11.
3. Purdie, N., P. Dudgeon, and R. Walker, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. 2014, Commonwealth of Australia: Canberra.
4. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project, *Fact Sheet 3: Suicide prevention for Aboriginal and Torres Strait Islander young people*, U.o.W. Australia, Editor. 2015, ATSISEEP.
5. Coroner's Court of Western Australia, *Inquest into the deaths of: Thirteen children and young people in the Kimberley region, Western Australia*. 2019, Coroner's Court Western Australia: Perth.
6. Nock, M.K., et al., *Prevalence, Correlates, and Treatment of Lifetime Suicidal Behavior Among Adolescents: Results From the National Comorbidity Survey Replication Adolescent Supplement*. Lifetime Suicidal Behavior Among Adolescents. JAMA Psychiatry, 2013. 70(3): p. 300-310.
7. Shain, B., *Suicide and Suicide Attempts in Adolescents*. Pediatrics, 2016. 138(1): p. e20161420.
8. Robinson, J., et al., *Raising the bar for youth suicide prevention*. 2016: Melbourne.
9. Kessler, R.C., et al., *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication*. Arch Gen Psychiatry, 2005. 62(6): p. 593-602.
10. McGorry, P., et al., *Age of onset and timing of treatment for mental and substance use disorders: implications for preventive intervention strategies and models of care*. Current Opinion in Psychiatry, 2011. 24(4): p. 301-306.
11. Sustainable Health Review, *Sustainable Health Review: Final Report to the Western Australian Government*. 2019, Department of Health, Western Australia: Perth.
12. Commissioner for Children and Young People, *Our Children Can't Wait – Review of the implementation of recommendations of the 2011 Report of the Inquiry into the mental health and wellbeing of children and young people in WA*. 2015, Commissioner for Children and Young People: Perth.
13. Mascie-Taylor, H. and J. Hoddinott, *Review of Safety and Quality in the WA health system – a strategy for continuous improvement*. 2017, Department of Health WA: Perth.
14. Caelear, A., et al., *A systematic review of psychosocial suicide prevention interventions for youth*. European Child & Adolescent Psychiatry, 2016. 25(5): p. 467-482.
15. Slade, T., et al., *The mental health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing*. 2009, Department of Health and Ageing: Canberra.
16. Michail, M., L. Tait, and D. Churchill, *General practitioners' clinical expertise in managing suicidal young people: implications for continued education*. Primary Health Care Research and Development, 2017. 18(5): p. 419-428.
17. King, K.A., et al., *High School Health Teachers' Perceived Self-Efficacy in Identifying Students at Risk for Suicide*. Journal of school health, 2009. 69(5): p. 202-207.
18. Carlisle, E., et al., *Youth Survey Report 2018*. 2018, Mission Australia.
19. Hooven, C., *Parents-care: A suicide prevention program for parents of at-risk youth*. Journal of Child and Adolescent Psychiatric Nursing, 2013. 26(1): p. 85-95.
20. Torok, M., et al., *Preventing adolescent suicide: A systematic review of the effectiveness and change mechanisms of suicide prevention gatekeeping training programs for teachers and parents*. Journal of Adolescence, 2019. 73: p. 100-112.
21. Ivancic, L., et al., *Youth Mental Health Report, June 2014*. 2014: Sydney.
22. de Girolamo, G., et al., *Age of onset of mental disorders and use of mental health services: needs, opportunities and obstacles*. Epidemiology and psychiatric sciences, 2012. 21(1): p. 47.
23. an Dyke, N., et al., *Young People's Experiences with Health Services – Final Report*. 2014: Perth, WA.
24. Commissioner for Children and Young People, *Report of the Inquiry into the mental health and wellbeing of children and young people in Western Australia*. 2011: Perth, WA.

25. Darbyshire, P., et al., *Engagement with health and social care services: perceptions of homeless young people with mental health problems*. Health Soc Care Community, 2006. 14(6): p. 553-62.
26. French, R., M. Reardon, and P. Smith, *Engaging with a Mental Health Service: Perspectives of At-Risk Youth*. Child and Adolescent Social Work Journal, 2003. 20(6): p. 529-548.
27. Brown, A., et al., *Systematic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people*. Asia-Pacific Psychiatry, 2016. 8(1): p. 3-22.
28. Colucci, E., et al., *In or out? Barriers and facilitators to refugee-background young people accessing mental health services*. Transcultural Psychiatry, 2015. 52(6): p. 766-790.
29. Aboriginal Mental Health First Aid Training and Research Program, *Cultural Considerations and Communication Techniques: Guidelines for Providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person*. 2008, Mental Health First Aid Australia and beyond blue: Melbourne.
30. South Australia Health, *Aboriginal Mental Health Clinical Practice Guideline and Pathways – A culturally appropriate guide for working with Aboriginal mental health consumers*. 2017: Adelaide.
31. Green, C., *Geraldton Streetwork Aboriginal Corporation, On Country Yarning Circles Snapshot*. 2018: Geraldton.
32. yourtown, *Kids Helpline Insights 2018 Statistical Summary Western Australia*. 2019: Brisbane.
33. yourtown, *Kids Helpline Insights 2017 Statistical Summary and Research ACT*. 2018: Brisbane.
34. Australian College of Emergency Medicine, *Quality standards for emergency departments and other hospital-based emergency care services*. 2015, ACEM: Melbourne.
35. Australian Institute of Health and Welfare. *Mental health services in Australia 2018*. 2018 05 December 2018 [cited 2019 22 May 2019]; Available from: <https://www.aihw.gov.au/reports/mental-health-services/mental-healthservices-in-australia/report-contents/hospitalemergency-services/patient-characteristics>.
36. Cooper, J., et al., “Well it’s like someone at the other end cares about you.” a qualitative study exploring the views of users and providers of care of contact-based interventions following self-harm. Gen Hosp Psychiatry, 2011. 33.
37. Shand, F.L., et al., *Experience of health care services after a suicide attempt: results from an online survey*. Suicide Life Threat Behav, 2018. 48(6): p. 779-787.
38. Hunter, C., et al., *Service user perspectives on psychosocial assessment following self-harm and its impact on further help-seeking: a qualitative study*. J Affect Disord, 2013. 145.
39. Taylor, T.L., et al., *Attitudes towards clinical services among people who self-harm: systematic review*. Br J Psychiatry, 2009. 194.
40. Ellis, J., *Training Needs for the Youth Mental Health Workforce in WA*. 2017.
41. Dragovic, M., A. Piscitelli, and A. Donnellan, *Planning for Youth Mental Health Services Mental Health Attendances at Hospital Emergency Departments 2013/2014 and 2014/2015*, N.M.H. Service, Editor. 2017, Mental Health Public Health and Ambulatory Care: Perth.
42. SANE. *Lessons for life: New research finds Australians who have attempted suicide find it difficult to access the professional help they need to recover*. 2014 [cited 2019 13/5/2019]; Available from: https://www.sane.org/images/Media_Release_2014/10_December_2014_lessons_for_life2.pdf.
43. Mental Health Commission. *Suicide Prevention 2020 (Together we can save lives)*. 2015; Available from: <https://www.mhc.wa.gov.au/media/1220/suicide-prevention-2020-strategy-final.pdf>.
44. World Health Organization. *Preventing Suicide: A global imperative*. 2014.
45. McGorry, P., T. Bates, and M. Birchwood, *Designing youth mental health services for the 21st century: examples from Australia, Ireland and the UK*. British Journal of Psychiatry, 2013. 202(s54): p. s30-s35.
46. Health, W.A.D.o., *WA Youth Health Policy 2018-2023*, W.A.D.o. Health, Editor. 2018, Health Networks: Perth.
47. Reibel, T. and T. Jackiewicz, *An evaluation of the accessibility and acceptability of the Innovative Health Services for Homeless Youth (IHSY) Program in the Perth metropolitan area*. 2011, Child and Adolescent Community Health and the Telethon Institute for Child Health Research.: Perth.
48. Hawton, K., et al., *Psychosocial interventions following self-harm in adults: a systematic review and meta-analysis*. Lancet Psychiatry, 2016. 3.

49. Robinson, J. and J. Pirkis, *Research priorities in suicide prevention: An examination of Australian-based research 2007–11*. Australian Health Review, 2014. 38(1): p. 18-24.
50. Robinson, J., et al., *What Works in Youth Suicide Prevention? A Systematic Review and Meta-Analysis*. EClinicalMedicine, 2018. 4: p. 52-91.
51. Lee, S., et al., *Differences by age and sex in adolescent suicide*. Australian and New Zealand Journal of Public Health, 2019. 0(0).
52. Robinson, J., et al., *Does Screening High School Students for Psychological Distress, Deliberate Self-Harm, or Suicidal Ideation Cause Distress — And Is It Acceptable? An Australian-Based Study*. Crisis: The Journal of Crisis Intervention and Suicide Prevention, 2011. 32(5): p. 254-263.
53. Robinson, J., et al., *A Systematic Review of School-Based Interventions Aimed at Preventing, Treating, and Responding to Suicide- Related Behavior in Young People*. Crisis, 2013. 34(3): p. 164-182.
54. LivingWorks. *safeTALK*. 2016 [cited 2019 March 30th 2019]; Available from: <http://www.livingworks.com.au/programs/safetalk/>.
55. Robinson, J., et al., *Universal Suicide Prevention in Young People: An Evaluation of the safeTALK Program in Australian High Schools*. Crisis: The Journal of Crisis Intervention and Suicide Prevention, 2017. 38(5): p. 303-308.
56. Mo, P.K.H., T.T. Ko, and M.Q. Xin, *School-based gatekeeper training programmes in enhancing gatekeepers' cognitions and behaviours for adolescent suicide prevention: a systematic review*. Child and Adolescent Psychiatry and Mental Health, 2018. 12(1): p. 29.
57. Victoria State Government. *Suicide prevention in Victoria*. 2018; Available from: <https://www2.health.vic.gov.au/mental-health/prevention-and-promotion/suicide-prevention-in-victoria>.
58. National Health Service. *Safe Haven Cafe in Aldershot*. [cited 2019; Available from: <https://www.england.nhs.uk/mental-health/case-studies/aldershot/>].
59. Leonard, W., A. Lyons, and E. Bariola, *A Closer Look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians*. 2015, The Australian Research Centre in Sex, Health and Society: Melbourne.
60. Rosenstreich, G., *LGBTI People Mental Health and Suicide*. Revised 2nd Edition. 2013: Sydney.
61. Hillier, L., et al., *Writing Themselves In 3: The Third National Study on the Sexual Health and Wellbeing of Same-sex Attracted and Gender Questioning Young People*. 2010, Australian Research Centre in Sex, Health and Society: Melbourne.
62. Westerman, T., *Engaging Australian Aboriginal youth in mental health services*. Australian Psychologist, 2010. 45(3): p. 212-222.
63. Wright, M., et al., *"If you don't speak from the heart, the young mob aren't going to listen at all": An invitation for youth mental health services to engage with new ways of working*. Early Intervention in Psychiatry, 2019: p. 1-7.
64. Ralph, S. and K. Ryan, *Addressing the Mental Health Gap in Working with Indigenous Youth: Some Considerations for Non-Indigenous Psychologists Working with Indigenous Youth*. Australian Psychologist, 2017. 52(4): p. 288-298.
65. Mohajer, N., D. Bessarab, and J.R.a.R.H.A.w.r.o.a.j.a. Earnest, *There should be more help out here! A qualitative study of the needs of Aboriginal adolescents in rural Australia*. Rural and Remote Health 2009; 9: 1137. Available: www.rrh.org.au/journal/article/1137 Rural and Remote Health, 2009. 9(2).



Appendix

Appendix one: Focus group discussions

Young people aged 16 to 25 years who had experience with a mental health service, had participated in suicide prevention activities or who had an interest in youth mental health and/or suicide prevention were invited to participate in a focus group discussion (referred to as focus groups throughout). The aim of the focus groups was to explore young people's experiences of organisations that are providing support for suicidal behaviour and mental health, challenges young people face in seeking help, what works well in youth suicide prevention and mental health and ideas to improve youth suicide prevention in WA.

Recruitment for the focus groups was promoted through the project partners, word of mouth and social media. Young people who were engaged with crisis accommodation, transitional supported accommodation, drug and alcohol treatment services, alcohol and other drug detoxification and withdrawal youth centres, a LGBTQI+ support agency, headspace youth reference groups and a youth advocate organisation participated in the project. Eleven focus groups were conducted in the Perth metropolitan area (N=9) and Albany in the Great Southern region (N=2).

Young people provided written consent to participate in the focus groups and were also required to complete a 'Wellness Plan' which enabled the facilitators to ensure the conversation was conducted safely and that potentially triggering conversations avoided.

The focus groups had between two and eight participants and lasted between 45 and 90 minutes. Each focus group was supported by two facilitators (including a provisional psychologist), and a staff member of the host organisation.

The focus groups were audio-recorded and transcribed verbatim, and the data analysed using NVivo 11 Plus. Barriers and enablers for young people accessing support for their mental health concerns and suicide prevention were the main themes. Individuals life circumstances were de-identified and therefore the views, experiences and perceptions of specific populations (i.e. Aboriginal, LGBTQI+, homeless youth) cannot be presented in this report; rather we report the views of young people more generally.

Demographics of young people participating in the focus group discussions

The focus groups were supported by the Youth Affairs Council of Western Australia (YACWA), the Freedom Centre, headspace Albany, headspace Joondalup and Youth Focus, Mission Australia, Ebenezer Aboriginal Organisation and the Albany Youth Support Association (AYSA). Fifty five young people participated in the focus groups and 53 completed a de-identified demographics and experiences questionnaire.

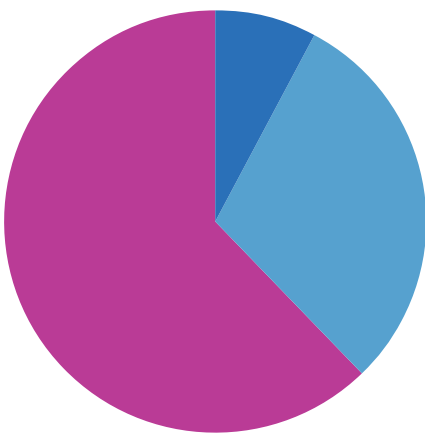
The demographics details of focus group participants:

GENDER

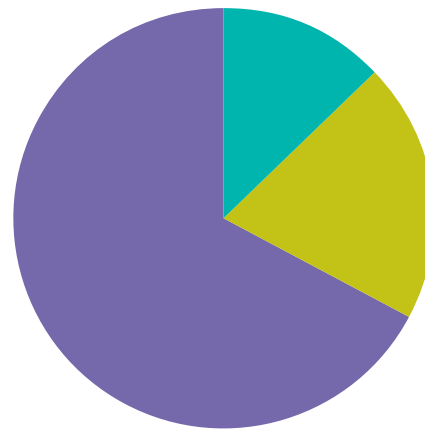
8%	(4) Non-identifying
30%	(16) Males
62%	(33) Female

ETHNICITY (missing 2)

13%	(7) Aboriginal
20%	(10) Born in another country
67%	(34) Born in Australian



- Non-identifying
- Male
- Female



- Aboriginal
- Born in another country
- Born in Australia

AGE

Average age:	19.5 years
Min age:	16 years
Max age:	25 years

LGBTIQ+

32% identified as LGBTIQ+

REFUGEE/MIGRANT/CALD

15% (N=8) of the young people identified as being a migrant or refugee or from a Cultural and Language Diverse Community, 25% (N=2) of those identifying as experiencing refugee status. Four percent of all the participants had experience of a refugee status.

YOUNG PERSON WITH A DISABILITY

13% (N=7) of the young people identified having a disability.

HOMELESSNESS

42% (N=22) of young people had an experience of homelessness.

YOUTH JUSTICE SYSTEMS/POLICE

36% (N=19) of young people had engagement with either youth justice systems or WA Police.

OUT OF HOME CARE/ CHILD PROTECTION SERVICES

25% (N=13) of the young people had experience with the Department of Communities (formally known as the Department for Child Protection and Family Support). This may have included either a direct experience of being in out of home care (OOHC) or interaction and involvement with the Department of Communities as an individual or through their family, but not formally placed in OOHC. The figures presented may be under-represented as the term OOHC was used by the facilitators in the focus group; some young people were unfamiliar with this term (despite having experienced OOHC) and used the terminology 'DCP' (Department for Child Protection).

IS THE CHILD OF A PARENT WITH A MENTAL ILLNESS?

49% (N=26) of the young people reported that their parent had a mental illness.

HAVE YOU EVER EXPERIENCED SUICIDAL THOUGHTS?

77% (N=41) of the young people reported that they had experienced suicidal thoughts.

HAVE YOU EVER MADE A SUICIDE ATTEMPT/S?

45% (N=24) of the young people reported that they had made a suicide attempt.

59% of young people who had experienced suicide ideation had made at least one suicide attempt.

Appendix two: Survey for youth mental health professionals

Professionals with experience in youth mental health and/or suicide prevention were invited to participate in an online survey between October 2018 and January 2019. The aim of the survey was to better understand how youth suicide prevention in WA could be improved, and what additional efforts are required for suicide prevention for marginalised young people in WA.

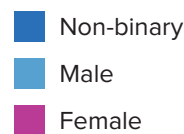
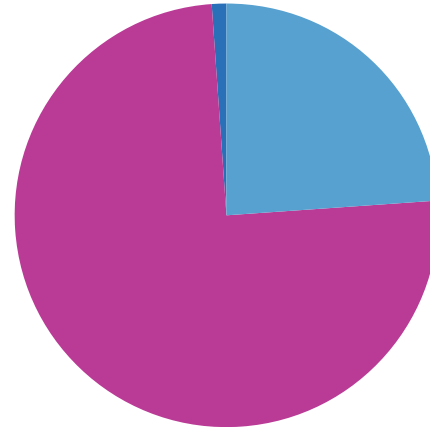
The survey comprised questions on: demographics, professional experience in youth mental health (including their participation in the delivery of suicide prevention), involvement in training and the suicide prevention programs, and strategies or frameworks that they have implemented. The survey included open-ended questions asking what improvements are required for youth suicide prevention in WA and how young, marginalised people could be better supported to reduce suicide risk.

The survey was promoted through the networks of project partners and social media. Participation in this research was voluntary and commencing the survey was considered evidence of consent to participate in the project. The survey took less than 30 minutes to complete.

Professional survey participants (192) demographics and experience (% may not total to 100 due to rounding)

GENDER (missing 8)

Gender	(n)	(%)
Male	44	24%
Female	138	75%
Non-binary	2	1%



AGE (missing 10)

Average age	41 years
Maximum	74 years
Minimum	19 years

GEOGRAPHICAL LOCATION (missing 9)

Location	(n)	(%)
Metropolitan area	137	75%
Rest of WA	46	25%

PROFESSION (missing 4)

Profession	n	%
Teacher	3	1.6
First Responder	3	1.6
Psychiatrist	4	2.1
Community Health Worker	4	2.1
Counsellor	9	4.8
Psychologist	24	12.8
Nurse	28	14.9
Social Worker	32	17
Youth Worker	34	18.1
Other	47	25
Total	188	100

MOST COMMON 'OTHER' PROFESSIONS (in order)

Occupational Therapists

Suicide Prevention Coordinators

Health Promotion Officers

Case mangers

Community Engagement Officers

MODE OF SERVICE DELIVERY?

(more than one response)

Type of service	n	%
Face to Face	177	96.2
Online	24	13
Phone	58	31.5
Text	29	15.8
Other	13	7.1

ARE YOUTH MENTAL HEALTH AND SUICIDE PREVENTION ADDRESSED SEPARATELY FROM EACH OTHER IN YOUR PLACE OF EMPLOYMENT?

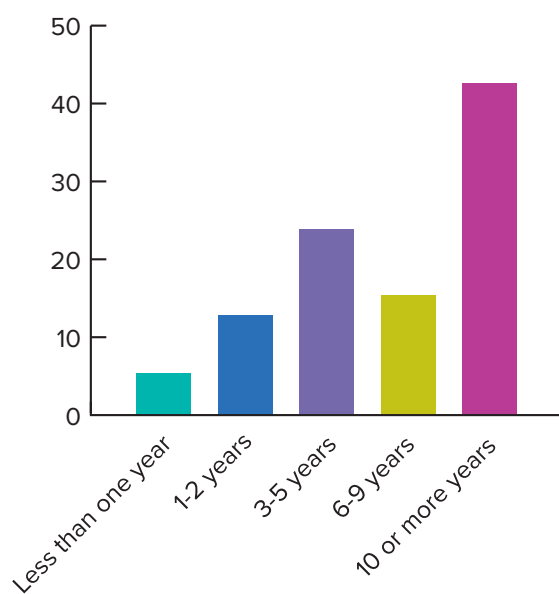
	n	%
Yes	53	31
No	107	63
Not applicable	10	6

ENGAGED DIRECTLY WITH YOUNG PEOPLE WHO HAVE SUICIDAL IDEATION OR WHO HAVE ATTEMPTED SUICIDE?

	n	%
Yes	139	82
No	24	14
Not applicable	7	

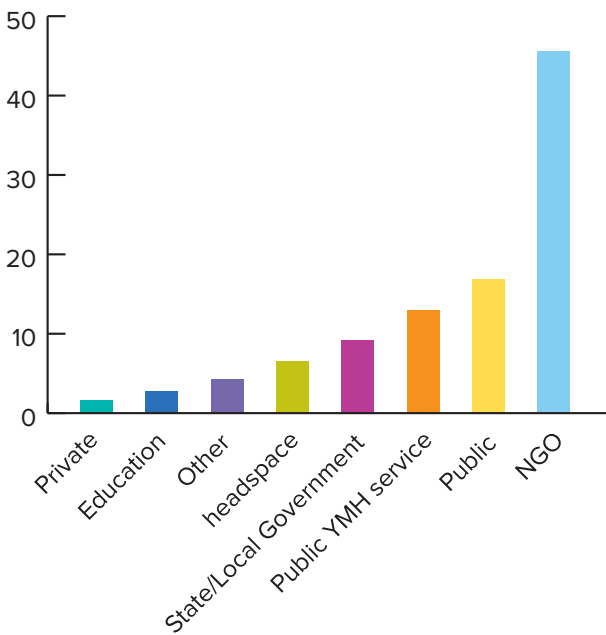
NUMBER OF YEARS WORKING IN MENTAL HEALTH AND/OR SUICIDE PREVENTION (missing 4)

Number of years	(n)	%
Less than one year	10	5.3
1 – 2 years	24	12.8
3-5 years	45	23.9
6-9 years	29	15.4
10 or more years	80	42.6
Total	188	100



WHAT BEST DESCRIBES YOUR CURRENT PLACE OF EMPLOYMENT? (missing 8)

Place Employment	n	%
Private	3	1.6
Education	5	2.7
Other	8	4.3
headspace	12	6.5
State/Local Government	17	9.2
Public YMH service	24	13
Public	31	16.8
NGO	84	45.6
Total	184	99.7



ARE YOUNG PEOPLE WITH STRONG SUICIDAL THOUGHTS MANAGED OR REFERRED TO A DIFFERENT SERVICE? (n=139) (able to answer more than one response therefore more than 100%)

Managed	(102, 73.4%),
Referred	(70, 50.4%)

WHERE ARE YOUNG PEOPLE WITH STRONG SUICIDAL THOUGHTS AND BEHAVIOURS REFERRED TO? (68 responses and multiple answers)

Organisation	Number
Hospital/Emergency Department	28
CAMHS	27
headspace	13
Youth Link	7
MHERL	7
Community Mental health Service	7
Youth focus	5
GP	4
Lifeline	3
Youth Reach	3
University/Student Services	3
Ambulance	2
Suicide call Back Service	2
Friends/Family	2
Qlife	1

Three open text questions were asked in the survey.

1. In the community, who do you think should be receiving suicide prevention training?
2. How can youth suicide prevention be improved in Western Australia?
3. How can marginalised young people be better supported?

The responses to the above three questions were thematically analysed using the data management tool NVivo 11 Plus. These responses have been incorporated into the report where appropriate and are referred to as ‘professionals’ throughout.



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