CHIEF PSYCHIATRIST
of Western Australia

Targeted Review

Chief Psychiatrist's Review into the Treatment of Ms Kate Savage by Child and Adolescent Mental Health Services

December 2020

Reviewers

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Acknowledgements

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We wish to thank Dr Aresh Anwar, Chief Executive of Child and Adolescent Health Service for his support.

We would like to thank Tania Rado and Maria Ferreira, the convenors of Perth Families with Children with Mental Health Issues for their assistance in conducting a survey of their members.

We also acknowledge the contribution of CAMHS and CAHS clinicians in sharing their knowledge and expertise.

Recommended citation

Office of the Chief Psychiatrist (2020). *Chief Psychiatrist's Targeted Review into the treatment of Ms Kate Savage by Child and Adolescent Mental Health Services.* Perth, WA: OCP.

The Reviewers would like to dedicate this report to Meron and Larry Savage and to the memory of their daughter Kate.

They have shown great courage and compassion in sharing the story of the tragic loss of Kate to shine a light on the systemic gaps in mental health services for children and young people. Their expectation in sharing their experience is that other parents will be spared the pain of losing a child.

CHIEF PSYCHIATRIST
of Western Australia

The Hon Roger Cook MLA
Deputy Premier of Western Australia; Minister for Health; Mental Health

Dear Minister

In the context of your request under s517 *Mental Health Act 2014*, I herewith provide the report of the *Chief Psychiatrist's Targeted Review into the treatment of Ms Kate Savage by Child and Adolescent Mental Health Services (the "Review")*. A government approach in response to this *Review* must consider the implementation of the full range of Recommendations, as any single Recommendation will not in and of itself remedy the significant challenges facing Child and Adolescent Mental Health Service (CAMHS) development, nor give due deference to learnings about deficits which contributed to Ms Kate Savage's death.

Given the complexity and importance of the issues explored in this *Review* to families across Western Australia, it is critical for CAMHS to be reviewed in significantly greater detail, as described in the enclosed Recommendations, beyond the scope of this time-limited *Review*. This will be essential to guide the stages of the process to rebuild CAMHS. I trust this will be of assistance to the development of services.

Yours sincerely

Dr Nathan Gibson
Chief Psychiatrist of Western Australia

10 December 2020

Contents

Message from the Chief Psychiatrist	6
Recommendations	7
1. Introduction	10
2. The treatment and care of Ms Kate Savage by CAMHS	14
3. A system under pressure	22
4. Findings on the adequacy of the current CAMHS system to respond to children, young people and their families	36
5. Rebuilding CAMHS	43
Appendix 1. Terms of reference	50
Appendix 2. Acronyms and abbreviations	53
Appendix 3. List of figures and tables	54
Appendix 4. Summary of treatment for Ms Kate Savage (Confidential – not for public release)	55

Message from the Chief Psychiatrist

The death of any child is appalling. The death of Kate Savage at the young age of 13 is not just a tragedy: it cannot be rationalised for her family or for any of us in the broader community.

The general public will find the death of such a young person hard to imagine or digest. Equally, most people find it difficult to imagine that very young people may have a mental illness, and yet half of all mental health conditions start by 14 years of age.

In Kate's case, her mental illness did not start at the age of 13. She had serious mental health issues beginning earlier in her life. While the primary focus of this Review is to consider Kate's treatment, it is clear there are significant system barriers preventing clinical staff from providing the level and timeliness of care they would seek to give. This Review sought to find, and publicise, critically important learnings to make our imperfect system better.

What is clear from this Review is that there has been a significant escalation of serious mental health issues for children, particularly in the number of young people who are self-harming. The investment in Child and Adolescent Mental Health Services (CAMHS) has, unfortunately, not kept pace with community need. Due to severe service pressure and the heightened focus on the older youth sector, CAMHS has largely morphed into a service for high-risk, often older adolescents. Yet, there remains long waitlists for adolescents and their families seeking to access specialised mental health treatment.

As a result, the critically important work of providing specialist mental health treatment for children under 12 years of age has been significantly diminished over the past decade. Specialist mental health treatment for this younger group is currently only available for the most severely unwell, and then often for only limited periods. This is despite the evidence that treatment for children earlier in life reduces serious mental health problems in adolescence.

I thank the Review team, whose examination of Kate's care was sensitive, consultative and in-depth, and whose commitment to capturing the critical broader issues within a limited time is evident in this Review.

What is clear is that the situation is now well-beyond a band-aid or temporary solution. While we need to begin with some immediate strategies, there is an urgent need to rebuild CAMHS as a whole-of-childhood service and restore public confidence. In the words of the WA Commissioner for Children and Young People, "Our children cannot wait."

Dr Nathan Gibson
Chief Psychiatrist of Western Australia

Recommendations

The treatment and care of Ms Kate Savage by Child and Adolescent Mental Health Services (CAMHS)

Recommendation 1

What the reviewers heard, not only from Kate's parents but also from other families, is that families do not always feel that they have a voice in the treatment and management of their children. This was particularly noted by families in relation to Perth Children's Hospital (PCH), although people also commented, in relation to the 'Choice and Partnership Approach' (CAPA) used by CAMHS, that they felt the power and control rested firmly with the staff. This recommendation is designed to enhance the relationship between families and staff.

It is recommended that funded positions for family peer workers be established; initially at PCH, but to be extended to all CAMHS services.

Recommendation 2

Parents feel that when there is a significant difference of opinion with regard to the treatment and management of their child, there needs to be some formal mechanism for reconciling this difference. Although at PCH parents have access to the Mental Health Advocacy Service, they feel that there needs to be a capacity for an independent review of their child's diagnosis, treatment and management.

It is recommended that a formal structure be established for independent review of the diagnosis and treatment in children and young people with complex problems where there is an unresolved difference of opinion between clinicians, families or other relevant agencies.

Recommendation 3

The current guidelines for the management of Emotionally Unstable Personality Disorder (EUPD) were developed for older adolescents/adults. This raises the question of whether they can simply be adopted for the management of young adolescents like Kate. This is particularly relevant given that children and young people are presenting with self-harm/suicidal ideation at a progressively earlier age.

It is recommended that consideration be given to a WA review of the application of the current guidelines for the management of Emotionally Unstable Personality Disorder in early adolescents; and that this review be undertaken in partnership with families.

Closing the critical service gaps in CAMHS

Recommendation 4

Establish Community Intensive Treatment Services (CITS)

It is recommended that three multidisciplinary Community Intensive Treatment Services (CITS), operating in each of the northern, eastern and southern metropolitan areas of Perth, be established to ensure that young people with complex mental health needs can receive appropriate, timely care in the community. The aim is to reduce ED presentations and inpatient admissions, as well as to facilitate more intensive community care to assist the timely and safe transition of children from hospital. The CITS will:

- operate 7 days a week over extended hours to deliver mental health care into a range of settings, including the young person's home and school; and
- function within the Community CAMHS Directorate.

Recommendation 5

Establish a CAMHS Emergency Service at PCH

It is recommended that a multidisciplinary CAMHS Emergency Service be established at PCH to provide two distinct, but complementary services:

- A Multidisciplinary Mental Health Team operating 24/7 to provide direct and timely access to specialist mental assessment and treatment for children and young people presenting to ED. In doing so, consideration should be given to reconfiguring the ED to establish a more appropriate physical environment where care can be delivered by the ED Mental Team.
- An enhanced CAMHS Emergency Telehealth Service to provide:
  - Support, assessment and crisis intervention for young people and their families during a mental health crisis as an alternative to presenting to PCH ED or other metropolitan EDs.
  - Specialist emergency mental health consultation for metropolitan EDs and health professionals in the community including GPs, school psychologists, school nurses.
  - Follow-up contact with families within 24 hours of receiving a mental health assessment in the PCH ED and within 48 hours of a young person being discharged from the PCH mental health inpatient unit.

Recommendation 6

Immediate uplift to Community CAMHS clinical workforce

It is recommended that the clinical workforce in Community CAMHS is expanded as a matter of urgency to respond to the growth in demand, reduce waiting times and address the need for extended hours of operation.

Rebuilding CAMHS: The way forward

Recommendation 7

Establish a *Child and Adolescent Mental Health Ministerial Taskforce to* rebuild CAMHS

It is recommended that a *Child and Adolescent Mental Health Ministerial Taskforce,* led by an independent chair, is appointed immediately. The Taskforce will actively engage clinicians, families and young people and other key stakeholders, in the design and rebuilding of the CAMHS system.

In rebuilding CAMHS, there is a need to harness the experience and knowledge of those who provide the services and those who use them to find local solutions that fit Western Australia's unique circumstances. Appointing a Western Australian to head up the Taskforce reinforces the message that this State has the capability to meet its own challenges and has the resolve to restore confidence in the sector.

The Taskforce will have two complementary tasks to be undertaken in parallel:

- Oversee the immediate staged implementation of the Review recommendations over the next 18 months.

  Recommendations 4, 5 and 6, which are designed to 'close the critical service gaps', need to be implemented in parallel. Given the interconnected nature of the CAMHS system and the limited availability of the highly specialised workforce, the implementation will need to be carefully planned and conducted in close partnership with CAMHS to avoid unintended consequences, such as staff moving to new services leaving the existing services potentially unworkable and unsafe.

- Develop a whole of system plan for Perth metropolitan and WA country specialist public child and adolescent mental health services and make recommendations to the Minister with actions aimed at achieving better mental health outcomes for children and young people, paying particular attention to the adequacy and equity of service provision across all age groups.

  The Taskforce will identify the investment which is required to implement the whole of system CAMHS plan for specialist treatment and care; develop an implementation strategy including a timeframe and responsibilities; and establish a mechanism to ensure that the reforms are achieving their intended outcomes.

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1. Introduction

1.1 Background

Ms Kate Savage was a 13 year old girl who tragically died on 23rd July 2020 while under the care of Child and Adolescent Mental Health Services.

On 6th August 2020, the Minister for Mental Health requested that the Chief Psychiatrist undertake an independent review into the treatment and care by public mental health services of Ms Savage in the period leading up to her death. Section 517 of the *Mental Health Act 2014* (MHA) enables the Minister to request that the Chief Psychiatrist report to the Minister on a particular matter.

The Chief Psychiatrist is responsible for overseeing the standards of treatment and care for patients of mental health services in Western Australia. The Chief Psychiatrist is empowered under Section 527 of the MHA to investigate notifiable incidents reported under Section 526, and Section 529 and provides powers to make any inquiries that are considered appropriate. Section 519 of the MHA also provides the Chief Psychiatrist with the power to do anything necessary or convenient to perform his function under the MHA.

The Chief Psychiatrist's Review process sits within a framework of safety, quality and learning with the aim of improving standards of care. The Chief Psychiatrist role does not preempt the role of the Western Australian Coroner, although the Coroner may consider the findings and recommendations of a Chief Psychiatrist's Review in any potential future coronial process.

Findings and recommendations from a Review requested under Section 517 of the MHA are provided to the Minister for Mental Health.

1.2 Purpose and scope of the Chief Psychiatrist's Review

The Review considered two main issues:

- Firstly, **Ms Savage's treatment and care across all settings** (inpatient, community and emergency department), the communication between services and the communication between services and her family. In considering Ms Savage's longitudinal treatment and care, relevant past medical records, as well as more recent records and information were reviewed.
- Secondly, **the adequacy of current services to respond to young people with complex needs and high-risk behaviour**, with recommendations to address any gaps in the services available to support them and their families.

While the Review was not tasked with considering child, adolescent and youth mental health

service provision in Western Australia beyond that described in the scope above, the Chief Psychiatrist retains the right to comment more broadly where such commentary may assist the Minister for Mental Health to improve the mental health of any individual and family using mental health services in Western Australia.

The findings of the Review will form part of the broader *Young People Priority Framework* already under development by the Western Australian Mental Health Commission (MHC), which will make recommendations for those aged 12 to 24 across both the public health system and non-government services. This Review comments beyond the *Young People Priority Framework*, to specifically address issues for younger age cohorts.

The Terms of Reference for the Review are detailed in Appendix 1.

1.3 Review process

The Review was conducted by:

- Clinical Associate Professor, Dr Geoffrey Smith, Office of the Chief Psychiatrist.
- Adjunct Associate Professor Theresa Williams, Office of the Chief Psychiatrist.
- Professor Helen Milroy, Stan Perron Professor of Child and Adolescent Psychiatry at the Perth Children's Hospital and the University of Western Australia.
- Dr Kyran Graham-Schmidt, Office of the Chief Psychiatrist.

The Review formally commenced on 20th August 2020. Within the time constraints, the Review aimed to provide opportunities for Ms Savage's parents, child and adolescent clinicians, families/carers, the Child and Adolescent Health Services (CAHS) Board/executive/management and key agencies to express their views.

1.3.1 Ms Savage's Treatment and Care

To examine the treatment and care provided to Ms Savage, the reviewers met with and communicated with Mr. and Mrs. Savage on multiple occasions. With their permission, the reviewers also spoke with relevant staff from two schools which Ms Savage had attended.

Face-to-face meetings were also held with clinicians at services where Ms Savage had been treated:

- Emergency Department, Perth Children's Hospital (PCH);
- PCH inpatient unit (Ward 5A), Child and Adolescent Mental Health Service (CAMHS); and
- Bentley Family Clinic (CAMHS community clinic).

Reviewers met with the Mental Health Advocacy Service as they had provided an advocacy service, at the request of Ms Savage's parents, while she was being treated at PCH. We also met with the Medical and Service Co-Directors of CAMHS, members of the CAHS Board, their Safety and Quality Sub-Committee and the Chief Executive of CAHS.

Ms Savage's medical records were provided by CAHS and were examined by the reviewers. In

addition, the reviewers examined policies, programs and other documentation relevant to her treatment and care.

1.3.2 The adequacy of current services to respond to young people with complex needs and high risk behaviour and gaps in services

Family views

An online survey was conducted of 54 families/carers of children with high-risk, complex mental health needs who have attempted to access or had received services from CAMHS. This was conducted during the Review by an on-line family/carer support group and provided to reviewers to gain a family/carer perspective on CAMHS services. An additional six submissions were received from families connected to the on-line support group.

The Mental Health Advocacy Service also provided the reviewers with 11 de-identified case studies of families receiving CAMHS services where they had provided advocacy.

Clinician views

The reviewers met with clinical services/teams who had provided treatment and care to Ms Savage. The reviewers met with and received a written submission from clinicians at the PCH ED. To gain the views of child and adolescent psychiatrists who work across CAMHS the reviewers met with the CAMHS Medical Advisory Committee. A workshop was conducted with CAMHS senior staff from across various services and professional disciplines to canvass their views on the adequacy of current services, service gaps and potential solutions.

The Faculty of Child and Adolescent Psychiatry, Royal Australian and New Zealand College of Psychiatrists (WA Branch) invited their members to provide individual input to the Review and a number of written submissions were received.

CAHS Board, Chief Executive and CAMHS leadership views

The reviewers met with the Chief Executive of CAHS and with representatives of the Board and their Safety and Quality Sub-Committee. The reviewers also engaged extensively with the CAMHS Medical Co-Director and Service Co-Director who provided the Review with relevant policies/business cases and other relevant information regarding CAMHS services.

Key agencies

The reviewers met with the following key agencies:

- The Commission for Children and Young People, to gain a greater understanding of the extensive work they have undertaken in relation to the mental health of children and young people, including their 2015 report *Our Children Can't Wait*;
- The Office of the Ombudsman, particularly to discuss the findings in their recently released report *Preventing Suicide by Children and Young People 2020*;
- The MHC in relation to the development of the *Young People Priority Framework*; and
- The Mental Health Advocacy Service (MHAS) to obtain their perspective as the agency which advocates for children, young people and their families who are receiving treatment and care from mental health services.

Submissions were not publicly requested as part of the Review process due to time constraints. However, a written submission was received from a not-for-profit agency which provides services to at risk, vulnerable young people including those with significant mental health conditions.

Literature scan, data, policies, program and other relevant documentation

The reviewers undertook a desktop analysis of relevant literature, reports and expert commentary relating to the treatment of young people with complex needs and high risk behaviour. The reviewers also examined data, policies and key documentation relating to CAMHS.

Queensland was identified as having a more comprehensive range of CAMHS services than WA. Based on this, the reviewers met by teleconference with the Acting Divisional Director, Child and Youth Health Services Queensland, to gain a greater understanding of their services.

2. The treatment and care of Ms Kate Savage by CAMHS

In reviewing the treatment of Ms Kate Savage by CAMHS, the reviewers had access to the case files detailing her history and treatment by Bentley Family Clinic and Perth Children's Hospital and met with staff in those services. A summary of her contact with and treatment by these services is contained in Appendix 4. This summary contains confidential information which will not be publicly released.

Kate was first referred to CAMHS by her GP in April 2015. Her initial contact with CAMHS was a telephone conversation with her mother by Bentley Family Clinic (BFC) in May 2015, following which Kate was referred for counselling with an external provider. After a follow up call by Bentley Family Clinical to see how Kate was progressing, the family was offered a 'Choice'[1] appointment in July 2015. The family were offered treatment commencing in September; but in the intervening period started seeing a psychologist at Curtin University. She was referred back to CAMHS by Curtin Psychology in November that year and commenced treatment with Bentley CAMHS in February 2016. Kate received individual therapy (Cognitive Behaviour Therapy) and medication over the following 10 months with notable benefit. Her parents also participated in group and individual sessions.

Kate was re-referred to Bentley Family Clinic by her GP in March 2018 with worsening symptoms. After assessment, Kate and her family were not accepted for treatment at the Clinic, but family therapy from a Tier 2[2] service provider was recommended.

In October 2019, she was referred back to Bentley Family Clinic with escalation of her problems associated with her transition to high school. She was accepted for treatment at a Choice appointment in October 2019 and subsequently seen on four occasions, but was discharged back to her GP in December because of her reluctance to engage in therapy.

In January 2020, she had her first admission to PCH after an episode of self-harm. The situation escalated rapidly from this point culminating in eight attendances at PCH ED and six admissions, for a total of 30 days to Ward 5A in the six weeks between June 3rd and July 17th.

[1] A 'Choice' appointment is an initial appointment to determine either entry to CAMHS or re-direction to alternative services.

[2] A system of care using a 'tiers of care' approach to delivering services for children and young people with mental health issues. Tier 2 services are largely provided for children and young people with less complex, severe or persistent mental health issues. These private and community services provide assessment and treatment for children and adolescents with moderately severe problems that are not complex or of high acuity.

In June 2020 Kate had been referred to Touchstone, a specialist intensive community-based program for the treatment of young people with Emotionally Unstable Personality Disorder (EUPD), which she was scheduled to commence in September 2020.

On 21st July 2020, following an appointment at Bentley Family Clinic (BFC), Kate stepped into oncoming traffic. She was admitted to Intensive Care at Royal Perth Hospital where she died 2 days later.

A timeline detailing Kate's treatment journey through CAMHS and the PCH ED between July 2015 and July 2020 is outlined in Figure 1 below.

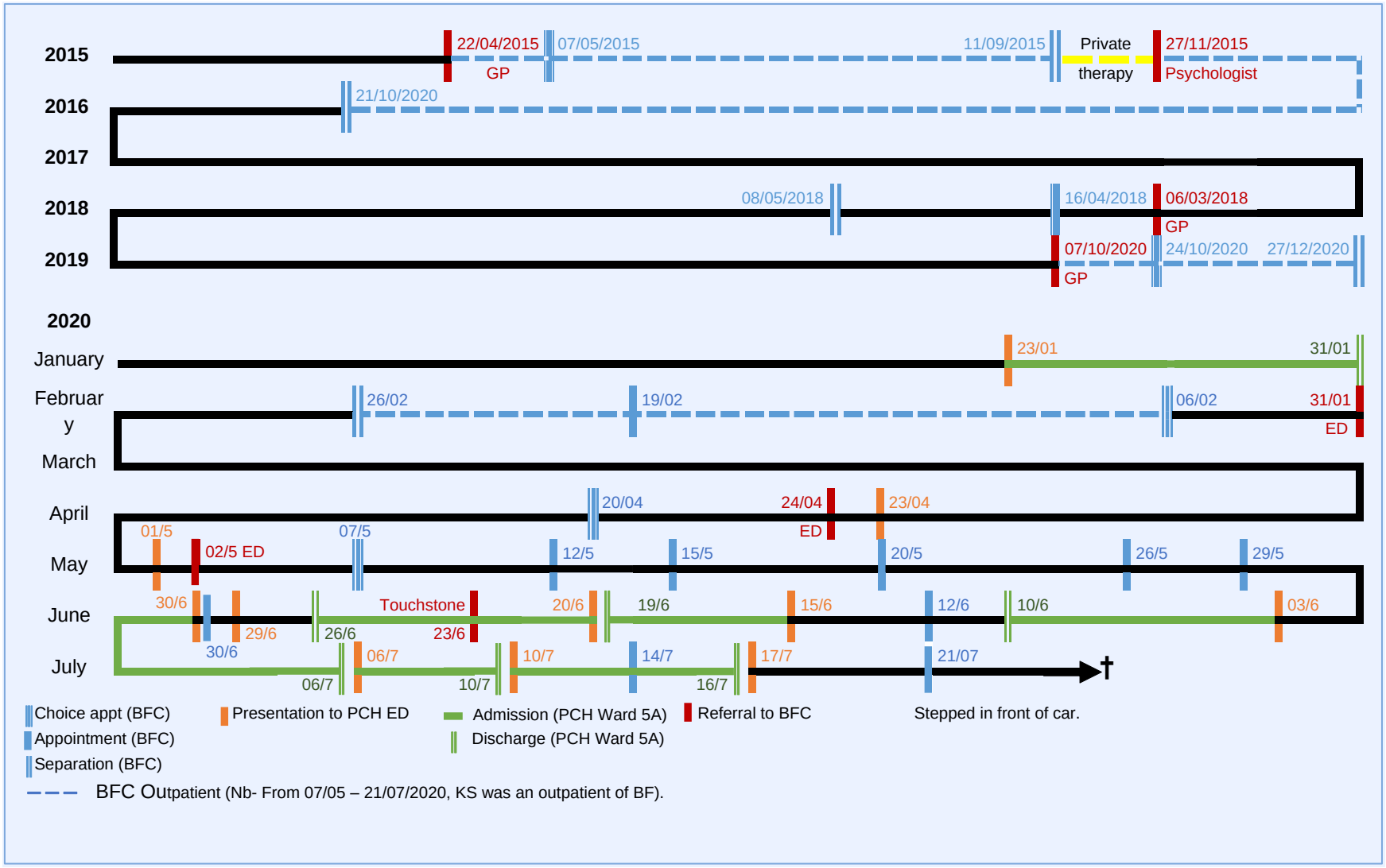


Figure 1: Timeline summary of Ms Kate Savage's treatment journey through CAMHS and PCH ED between July 2015 and July 2020

2.1 Management in the 6 months from January to July 2020

During the last 6 months of her life, Kate attended the ED at PCH on 11 occasions and had 7 admissions to Ward 5A, 6 of which occurred in the 6 weeks between 3rd June and 17th July 2020. During those 6 weeks, she attended the ED 8 times and spent a total of 30 days in hospital.

Kate's parents, Meron and Larry Savage, first contacted the Mental Health Advocacy Service (MHAS) on 8th June 2020, expressing their concern about Kate's imminent discharge from PCH, feeling that they could not keep her safe at home. They again contacted MHAS on the 9th June after being told that a decision had been made to discharge Kate, despite her still expressing thoughts of suicide.

On the 13th July 2020, her parents contacted MHAS having been informed that Kate was going to be discharged the next day. They expressed concern about her being sent home with what they considered "*a minimal, ineffective safety plan that ends in her readmission after seriously dangerous behaviour.*" They informed the Mental Health Advocate that they were uncomfortable with what they experienced as being *"pushed"* to lay a formal complaint with the police to demonstrate to Kate that there were *"consequences for her actions."*

The involvement of, and communication with, MHAS highlights the fact that her parents did not accept the diagnosis of Emotionally Unstable Personality Disorder (EUPD) reached by Kate's treating team or the treatment she was receiving. In the light of their strong familial genetic loading for mental illness they had, on a number of occasions both during 2020 and earlier, questioned the possibility of Kate having a Bipolar Disorder or an Obsessive Compulsive Disorder and suggested a possible change in medication, including the use of a mood stabiliser. They felt throughout that they had not been listened to by staff and felt that their suggestions had never been seriously considered or adequately investigated. However, the treating team did consider these possibilities but did not find any evidence to support a diagnosis of a mood disorder or Obsessive Compulsive Disorder.

This impasse between the treating team and the family was never resolved.

EUPD is characterised by a pervasive pattern of emotional instability (affective dysregulation), poor impulse control, intense but unstable relationships with others and disturbed self-image. Clinical signs of the disorder include unstable moods (including inappropriate intense anger), impulsive behaviour (including risky behaviours), recurrent episodes of self-harm/attempted suicide and poor view of self (e.g. as inadequate, bad).

What was observed with Kate, in the months leading up to her death, was rapidly escalating impulsive behaviour, persistent thoughts of death with both self-harm and suicide attempts in a young adolescent with poor emotional regulation, long standing anxiety and poor social relationships. The signs and symptoms Kate displayed were consistent with her diagnosis of EUPD.

There was also a significant difference between the views of the clinical team and her parents with regard the degree of risk of suicide and the level of control that Kate had over her behaviour. While Kate was repeatedly assessed by the services as being at chronic risk of death by *misadventure* as a result of her *impulsivity*, the family considered that she was at high risk

and actively planning to take her own life. The way that she expressed her intent to her parents was, *"I have to die."*

Her parent's perception of the message they were getting from the treating team at PCH was that Kate was *"in complete control …. she needs firm boundaries …. if she does anything wrong, get the police and have her charged."* As the impulsive behaviour escalated, her parents found it increasingly difficult to provide a safe environment at home for their daughter.

Medications and sharp objects were locked away and windows and doors secured. On one occasion, Kate became agitated at home and started pacing and trying to unscrew the windows. The police had to be called and it took four officers to restrain her. On another occasion her parents had to restrain her in the PCH car park to prevent her from running in front of traffic. Again, the police had to be called to assist. Although her parents had been engaged in safety planning by the treating teams, they felt that it was impossible to implement the plan when Kate became agitated and out of control.

Recognising that the family were feeling exhausted and overwhelmed and were in need of more intensive support than could be provided by Bentley Family Clinic (BFC), a referral was made by the community treating team to the Department of Communities; Child Protection and Family Support for intensive in-home family support. This request was declined, however, as the service was at full capacity.

The fundamental principle in the treatment and management of EUPD (more commonly referred to as Borderline Personality Disorder or BPD) is that patients are encouraged to govern and control their own lives and have responsibility for their behaviour as far as they are capable. Clinical Practice Guidelines[3] generally state that BPD is most effectively treated in outpatient settings and that, if hospitalisation is required, it should only be short admissions for crisis management and treatment rather than for treatment of the BPD. The management and treatment of Kate's illness by both the treating teams in PCH and Bentley Family Clinic was conducted broadly in accordance with these guidelines. Although many experts believe that hospitalisation can be potentially harmful, there is little empirical evidence to draw on to support this conclusion.

This raises the question of what could have been done under the circumstances. Kate was first diagnosed with EUPD in mid-May 2020 at the age of 13. Diagnosing EUPD in early adolescence, a time characterised by rapid changes in physical, psychological and social development, is uncommon. This period is often marked by difficulty in differentiating and regulating emotions, increased impulsivity and risk taking, the result of the relatively late development of the prefrontal cortex, which is the decision-making part of the brain, responsible for a young person's ability to plan and think about the consequences of actions, solve problems and control impulses.

The treatment and management of EUPD in this age group presents a challenge given the complexity and the limited nature of the evidence base for working with this age group.[4] The Clinical Guidelines referred to above were developed for an older age group, which raises the

[3] NICE (2018). Borderline personality disorder: *The NICE guideline on treatment and management update information August 2018.* UK: NICE.
[4] Ibid.

question of how usefully they can be applied in this particular situation with a recently diagnosed 13 year old with rapidly escalating, poorly controlled impulsivity combined with persistent thoughts of death.

This highlights two key issues:

1. There is a major gap in the CAMHS system between the hospital (ED and acute inpatient unit) and a 9:00am to 5:00pm, five day a week clinic-based community CAMHS. Kate had been referred to Touchstone, a specialist intensive community-based program for the treatment of young people with EUPD, which she was scheduled to commence in September 2020. What was needed was a comprehensive, extended hour service that could reach out into the home to support Kate and her family during this critical period. In situations like the one CAMHS encountered with Kate, the service should not have to seek the assistance of the child protection system to provide in-home support.
2. The rising rates and the progressively earlier presentation of self-harm and suicidal ideation in children and young people speaks to the need for a re-evaluation of the current clinical guidance and its application to the treatment and care of young adolescents with (emerging) EUPD. While it is always easier to be wise in hindsight, the question needs to be asked as to the appropriateness of rapid, short crisis admissions, particularly in the absence of intensive community treatment services, in a 13 year old with relatively immature executive functioning and a family that, despite their best efforts, were struggling to keep their child safe. What is needed is the development of evidence-based comprehensive models of care for this early adolescent group.

2.2 Missed opportunities

What Kate's story clearly illustrates is that self-harm and suicidal ideation/attempted suicide do not suddenly emerge de novo in adolescence but have their origins early in life. Although her parents reported earlier difficulties, it was in Grades 1 and 2 at school, that Kate started to develop social anxiety, concern about her appearance and weight and about what other children thought of her. She also started developing fears about blood and vomiting. In year 3, aged eight she presented for the first time to CAMHS with trichotillomania (pulling out eyelashes), nightmares, fear of sleeping alone and withdrawal from social activities. In 2016, Kate was diagnosed with Generalised Anxiety Disorder and treated with medication and cognitive behaviour therapy over a ten-month period with notable benefit.

Kate was referred back to community CAMHS by her GP in March 2018 with worsening symptoms of anxiety and trichotillomania but was referred on to another agency (Tier 2) for individual counselling and support for the family.

Kate was re-referred to CAMHS by her GP in October 2019 with escalating anxiety associated with her transition to high school. She reported having been subjected to bullying at school and, at the time of her assessment was house-bound and being home schooled whilst waiting to start a new school later that term. She was diagnosed with an Anxiety Disorder and Agoraphobia and offered treatment, but, by mid-December was discharged because she did not wish to engage in treatment. 0n 24th January 2020, Kate had her first admission to hospital with self-harm.

Kate's early history highlights the opportunities that existed, particularly after her first contact with CAMHS, to potentially change the course of her life. With her presentation and family history of, and genetic loading for mental illness, Kate was at high risk for mental health problems. It leaves open the question of what could have been achieved with greater continuity of care and more comprehensive services considering the benefit she got from her first period of treatment. As Meron put it, *"Kate only had brief involvements with Community CAMHS but she required intense support from a young age."*

It raises the question of why, when children have already been treated by CAMHS for a mental health problem that is having a significant impact on their lives, it can prove so difficult for them to get access to treatment at a later date when their condition again deteriorates. What this reflects is a significant problem of chronic under-resourcing of CAMHS associated with a rise in demand for services for high-risk adolescents which has led to the need to ration services, particularly for children in the 0-12 age group.

2.3 Recommendations

The recommendations in this section cover issues to do with the experience of families in dealing with CAMHS and the management of early adolescents who present with self-harm/suicidal ideation.

The treatment and care of Ms Kate Savage by Child and Adolescent Mental Health Services (CAMHS)

Recommendation 1

What the reviewers heard, not only from Kate's parents but also from other families, is that families do not always feel that they have a voice in the treatment and management of their children. This was particularly noted by families in relation to Perth Children's Hospital (PCH), although people also commented, in relation to the 'Choice and Partnership Approach' (CAPA) used by CAMHS, that they felt the power and control rested firmly with the staff. This recommendation is designed to enhance the relationship between families and staff.

It is recommended that funded positions for family peer workers be established; initially at PCH, but to be extended to all CAMHS services.

Recommendation 2

Parents feel that when there is a significant difference of opinion with regard to the treatment and management of their child, there needs to be some formal mechanism for reconciling this difference. Although at PCH parents have access to the Mental Health Advocacy Service, they feel that there needs to be a capacity for an independent review of their child's diagnosis, treatment and management.

It is recommended that a formal structure be established for independent review of the diagnosis and treatment in children and young people with complex problems where there is an unresolved difference of opinion between clinicians, families or other relevant agencies.

Recommendation 3

The current guidelines for the management of Emotionally Unstable Personality Disorder (EUPD) were developed for older adolescents/adults. This raises the question of whether they can simply be adopted for the management of young adolescents like Kate. This is particularly relevant given that children and young people are presenting with self-harm/suicidal ideation at a progressively earlier age.

It is recommended that consideration be given to a WA review of the application of the current guidelines for the management of Emotionally Unstable Personality Disorder in early adolescents; and that this review be undertaken in partnership with families.

3. A system under pressure

3.1 Current CAMHS services

The focus of this Review is on CAMHS services which are delivered in Perth. Throughout this report references to CAMHS are to services which are provided in the metropolitan area by CAHS.

CAMHS currently consists of three major treatment streams:

- Community treatment services provided to children under 18 years of age in the Perth metropolitan area through community CAMHS clinics.
- State-wide hospital-based services provided through PCH.
- State-wide specialised services for target groups with particular clinical conditions or complex and high-level needs.

> *We are mopping the floor with the taps turned on full.*
>
> *I feel that we have already missed the boat with this generation and I fear that we may already have missed it with the next.*
>
> **(CAMHS Clinicians)**

The CAMHS services which are provided in metropolitan Perth are outlined in Table 1.

Table 1: Summary of CAHS CAMHS Services

Service	Service details	Location(s) & operating hours	Specific target group	Referral source
Community services				
Community CAMHS	Community treatment: Individual, Family and group interventions. Includes Aboriginal Mental Health workforce.	Community CAMHS clinics (Armadale, Bentley, Clarkson, Fremantle, Hillarys, Peel, Rockingham, Shenton, Swan, Warwick). 09:00-17:00, 5 days a week.	Children under 18 years of age in the Perth metropolitan area who are experiencing mental health illness which is having a moderate or severe impact upon their functioning.	Open
Hospital-based services				
Inpatient Unit, Ward 5A.	20 bed facility for assessment and treatment of both voluntary and involuntary patients.	PCH	Children aged up to 16 years with complex and acute mental health issues.	Psychiatrists, authorised mental health practitioners, community CAHS, Paediatric Consultation Liaison service; Eating Disorders Program.
Emergency Telehealth Service (ETS)	Phone and video call support for children, young people, families and carers who are experiencing a mental health crisis.	Located in PCH and services Perth metropolitan area. Operates 08:00am – 2.30 am, 7 days a week.	Children aged up to 18 years of age who are experiencing a mental health crisis.	Open.
Paediatric Consultation Liaison (PCL)	Short-term treatment or management of mental health problems in PCH inpatients or outpatients.	PCH	PCH patients who have mental health issues related to their medical conditions or central to their treatment plan.	Medical and surgical consultants of PCH.

Specialised services

Touchstone	Six-month structured day program.	Bentley Health Service. Attendance for at least three days of the week.	Children aged 12-17 years with relationship difficulties, mood difficulties and impulsive self-harming behaviours.	Community CAMHS.
Touchstone Service User Network for adolescents	Structured therapeutic support group that is facilitated by the Touchstone team.	Bentley Health Service.	Children aged 12-17 years who are struggling to cope in a variety of ways.	Community CAMHS and Youth Axis.
Gender Diversity Service	State-wide service for the assessment and care of gender diversity issues.	PCH (outpatient)	Children with concerns regarding their gender, gender non-conforming behaviour or gender dysphoria.	GPs, paediatricians and CAMHS clinicians
Eating Disorders Service (EDS)	State-wide service for the assessment and treatment of eating disorders.	PCH (outpatient, day treatment and inpatient services)	Children under 16 with eating disorders.	GPs or other care providers
Complex Attention and Hyperactivity Disorders Service (CAHDS)	State-wide assessment and consultation service.	PCH (outpatient)	Children under 18 years with persistent complex attention, concentration, emotional and behaviour disorders.	Authorised stimulant prescribers including: paediatricians, psychiatrists, neurologists and GPs
Multi-systemic Therapy (MST)	Intensive four to five-month community program.	Home-based program in the Perth metropolitan area. Three meetings per week, including after normal work hours & 24/7 phone support.	At-risk children aged 12 to 16 years experiencing serious behavioural and mental health problems.	A wide range of agencies & departments.
Pathways	Specialised state-wide service providing intensive therapeutic day program.	Predominantly site-based. Two meetings a week with one day of school and Family outreach.	Children aged 0-12 with complex educational, social, behavioural, mental health and developmental issues.	Mental health practitioners, Community CAMHS, Child Development Services and Department for Child Protection and Family Support

3.2 Listening to families

Given the tight time-frame for the Review, the reviewers approached a Facebook group, Perth Families with Children with Mental Health Issues, a support group for parents of children with high risk, complex needs. The aim was to canvass their experiences on the adequacy of services, not just at the age of 12 or 13, but in the years leading up to this. The reviewers were particularly interested in their views about barriers to accessing mental health services for their children, gaps in services and what could be done to improve services for children with complex, high-risk needs.

The conveners of the Facebook group conducted an online survey of members, receiving 54 responses. The Review also received six separate written submissions from families. The Mental Health Advocacy Service (MHAS) provided the Review with reports on 11 cases in which carers had raised significant concerns with them between April 2019 and September 2020.

3.2.1 Service gaps and barriers

Families identified the following key themes.

(1) Access to services

> *"In and out of CAMHS four times now. Been in Pathways. Headspace won't take him. Been in PCH for 2 weeks. And everything has always been either too young or too old for services or too high risk for us or not complex enough for us."*

> *"The burden of support and fighting for services falls on the Family. It shouldn't be this difficult."*

> *"The wait time for appointments needs to be shortened immensely. Then there's a gap between initial assessment and first appointment."*

> *"Private psychologists and psychiatrists …. their wait lists and even finding one with their books open to take on a client is such a struggle. The huge costs are not sustainable either."*

Access to CAMHS was the most pressing issue identified by families. Many talked about their experience of being passed between services without being able to obtain treatment for their child. Accessing private psychologists and psychiatrists was difficult and the out-of-pocket expense was beyond the reach of most families.

Wait times for initial assessment and between initial assessment and commencement of treatment was of concern to families.

(2) Need for earlier intervention

> *"It shouldn't take a suicide attempt to be able to access help. It feels like the system doesn't want to repair them before they break; it only wants to try and put them back together once they are actually broken which is so much harder to do."*

"It's time to help the kids when signs first begin; before they escalate to alcohol and drugs, suicidal thoughts, eating disorders. …. It starts younger than 12 for many and that group is not being looked at in time."

Children being refused access to CAMHS because their mental health problems were assessed as being insufficiently severe for treatment was raised by a significant number of families. This was seen as a missed opportunity, particularly in the under 12s, for intervening earlier before they presented in crisis as adolescents.

(3) Short episodes of treatment

"CAMHS just wanted to discharge her as soon as she showed signs of improvement – which was followed by a deterioration again as she needs ongoing, long-term treatment."

"On our first visit we were told, it's a short-term service. Where does long-term care happen if kids are not fixed in a week?"

"Services need to be offered unless and until they are not needed by the child and Family, not just until there is no more room in the system."

"She was discharged from CAMHS …. She ended up being referred back to CAMHS a month later. She has now been discharged again before she was ready … and she had to get suicidal "enough" to get referred back again."

Families wanted to see longer, more consistent treatment for their child, which goes beyond the resolution of a 'crisis' or some arbitrary time-limit, in some cases leading to multiple re-presentations.

(4) Beyond the hospital

"The psychiatrist had said she was low risk …. She won't do it. But I didn't agree. I didn't feel that I could keep her safe at home."

"Many hospital admissions, only to be sent back home with nothing much to fall back on once at home. No real support while they know there is a mother to do the 24/7 surveillance to keep him safe."

"A path in times of crisis that doesn't involve 'a revolving door emergency department, sorry no beds available, nothing we can do other than drug and discharge, refer you on to other supports that 'don't accept you' process."

"If a child has cancer, there is so much wrap around support for the child and family. With mental health they get nothing."

Families are asking for better options during a crisis and greater support when their child leaves the ED or is discharged from the inpatient unit. In the absence of greater community support from CAMHS, families feel they are left carrying the burden of risk of suicide/self-harm and are concerned that they cannot keep their children safe.

(5) Lack of services for children/young people with neurodevelopmental disorders

Huge gaps for my son, no quality publicly funded services for a teen with autism and mental illness.

I believe there needs to be a special team just for children with autism spectrum disorders (ASD) and mental health issues to prevent them being passed around the system and ultimately slipping through with little to no help.

There is a barrier to services when disability is concerned. The toll is not just on my son, but our whole family.

A major issue that arose was the difficulties faced by families in accessing services for their child with both a mental health and a neuro-developmental disorder. They felt that they 'fell between the gaps' of both mental health and disability services.

3.2.2 What do families want?

The overwhelming message from families was the need to increase the availability of public specialist mental health treatment services for children adolescents. Specific priority areas include:

- Greater and more timely **access to treatment**.
- Longer, more **intensive and comprehensive therapy** for their child beyond crisis support.
- **Expansion of services** provided by CAMHS, both in terms of the range of services, the types of therapies and a more flexible approach that is responsive to families' needs and circumstances.
- The development of **age appropriate services** to cover the full age range from 0 to 17 years, ensuring that the 0 to 4, and 5 to 11 age groups are suitably serviced.
- An **intensive, in-home** mental health service consisting of highly-trained mental health workers that can support both children and families that operates both after discharge from an inpatient unit or ED as well as in response to acute crises.
- Greater **support for families** with services such as Family respite, counselling/psychological therapy, parenting help, and advice.
- Increased capacity of CAMHS to treat children and young people with both **neurodevelopmental** and mental health disorders.
- An overall improvement in **communication** regarding the assessment and treatment of their child.

3.3 Listening to clinicians

To gain the perspectives of the clinicians, the reviewers held face-to-face meetings with clinical staff at PCH (inpatient unit and ED), Bentley Family Clinic, CAMHS Medical and Service Co-Directors and the Medical Advisory Committee. In addition, the reviewers held a workshop with

CAMHS senior staff from across various services and professional disciplines to hear their views about gaps in services and what could be done to improve services for children with complex, high-risk needs. An invitation was extended to Fellows of the WA Branch of the Royal and Australian and New Zealand College of Psychiatrists (RANZCP) Faculty of Child and Adolescent Psychiatry to provide individual written submissions.

The overwhelming message from clinicians was the urgent need to increase the range and availability of public child and adolescent mental health services. They identified the following key service gaps and barriers to accessing specialist mental health treatment.

Access to community CAMHS

> *"The Choice and Partnership (CAPA) model has often been presented as an achievement by CAMHS but thus far, I believe it hasn't delivered good outcomes for families and referrers. The system could be described as rejectionist, as strong emphasis is being placed on diverting families to other agencies. This system also requires members of the multidisciplinary team to spend the majority of their clinical activity in triage and case-management, hence sought-after expertise that could be delivered by clinical staff in treatment is instead lost to generic triage work in order to meet demands of offering urgent Choice appointments."*

> *"Families consistently provide negative feedback about being put though the CAPA system which often "irritates" the young person as it's being perceived as all talk and no help."*

Becoming a high-risk adolescent service

> *"Community CAMHS largely see acute, high risk clients and the demand continues to rise. Management is focused on risk assessment/safety planning and liaison with ED/hospital, leaving less capacity for therapy and extremely limited capacity for a co-working model."*

> *"When a mental health service is reduced to primarily functioning as a service managing risk, it is difficult for clinicians to get away from a sense of therapeutic nihilism."*

Need for earlier intervention

> *"Patients with seemingly lower complexity are often refused access to CAMHS with a sense that they have to be either psychotic or suicidal before being able to access a service that should be available to all children with mental health issues. We should be working with an early intervention and prevention model."*

> *"The ability of community CAMHS to respond to infants and young people with an emerging disorder is severely limited and opportunities for early intervention are essentially non-existent. Clinics are also unable to offer the intensity of service required for infants and young people with the most severe and complex mental health conditions."*

Providing full a range of treatment

"There is a lack of financial investment with increasing demand and, therefore, we are unable to provide an extensive array of specialist or group work services … and this is out of step with evidence-based practice …."

Intensive community services to bridge the gap between community and hospital

"There is a lack of step-down services for inpatient to community or 'hospital-in-the home' provision for clients who require more intensive support and do not warrant an inpatient admission."
"The most significant gap identified is there is very limited capacity to provide in-reach and out-reach services or after-hours support, which results in unnecessary ED presentations and hospital admissions and ultimately, much poorer patient outcomes."

Training and retaining child and adolescent psychiatrists

"Trainees see the lack of capacity in the system … and don't want to train/work in the area. Who wants to join a failing system?"

"We are currently not able to recruit trainees to this subspecialty in the numbers required to maintain even the current levels of psychiatrists. … The emphasis on complexity and acute risk in admissions to public sector services have resulted in limited exposure to children under 12 and particularly access to children under 6, which has the potential to delay the completion of training. They also have concerns about adequate exposure to children with neurodevelopmental disorders."

3.4 Bringing their voices together

There is a high level of consensus between families and clinicians that the current CAMHS is not meeting the needs of WA families and their children. While they see an immediate need to address the gaps there is also widespread recognition that the whole system is in need of urgent review.

CAMHS put forward a business case for new and increased services earlier this year entitled *Early in Life; Early in Illness; Early in Crisis: Improving the mental health of infants, children and adolescents in WA*. It outlined measures to refocus public infant, child and adolescent mental health services by establishing a state-wide infant mental health service, increasing access to and the range of community CAMHS and developing alternatives to hospital presentation through establishing intensive community treatment services. These initiatives, if implemented, would have gone much of the way towards meeting the priorities that have been identified by families and clinicians.

3.5 Growing demand not matched by investment

3.5.1 Growth in referrals far outstripping population growth

The number of children 0-17 referred to community CAMHS rose from 3,848 in 2015 to 5,794 in 2019, an increase of 50%. This growth in referrals by far outstripped the increase in population in this age group in WA which grew from 584,301 to 603,109 (3.3%) over the same period.

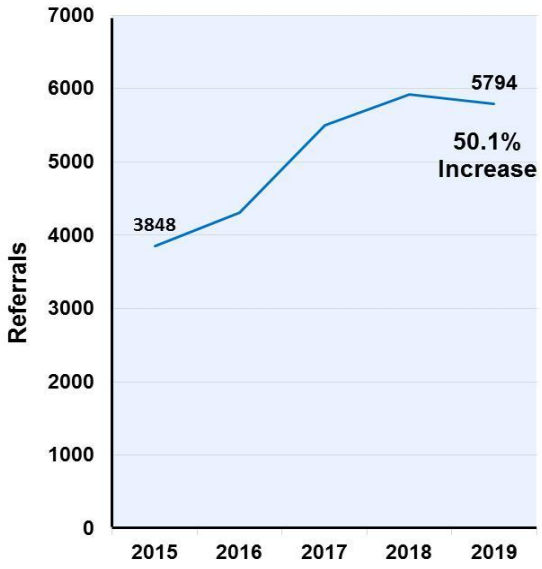


Figure 2: Growth in Community CAMHS referrals from 2015 – 2019

3.5.2 Admissions to services grew but could not keep pace with growth in referrals

Between 2015 and 2019, the activation of Community CAMHS referrals grew substantially from 1,180 to 1,507, an increase of 28%.

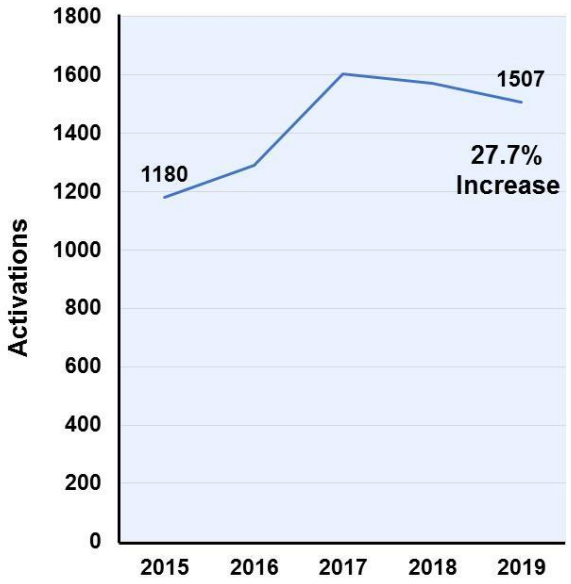


Figure 3: Growth in Community CAMHS activations from 2015 – 2019

However, the activation of referrals could not keep pace with the growth in referrals, with the percentage of activations of referrals falling from 31% to 26%.

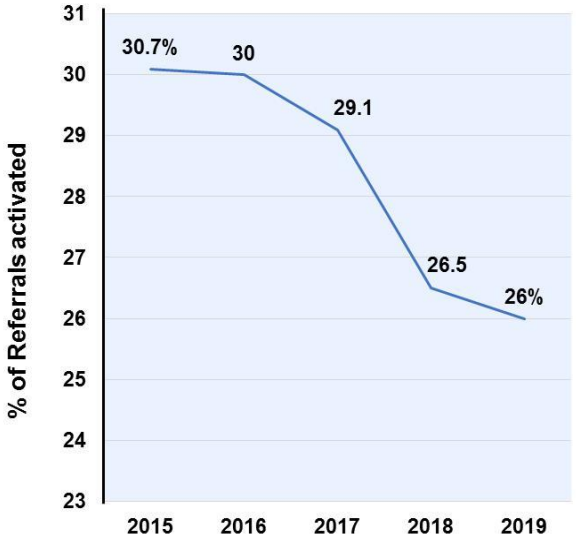


Figure 4: Percentage of referrals activated by Community CAMHS from 2015 – 2019

3.5.3 The management of adolescents has increasingly dominated the work of CAMHS

In the period 2015-2019, there was a 62% increase in referrals of young people aged 12 to 17, 39% increase in referrals of children aged 5-11 and a 13% fall in referrals of 0-4 year-olds.

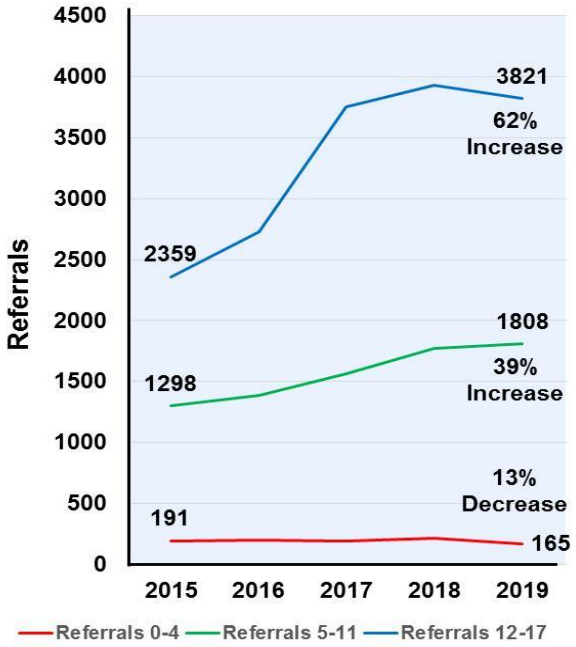


Figure 5: CAMHS referrals by age group 2015 - 2019

The management of 12-17 year-olds, which in 2019 made up 79% of all activations, has increasingly come to dominate the work of CAMHS reducing its capacity for the treatment of younger children.

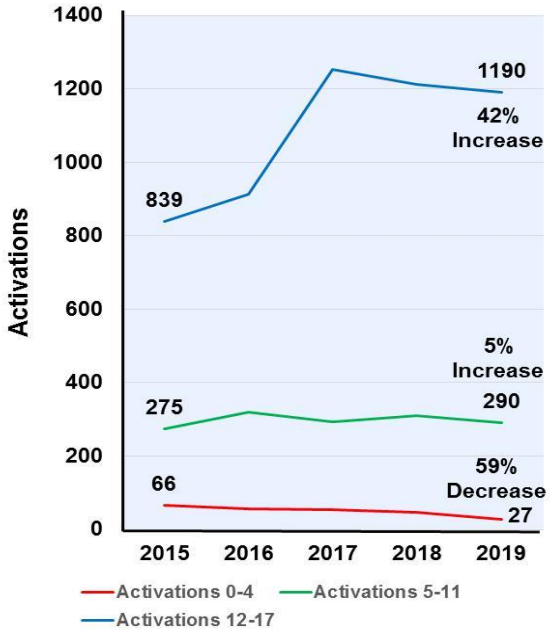


Figure 6: CAMHS activations by age group 2015 - 2019

3.5.4 Growth in attempted suicide/self-harm amongst adolescents has become the major focus of CAMHS at the expense of services for infants and children

This shift in workload parallels the steep growth in self-harm/suicide risk/attempted suicide that has been seen in children and young people presenting to EDs over the past 10 years. This trend has been particularly notable in the 13-17 year age group; but, although less common amongst 0-12 year-olds, has also shown a significant and worrying rise.

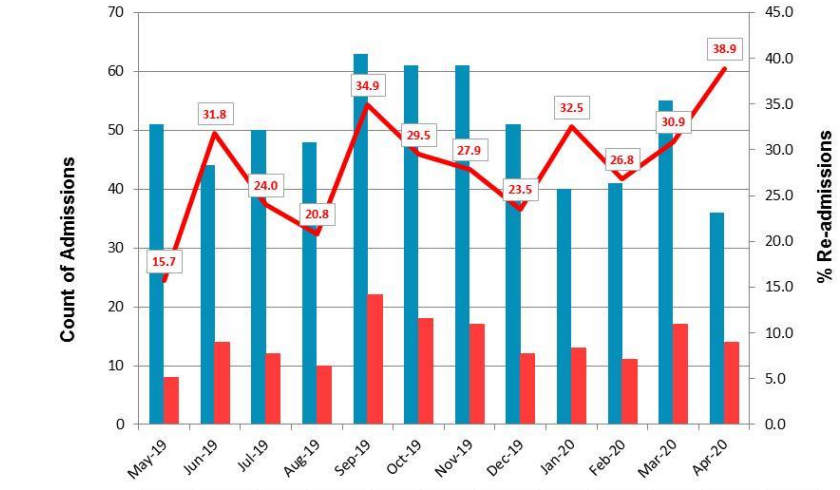
* Metro EDs data only as there were changes in reporting in rural area during this period

Figure 7: Number of ED attendances in metropolitan Perth by children and young people under the age of 18 that attempted suicide, were a suicide risk, or self-harmed by age 2009/10 – 2019/20

3.5.5 Pressure on inpatient beds at PCH

There has been an increasing number of children and young people with mental health disorders admitted to, and cared for in non-mental health ward settings ('outliers'); 52 to date during 2020 compared with 15 for the whole of 2019 and 9 for 2018. This has been particularly evident from July to September 2020 (9, 22, 8 respectively).

Rates of 28-day re-admission (including planned re-admissions) have also been high, with a median rate of 32% for the first 4 months of 2020. This high level of re-admissions reflects the rising acuity and complexity of the children and young people presenting to PCH.

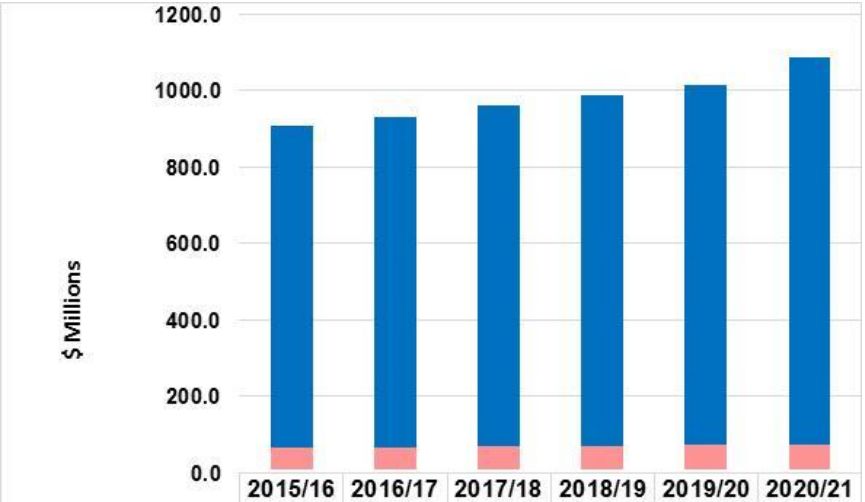


	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
Admissions	51	44	50	48	63	61	61	51	40	41	55	36
Re-admissions	8	14	12	10	22	18	17	12	13	11	17	14
Rate	15.7	31.8	24.0	20.8	34.9	29.5	27.9	23.5	32.5	26.8	30.9	38.9

Figure 8: Re-admissions within 28 days to PCH Ward 5A

3.5.6 There has been a lack of real investment in CAMHs over many years

Children and young people in Western Australia aged between 0 and 17 make up 23% of the population. However, CAHS CAMHS current funding represents 6.5% of the 2020/21 Mental Health Services budget of $1.013B. In the 6 years from 2015/16 to 2020/21, the budget for CAHS CAMHS Mental Health Services increased from $59.1M to $65.9M (an annual average increase of 1.9% per annum).



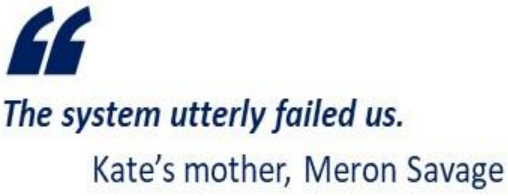
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
MH Budget	843.2	863.1	894.9	918.4	942.1	1013
CAMHS Budget	59.1	59.5	60.2	62.4	64.6	66
%	7.0	6.9	6.7	6.8	6.9	6.5

Figure 9: CAHS CAMHS budget as percentage of total mental health budget 2015/16 - 2020/21

Between 2015/16 and 2020/21, the CAHS CAMHS budget rose by 11.7% compared with a 20% rise in the total WA mental health budget. Funding for CAMHS has essentially not kept pace with the increasing demand for services. This, coupled with the sharp rise in referrals of 13 to 17 year-olds presenting with self-harm/suicide risk/attempted suicide, has led to a significant shift in the provision of treatment services, with currently only 14% of those receiving care coming from the 5-11 age group and 1% from the 0-4 age group.

The ability of CAMHS to respond to infants and children with an emerging disorder is severely limited, as is the intensity of services required for infants and young people with the most severe and complex mental health conditions. Essentially, CAMHS is rapidly being transformed into a high risk, high acuity service for adolescents and, with its current level of funding, cannot even adequately meet the demand for this group.

4. Findings on the adequacy of CAMHS to respond to children, young people and their families



4.1 The need to intervene early in crisis

Kate's 'journey' through CAMHS during 2020 is becoming all too common for many young people and their families. It highlights a serious problem with a system that is both struggling to cope with an overall rise in demand (51% over four years) and is not set up to properly respond to the steep growth in self-harm/suicidal ideation/attempted suicide in young people that is emerging; primarily in the 13 to 17 year age group, but also worryingly, in the younger age groups.

The effects of this steep growth are being experienced throughout all parts of the system including hospital EDs, the mental health inpatient unit at PCH and CAMHS community clinics.

Within the hospital system, over the past decade, metropolitan EDs have experienced a 214% increase in self-harm/suicide risk/attempted suicide presentations of 13 to 17 year-olds and a 403% increase in the under 13s. The mental health inpatient unit at PCH is under growing pressure with high rates of 28-day readmission and an increasing number of children and young people with mental health disorders admitted to other wards in the hospital because of a lack of available specialist mental health beds in Ward 5A (52 to date in 2020 compared with 15 for the whole of 2019).

Within the CAMHS community clinics there has been a 62% increase in referrals of 12 to 17 year-olds over the last four years. In 2019 this age group accounted for 85% of all those accepted for treatment. Essentially, Community CAMHS has become largely a service for complex, high-risk adolescents, which has had a substantial impact of the way that clinicians are able to practice.

4.1.1 A system not well set up to effectively respond to a mental health crisis

CAMHS community clinics largely operate weekdays, 9am to 5pm. For young people and families experiencing a mental health crisis, this often leaves only one real option for obtaining face to face services – and that is the hospital ED.

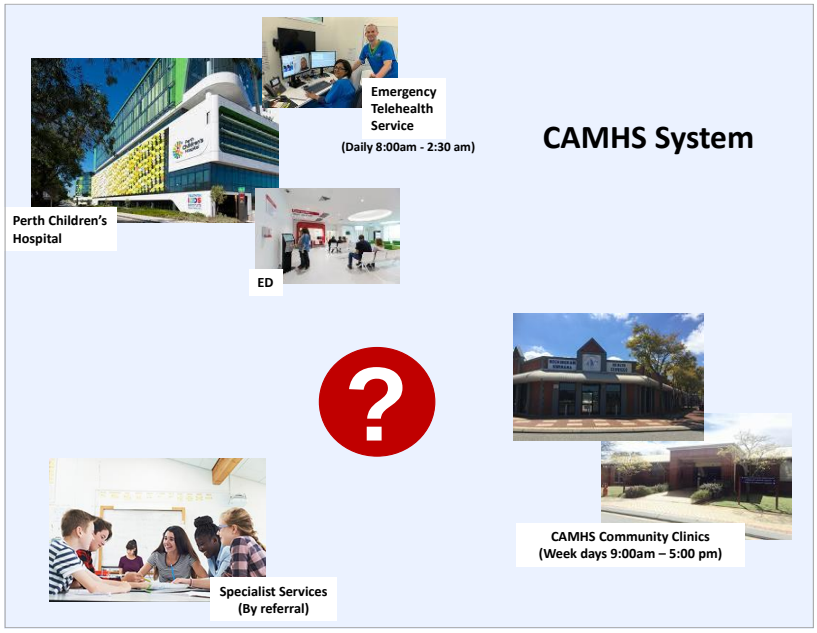


Figure 10: The service gap between hospital and community clinics

In the absence of 7-day a week intensive community treatment, there are limited options available from the ED, namely: 1) admission to a mental health inpatient unit, which is often operating at capacity; 2) referral to a largely office based, Monday to Friday CAMHS community clinic; or 3) discharge to home, which many families have reported leaves them feeling that they are left carrying the burden of trying to keep their children safe.

The limitations in the current system to provide intensive care in the community is particularly concerning in view of the evidence of a heightened risk of further self-harm/suicide attempt post discharge from ED or hospital. This serious gap in services has been recognized by families, by CAMHS and recently highlighted by the Chief Mental Health Advocate:

> *Public community mental health services have long delays for referrals (over six weeks) and are limited in scope, hours of operation and ability to provide the intensity of care required for children the Advocacy Service assists.*
>
> Chief Mental Health Advocate, Annual Report 2019/20[5]

This lack of an intensive community treatment option has resulted in continued pressure on inpatient beds with high levels of readmissions within four weeks of discharge. It is also leading to increased pressure on the EDs and stress on families where:

[5] Mental Health Advocacy Service (2020). *Annual Report 2019/20: MHAS*. Perth, WA: MHAS.

> *Sometimes the child and Family give up waiting in the ED - because the ED is a distressing and, in some cases, unsafe place – and the child remains on a waitlist but concerns for the safety of the child remain.*

Chief Mental Health Advocate, Annual Report 2019/20[6]

CAMHS has attempted to address the need for community-based assertive and intensive treatment and support needs of young people and their families. Between 2008 and 2016 CAHS established and operated an acute and urgent assessment and treatment service: the Acute Community Intervention Team (ACIT) and the Acute Response Team (ART). ACIT provided intensive, timely, acute community follow up, while ART provided child-specialist support for EDs (primarily at the now decommissioned Princess Margaret Hospital) dealing with acute presentations. These teams aimed to provide alternatives to an inpatient admission for those presenting to Princess Margaret Hospital ED and for those needing urgent follow up and support post discharge from the mental health inpatient ward.

Following changes made to the funding of CAHS CAMHS services in the 2015/16 and 2016/17 financial years, a decision was made to integrate ACIT and ART into Community CAMHS. An evaluation of the integrated services recognised the limited capacity to deliver an intensive service given the current demand on Community CAMHS and the resources available.

In 2020 CAMHS put forward a business case to the MHC proposing an intensive community based outreach and intervention service for managing complex mental health disorders in young people who need more care than is able to be provided within Community CAMHS. The proposal remains unfunded.

4.1.2 Improving the crisis response in the community

There are some young people whose mental ill-health is so persistent, serious and complex that their needs cannot be met by the current Community CAMHS. They are often likely to present to EDs during a crisis where they often wait for hours to receive appropriate treatment and care. They are also at risk of multiple inpatient re-admissions in times of crisis. There is an urgent need to improve the capacity of both the community and the hospital services to respond to children, young people and their families experiencing a mental health crisis.

Establishing Community Intensive Treatment Services (CITS) would provide treatment and support to children, young people and their families in a mental health crisis. Given the large and expanding geographical footprint of Perth it will be necessary to establish a CITS in each of the northern, southern and eastern metropolitan areas.

The CITS would provide an alternative pathway to ED presentation, an alternative to inpatient admission and a step down option for young people being discharged who require more intensive support that cannot be provided by Community CAMHS. It would bring significant benefits for health services, including decreased numbers of ED presentations, fewer admissions and earlier discharge. Importantly, young people and their families would be able to access the help they need to prevent a crisis escalating to the point where they attend an

[6] Ibid.

ED or require admission to a mental health inpatient unit. Both families and clinicians have been calling for this gap to be addressed as a matter of urgency.

4.1.3 Improving the crisis response in the hospital

There is a need to provide a specialist mental health team to rapidly assess and treat these young people presenting to the ED at PCH. There is also an urgent need to meet the increasing demand from ED staff in other metropolitan hospitals who seek specialist mental health assessments of children and young people under 16 years who present to a general hospital. This is particularly important in light of recent advice from the Chief Psychiatrist to the MHC and the Department of Health:

> *..there must be specialist Child and Adolescent involvement in the assessment of all children under 16 years old who present with mental health issues to a generalist hospital, and the adult psychiatrist or doctor at the generalist hospital who has governance over the child must be able to escalate the matter and have the child seen face-to-face (in the metro area) or by AV (where appropriate) by a CAMHS Psychiatrist/Registrar if disagreement remains between CAMHS and the generalist hospital about the disposition.*[7]

It has been recognised that the ED is *"not the right environment for mental health patients. It is noisy, the lights are constantly on and it is stimulating"* (PCH ED clinician). A 'one-door, two-pathways' model would provide a single entry point to the ED, where young people who require mental health treatment and care would be directed to a separate quiet area serviced by specialist mental health staff. A separate mental health area within the ED would deliver two benefits: direct and timely access to specialist mental health assessment and treatment and an appropriate physical environment for young people and their families.

As part of the COVID response, time-limited funding was provided to develop an Emergency Telehealth Service (ETS) which aimed to reduce presentations to ED. There is potential, with additional resources, for the ETS to provide an expanded service including:

- specialist consultations to other metropolitan EDs;
- specialist consultation to health professionals in the community dealing with a mental health crisis; and
- follow up contact for families after a PCH ED assessment or discharge from a PCH mental health inpatient unit.

4.2 The need to intervene early in life and early in illness

Kate's mental health issues did not begin at 13 years of age. While she first came into contact with community CAMHS at the age of eight, her mother reported that Kate had experienced some difficulties much earlier in her life. This experience was reflected in the stories of many of the families who participated in the survey. While the average age of their children was now 13.9 years, their first contact with mental health services was at 8.7 years.

[7] Child and Adolescent Health Service (2020*). Child and Adolescent Mental Health Services (CAMHS) Emergency Service.* Perth: WA. CAHS

Early intervention - whether early in life or early after the detection of risk factors that may lead to mental illness - is important to prevent the onset of illness or curtail deterioration in mental health. Early identification of risks in children offers the greatest potential for improving mental health, social and economic outcomes. The lack of investment and the increase in demand has severely curtained the current ability of community CAMHS to respond to the mental health needs of infants and children.

The Ombudsman, in his Report *Preventing suicide by children and young people 2020*, noted:

> *"The increasing demand for CAHS Community CAMHS services in the context of stagnant clinical FTE has resulted in a situation in which only the most acutely unwell young people are able to access CAHS CAMHS services."*[8]

There has been a 39% increase in referrals to community CAMHS of children aged 5-11 years over the past 4 years. Many, however, are not getting into CAMHS. For example, in 2019, there were 1,808 children referred to CAMHS of which only 290 (16%) were accepted. This contrasts with an acceptance rate of 23% in 2015. Over the same period, the under 5s getting into community CAMHS has dropped by 59% and they now make up only 1% of the total acceptances.

… as the pressure to respond to high-risk adolescents has grown, it has become increasingly more difficult for the 5-11 year olds to get into CAMHS and almost impossible for the under 5s.

Essentially, as the pressure to respond to high-risk adolescents has grown, it has become increasingly more difficult for the 5-11 year olds to get into CAMHS and almost impossible for the under 5s. If the demand continues without a significant injection of funding, CAMHS will become increasingly focused on adolescents and even less able to treat the 0-11 year olds.

A number of concerns have been raised by families and clinicians about the current process for obtaining access to Community CAMHS. The Choice and Partnership Approach (CAPA) comprises an initial consultation, a 'Choice' appointment to determine either entry or re-direction to alternative services, followed by a 'Partnership' appointment for those accepted into treatment, where families are offered an initial treatment period of three months. The successful operation of the CAPA mo0del, which was developed in the UK, relies heavily on adequate staffing levels in CAMHS and the availably of an appropriate range of alternative services that are readily accessible and affordable.

In the context of increasing demand and limited funding, CAPA is operating largely as a demand management tool and is seen by Families as a having a strong emphasis on diverting them to other services.

[8] Ombudsman Western Australia (2020). *Preventing suicide by children and young people.* Perth, WA: Ombudsman WA.

Many families are concerned about the lengthy waiting time for their first Choice appointment. Although the target maximum wait time from referral to a Choice appointment is 28 days, the median time in September 2019 had blown out to 52 days. Families also complained about the waiting time between their first Choice appointment and their first treatment (Partnership) appointment.

There was a strong feeling amongst families that there was an emphasis on short-term, time-limited treatment with a focus on discharge. They want longer-term, more consistent treatment for their child to prevent deterioration and minimise the likelihood of re-presentation. For those not accepted into Community CAMHS, many families have found it extremely difficult to find alternative services. In particular, many experienced considerable difficulty in accessing a private psychiatrist or psychologist and, when they were able to do so, found the cost "*unsustainable*".

Clinicians clearly recognise these problems and share many of the concerns expressed by families. As highlighted earlier, they report that they are spending a lot of their time in triage and case management to meet the demands of offering urgent Choice appointments.

Clinicians expressed concern that the growing demand for treatment services from high-risk, young people with complex needs, coupled with the lack of investment in CAMHS, meant that they were unable to provide an appropriate range of evidence-based treatments. They also did not feel able to provide the level of ongoing care that many children and young people require.

Clearly in today's world, there is a need for greater flexibility in the hours of operation and greater responsiveness in the way that services work – providing services into schools/homes and working in partnership with other agencies. This need has been recognised within CAMHS, but cannot happen without a significant increase in clinical staffing.

4.3 Recommendations

The recommendation in this section address the priority actions required to address immediate gaps in CAMHS services.

Recommendation 4

Establish Community Intensive Treatment Services (CITS)

It is recommended that three multidisciplinary Community Intensive Treatment Services (CITS), operating in each of the northern, eastern and southern metropolitan areas of Perth, be established to ensure that young people with complex mental health needs can receive appropriate, timely care in the community. The aim is to reduce ED presentations and inpatient admissions, as well as to facilitate more intensive community care to assist the timely and safe transition of children from hospital. The CITS will:

- operate 7 days a week over extended hours to deliver mental health care into a range of settings, including the young person's home and school; and
- function within the Community CAMHS Directorate.

Recommendation 5

Establish a CAMHS Emergency Service at PCH

It is recommended that a multidisciplinary CAMHS Emergency Service be established at PCH to provide two distinct, but complementary services:

- A Multidisciplinary Mental Health Team operating 24/7 to provide direct and timely access to specialist mental assessment and treatment for children and young people presenting to ED. In doing so, consideration should be given to reconfiguring the ED to establish a more appropriate physical environment where care can be delivered by the ED Mental Team.
- An enhanced CAMHS Emergency Telehealth Service to provide:
    - Support, assessment and crisis intervention for young people and their families during a mental health crisis as an alternative to presenting to PCH ED or other metropolitan EDs.
    - Specialist emergency mental health consultation for metropolitan EDs and health professionals in the community including GPs, school psychologists, school nurses.
    - Follow-up contact with families within 24 hours of receiving a mental health assessment in the PCH ED and within 48 hours of a young person being discharged from the PCH mental health inpatient unit.

Recommendation 6

Immediate uplift to Community CAMHS clinical workforce

It is recommended that the clinical workforce in Community CAMHS is expanded as a matter of urgency to respond to the growth in demand, reduce waiting times and address the need for extended hours of operation.

5. Rebuilding CAMHS

The lack of any real investment in CAMHS over many years and the shift in the pattern of referrals of young people for treatment pose a very serious threat to the future delivery of high quality, safe services for children and adolescents in Western Australia. This chronic underfunding has continued despite the sustained efforts of CAHS and the CAMHS leadership to highlight the issues and put forward business cases for additional services.

The lack of any real investment in CAMHS over many years and the shift in the pattern of referrals of young people for treatment pose a very serious threat to the future delivery of high quality, safe services for children and adolescents in Western Australia

Currently, services cannot effectively respond ***'early in crisis',*** which puts more pressure on EDs and hospital beds and more stress on young people and their families. They are progressively less able to respond to children ***'early in illness'***, losing the opportunity to intervene early, provide more effective treatment and minimise crises. There is now almost no capacity to intervene ***'early in life'*** by treating very young children under the age of four years. It is distressing and demoralising for many clinicians who, despite experiencing these system failings every day, continue to provide the best treatment and care that they can.

There has been no shortage of reviews and reports over many years identifying the need to increase services and invest more in mental health services for children and adolescents. These include the Stokes Review[9] (2012), inquiries and reports by the Commissioner for Children and Young People (2011, 2015, 2020)[10,11,12] and the WA Ombudsman reviews into preventing suicide for children and young people (2014, 2020).[13,14]
In 2015 the MHC, as the funder of mental health services, identified a *"substantial"* shortfall in infant, child and adolescent community mental health in the State strategic mental health plan,

[9] Stokes, B. (2012). *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia.* Perth, WA: Department of health
[10] Commissioner for Children and Young People (2011). *Report of the Inquiry into the mental health and wellbeing of children and young people in Western Australia.* Perth, WA: Commissioner for Children and Young People.
[11] Commissioner for Children and Young People (2015). *Our Children Can't Wait Report: Review of the implementation of the Inquiry into the mental health and wellbeing of children and young people in Western Australia.* Perth, WA: Commissioner for Children and Young People.
[12] Commissioner for Children and Young People (2020). *Progress update for agencies on the recommendations from the 2015 Our Children Can't Wait report.* Perth, WA: Commissioner for Children and Young People.
[13] Ombudsman Western Australia (2014). *Investigation into the ways that State government departments and authorities can prevent or reduce suicide by young people.* Perth, WA: Ombudsman WA.
[14] Ombudsman Western Australia (2020). *Investigation into the ways that State government departments and authorities can prevent or reduce suicide by young people.* Perth, WA: Ombudsman WA.

requiring *"urgent resources."*[15] In 2018, in its updated modelling in the strategic mental health plan, the MHC identified that the need for a three-fold increase in funded community mental health hours by 2020 and a four-fold increase by 2025.[16]

In 2020, the MHC identified children and youth as one of six State priorities to 2024.[17] The MHC is currently developing a *Young People Priority Framework* (the Framework) to guide the mental health and alcohol and other drugs sector to respond to the needs of those aged 12 to 24 years. The Framework will provide an overview of the current service system, identify gaps and identify key areas for action. There is no funding currently allocated to implement the Framework. There is an inherent risk in focussing on youth sector development at the expense of services for children.

Inadequate funding of mental health services for children and adolescents over many years remains a key barrier to providing the services that our children, young people and their families need.

[15] Western Australian Mental Health Commission (2015). *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025.* Perth, WA: MHC.
[16] Mental Health Commission 2019. *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Plan) Update 2018. Perth,* WA: MHC.
[17] Mental Health Commission 2020. *WA State Priorities Mental Health, Alcohol and Other Drugs 2020-2024.* Perth, WA: MHC.

5.1 The way forward: A Child and Adolescent Mental Health Ministerial Taskforce

After so many years of neglect,[18] there is a need to build confidence among young people and their families and the child and adolescent clinicians that their voices are being heard and their concerns will be acted on. A Child and Adolescent Mental Health Ministerial Taskforce will go some way to restoring their confidence and beginning the journey towards rebuilding the CAMHS system.

There is an urgent need to move beyond the current piecemeal approach to commissioning services. Without a CAMHS clinical services plan, this approach is like building a house, *"…one brick at a time in the belief that they will eventually have everything necessary to build a house …* [but] *all they will have is a pile of bricks."*[19] The Taskforce must consider not only what services are required but how they work together as a whole system to ensure clear pathways of care for children, young people and their families.

> ***"There is clear evidence that the current system is not meeting the needs of children and young people. We must improve our planning, commissioning and investment of services for children and young people and their families, to ensure that they can receive the help and support that they need.***
>
> **(Commissioner for Children and Young People)** [18]

The Taskforce, led by an independent chair with credibility and standing in the WA community, will bring together experts on children and young people's mental health, families and young people and other key stakeholders. This process will allow for a co-designed approach where those who provide services and those who use them can work together to achieve shared outcomes.

The Taskforce will have two complementary tasks to be undertaken in parallel:

- Oversee the immediate staged implementation of the Review recommendations over the next 18 months.
- Develop a whole of system plan for Perth metropolitan and WA country specialist public child and adolescent mental health services.

[18] Commissioner for Children and Young People (2020). *Progress update for agencies on the recommendations from the 2015 Our Children Can't Wait report.* Perth, WA: Commissioner for Children and Young People.

[19] Adapted from the opinion piece on education by Bill Boylan (2014). *Kids must learn how to think.* The West Australian, September 2, 2014

5.2 Systemic challenges to be addressed by the Ministerial Taskforce

During the Review, the reviewers identified a number of significant systemic challenges that could not be adequately addressed in the time available or without wider consultation with the key stakeholders. These issues are complex and should be addressed by the Taskforce as part of their whole of system re-build of CAMHS.

(1) Culture, clinical leadership and governance

The Reviewers observed high levels of distress and low morale amongst CAMHS clinical staff. There was considerable dissatisfaction with the current governance structure associated with a sense of disempowerment. Staff also expressed concern at the rising demand for services which, combined with a lack of investment over a number of years, was preventing them from providing the level and quality of care they felt necessary. This is particularly concerning given that staff well-being is strongly associated with the quality and safety of patient care. As Mannion, an international expert on culture in healthcare argues, enabling and supporting compassionate care in health requires *"not only a focus on the needs of the patient, but also those of the care-giver"* and attention needs to be paid to organisational arrangements that support this.[20] The importance of strong clinical leadership, supported by an appropriate governance structure and resourcing, is key to re-building CAMHS.

(2) Children with neurodevelopmental and mental health disorders

Many families told of their frustration at the lack of services for their child with Autism Spectrum Disorder or with Attention Deficit Hyperactivity Disorder and the 'run around' they get between autism services and CAMHS. One mother, whose 12 year old son has both of these disorders, spoke of being caught in an endless cycle of ED visits/referrals to the CAMHS Emergency Telehealth Service (ETS)/autism services.

> *"Eleven hours we spent at emergency on Wednesday night. And after all the waiting, walked out with the phone number for the CAMHS ETS service. Again. CAMHS have told us that they couldn't help because he has the autism diagnosis. That triggers for his self-harm were autism related and not depression related and to ring an autism service. When we ring the autism association, they say self-harm is a mental health issue and to ring CAMHS. We've been around in circles…Parents are begging for help and even in these times of such awareness of autism and mental health, there isn't enough linking between services."*

The Office of the Chief Psychiatrist is frequently asked to intervene when senior psychiatrists have opposing views as to whether a child or young person with a neurodevelopmental disorder has a mental illness or whether the change in their behaviour is due to the neurodevelopmental disorder itself. In CAMHS, where services are under significant stress, people with a neurodevelopment disorder are being increasingly excluded from services. As a result, clinicians working in CAMHS are becoming deskilled in providing treatment and care for children and young people with a dual diagnosis.

[20] Mannion R (2014). Enabling Compassionate Health Care: Perils, Prospects and Perspectives. *International Journal of Health Policy and Management*; 2:115-117.

Early this year, the MHC in its report *WA State Priorities: Mental Health, Alcohol and Other Drugs 2020 – 2024* identified 'people with neuropsychiatry and developmental disabilities' as a priority population requiring special focus.[21] The need to establish state-wide specialised services for children with mental illness and co-occurring intellectual or developmental disability and mental illness has been identified but there has been limited progress to date.

(3) 'Early in life' and 'Early in treatment'

There is a risk that the increasing demand for services from high-risk adolescents will continue to dominate Community CAMHS at the expense of providing services 'early in life' to the under 4s and 'early in treatment' for the under 12s. Strategies need to be developed to ensure that Community CAMHS can provide an adequate level of services for these younger age groups.

(4) Improving access to care

The reviewers heard a number of serious concerns from families and clinicians about the Choice and Partnerships Approach (CAPA). These concerns include a focus on diverting families to other agencies, long waiting times, time-limited treatment, lack of continuity of care and reduced capacity to deliver evidence-based treatment. In a system under pressure, CAPA can start to operate more like a demand management tool. This warrants further examination of CAPA.

A common complaint from families was of 'falling between the gaps' in the 'Tiered' model of service delivery, where the different tiers of service effectively 'passed the buck' from one to another. The Tiered model has been criticised for unintentionally creating barriers between services, fragmenting care and reducing the opportunity for the provision of treatment early in illness.[22] Consideration needs to be given to alternative service delivery models that promote collaborative ways of working between providers, such as shared care, to ensure that children and young people receive the treatment and care most appropriate to their current need.

(5) Better connected services

There are multiple services in the public system providing mental health services to children and young people, with complex intersections between them. While Community CAMHS provides services for young people up to 18, PCH limits access to its services to the under 16s. CAMHS services in the country are provided by WACHS but if a child requires specialist inpatient services they are transferred to PCH.

There is an array of specialist youth mental health services in the public system. Youth mental health services operate separately from the CAMHS system. Some of these youth mental health services are available for individuals as young as 13 years (YouthReach South; YouthLink). This web of services needs to be examined to ensure better integration and seamless pathways for children, young people and their families.

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[21] Mental Health Commission 2020. *WA State Priorities Mental Health, Alcohol and Other Drugs 2020-2024.* Perth, WA: MHC.

[22] NHS England 2015. *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing.* UK: Department of Health.

The interface between CAMHS and adult mental health services needs to be further developed to ensure smooth transition for those young people who progress to adult services.

(6) A sustainable skilled workforce

As a result of the current shortage of child and adolescent psychiatrists, CAMHS has not been able to recruit and retain the numbers required to maintain existing service levels. High service demands and workload, the limited number of specialist positions available, and the current nature of public sector work with its limited exposure to younger children and infants, are deterring psychiatry trainees from entering the subspecialty. Morale amongst all professional disciplines is low which is having a deleterious effect more generally on the recruitment and retention of all professional disciplines. There is currently just over a 7% vacancy rate for clinical staff.

(7) Rural and remote services

There is a need to address the challenges of providing specialist mental health treatment services in rural and remote WA. These include the lack of dedicated mental health inpatient units for young people and the need to facilitate more equitable access to specialised state-wide services located in the Perth metropolitan area.

(8) Specialist services for children and young people in care

There is an urgent need to ensure that children in care with a significant mental health disorder have access to treatment. Consideration needs to be given to developing a specialist CAMHS service to provide mental health interventions for children and young people most at risk of entering, or who have entered the care of the Department of Communities; Child Protection and Family Support.

(9) Collaboration with key partner agencies

The need for enhanced intersectoral collaboration with key partner agencies such as schools has been well recognized by CAMHS, with initiatives such as the Public Schools and Mental Health Project already underway. Future strategies to promote stronger collaboration and pathways, such as strengthening the connection with the Department of Child Protection and Family Support, primary care, NGOs and NDIS disability services need to be explored.

5.3 Recommendation

Recommendation 7

Establish a *Child and Adolescent Mental Health Ministerial Taskforce* to rebuild CAMHS

It is recommended that a *Child and Adolescent Mental Health Ministerial Taskforce,* led by an independent chair, is appointed immediately. The Taskforce will actively engage clinicians, families and young people and other key stakeholders, in the design and rebuilding of the CAMHS system.

In rebuilding CAMHS, there is a need to harness the experience and knowledge of those who provide the services and those who use them to find local solutions that fit Western Australia's unique circumstances. Appointing a Western Australian to head up the Taskforce reinforces the message that this State has the capability to meet its own challenges and has the resolve to restore confidence in the sector.

The Taskforce will have two complementary tasks to be undertaken in parallel:

- Oversee the immediate staged implementation of the Review recommendations over the next 18 months.

  Recommendations 4, 5 and 6, which are designed to 'close the critical service gaps', need to be implemented in parallel. Given the interconnected nature of the CAMHS system and the limited availability of the highly specialised workforce, the implementation will need to be carefully planned and conducted in close partnership with CAMHS to avoid unintended consequences, such as staff moving to new services leaving the existing services potentially unworkable and unsafe.

- Develop a whole of system plan for Perth metropolitan and WA country specialist public child and adolescent mental health services and make recommendations to the Minister with actions aimed at achieving better mental health outcomes for children and young people, paying particular attention to the adequacy and equity of service provision across all age groups.

  The Taskforce will identify the investment which is required to implement the whole of system CAMHS plan for specialist treatment and care; develop an implementation strategy including a timeframe and responsibilities; and establish a mechanism to ensure that the reforms are achieving their intended outcomes.

Appendix 1. Terms of reference

Chief Psychiatrist's Targeted Review into the treatment of Ms Kate Savage by Child and Adolescent Mental Health Services

Terms of Reference

Background

Kate Savage was a 13 year old girl under the care of Child and Adolescent Mental Health Services who died on 23rd July 2020. The Minister for Mental Health, on 6 August 2020, requested that the Chief Psychiatrist undertake a targeted, independent review into the treatment and care by public mental health services of Ms Kate Savage in the period leading up to her death.

In undertaking this Review, the Chief Psychiatrist will not only consider the clinical care provided to Ms Savage but will also consider any systemic gaps in current services for young people with high-risk complex needs, particularly for children between 12 to 16 years old, and identify how services can be improved.

The findings of the Review will form part of the broader *Young People Priority Framework* already underway by the Western Australian Mental Health Commission, which will make recommendations for those aged 12 to 24 across both the public health system and non-government services.

The Minister for Mental Health, with the powers invested by s517 *Mental Health Act (MHA) 2014*, requested the Chief Psychiatrist to consider this matter. As specified by s515 *MHA 2014*, the Chief Psychiatrist has a responsibility for overseeing the standards of treatment and care for patients of defined mental health services in Western Australia. S527 *MHA 2014* empowers the Chief Psychiatrist to investigate notifiable incidents reported under s526, and s529 and provides powers to make any inquiries that are considered appropriate.

Scope of the Chief Psychiatrist's Review

The Review will consider Ms Savage's treatment and care across all settings (inpatient, community and emergency department), and the communication between services and between services and her Family. The review will consider Ms Savage's longitudinal care and

will consider any relevant past care records and information as required, as well as more recent records and information.

The Review will pay particular attention to the adequacy of current services to respond to young people with complex needs and high risk behaviour and make recommendations aimed at addressing any gaps in the services available to support them and their families.

The Chief Psychiatrist's Review process sits within a framework of safety, quality and learning. The context of this Review will be consideration of the standards of care and the enhancement of these standards. The aim of the Chief Psychiatrist is to improve standards. The Chief Psychiatrist is not a statutory professional disciplinary body. The Chief Psychiatrist role does not preempt the role of the Western Australian Coroner, although the Coroner may consider the findings and recommendations of a Chief Psychiatrist's Review in any potential future coronial process.

Out of Scope

The Review will not consider child, adolescent and youth mental health service provision in Western Australia beyond that described in the scope above, but the Chief Psychiatrist retains the right to comment more broadly where such commentary may assist the Minister for Mental Health to improve the mental health of any individual and Family using mental health services in Western Australia.

Methodology

The Review procedure will include:

- Examination of Ms Savage's medical records and other relevant information;
- Interviews with her Family and other appropriate third parties;
- Interviews with relevant staff from mental health services;
- Examination of policies or programs, in so far as they are relevant to her treatment and care;
- The Chief Psychiatrist may consider any relevant literature, reports, expert commentary or jurisdictional data relating to the treatment of young people with complex needs and high risk behavior.

S519 *MHA 2014* also provides the Chief Psychiatrist with the power to do anything necessary to perform his function.

Standards

The standards against which the care will be considered will include relevant national clinical care standards, the Chief Psychiatrist's Standards for Clinical Care as well as consideration in the context of relevant contemporary guidelines or other standards.

Review Team

The Review will be undertaken by:

- Clinical Associate Professor, Dr Geoffrey Smith, Office of the Chief Psychiatrist.
- Adjunct Associate Professor, Ms Theresa Williams, Office of the Chief Psychiatrist.

- Professor Helen Milroy, Chair in Child & Adolescent Psychiatry, University of Western Australia.
- Dr Kyran Graham-Schmidt, Office of the Chief Psychiatrist.

Timeframe

The Review will formally commence on the 20 August 2020. It is intended that the Review will be completed by the end of October 2020.

Reporting

Findings and recommendations from the Review will be provided to the Minister for Mental Health.

Appendix 2. Acronyms and abbreviations

ACIT	Acute Community Intervention Team
ADHD	Attention Deficit Hyperactivity Disorder
AOD	Alcohol and Other Drugs
ART	Acute Response Team
ASD	Attention Spectrum Disorder
BFC	Bentley Family Clinic
BPD	Borderline Personality Disorder
CAHDS	Complex Attention and Hyperactivity Disorders Service
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CITS	Community Intensive Treatment Service
ED	Emergency Department
EDS	Eating Disorders Service
ETS	Emergency Telehealth Service
EUPD	Emotionally Unstable Personality Disorder
GP	General Practitioner
MHA	Mental Health Act
MHAS	Mental Health Advocacy Service
MHC	Mental Health Commission
MST	Multi-systemic Therapy
PCH	Perth Children's Hospital
PCL	Paediatric Consultation Liaison
WACHS	WA Country Health Service

Appendix 3. List of figures and tables

Figures

Figure 1 A timeline detailing Kate Savage's treatment through CAMHS and the PCH ED between July 2015 and July 2020

Figure 2 Growth in Community CAMHS referrals from 2015 – 2019

Figure 3 Growth in Community CAMHS activations from 2015 – 2019

Figure 4 Percentage of referrals activated by Community CAMHS from 2015 – 2019

Figure 5 CAMHS referrals by age group 2015 – 2019

Figure 6 CAMHS activations by age group 2015 – 2019

Figure 7 Number of ED attendances in metropolitan Perth by children and young people under the age of 18 that attempted suicide, were a suicide risk, or self-harmed by age 2009/10 – 2019/20

Figure 8 Re-admissions within 28 days to PCH Ward 5A

Figure 9 CAHS CAMHS budget as percentage of total mental health budget 2015/16 - 2020/21

Figure 10 CAMHS system components

Tables

Table 1 Summary of CAHS CAMHS Services

The Chief Psychiatrist aims to ensure that Western Australians receive the highest standard of mental health treatment and care.

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