Relationships Australia

SOUTH AUSTRALIA™

18 November 2009

Senator Rachel Siewert
Chair of Community Affairs Committee
PO BOX 6100
Parliament House
CANBERRA ACT 2600

Dear Senator Siewert

On behalf of Relationships Australia (SA), I welcome this opportunity to present a submission focusing on the impact of suicide on the Australian community, including high risk groups.

Our submission will specifically address 3 of the 8 terms of reference for the inquiry. They include:

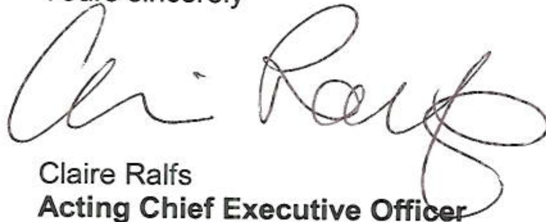
c) The appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide.

d) The effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide.

e) The efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk.

I am happy to provide additional information if required and welcome the opportunity to discuss our submission in more detail.

Yours sincerely



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Acting Chief Executive Officer

Enclosed: *Submission - Relationships Australia (SA) and Suicide*

Relationships Australia (SA) and Suicide

Relationships Australia (SA) (RASA) is a non-government organisation (NGO) that provides a range of services to support human and family relationships. Suicide risk is a key concern. This key concern is a common issue arising in our work when supporting people through issues associated with separation, childhood sexual abuse, family and domestic violence and problem gambling. RASA engages in a range of roles, relating to suicide risk including:

- provision of training to other services
- provision of front line services
- research into suicide risk factors
- development of programs addressing suicide risk factors.

This submission addresses points 3, 4 and 5 of the terms of reference for the inquiry in the following order:

3. ***The appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide.***

   We advocate for each service involved in suicide risk assessment to *share responsibility* for consumers rather than establishing lines of demarcation to determine who has *sole responsibility*.

4. ***The effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide.***

   Child sexual abuse, domestic violence and problem gambling must be included in suicide prevention training as significant risk factors for suicide.

5. ***The efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk.***

   The efficacy of training community workers to identify and respond to suicide risks is compromised if this information is not taken on by acute services.

1. Child sexual abuse, domestic violence and problem gambling must be included in suicide prevention training as significant risk factors for suicide

We suggest that childhood sexual abuse (CSA), domestic violence (DV) and problem gambling are three risk factors for suicide that demand greater attention in community services training. These three factors have traditionally been underplayed as risk factors, with emphasis instead being placed on mental illness and diagnosable conditions. Yet CSA, DV and problem gambling are severely stressful events that often result in feelings of shame or humiliation that is compounded by the secrecy surrounding them. Our many years of practice in these fields indicates a need for greater recognition of suicide risk within this work.

Childhood sexual abuse

The Living Is For Everyone framework (LIFE) (Commonwealth Department of Health and Aged Care, 2000) shows that child abuse is a significant risk factor for suicide. CSA affects between
10% - 27% of women and 3% - 10% of men reflecting not only a high prevalence. The Cry for Help Report (Breckenridge, Cunningham & Jennings, 2008) commissioned by RASA shows that CSA is independently associated with repeated suicidal behaviours into adulthood (Ystgaard et al. 2004). The report shows that 5% - 17% of people attempting suicide have CSA as a risk factor, but that it is often not disclosed.

CSA is kept secret by the individual and society. Survivors may not recognise it as abuse, they fear breaking up the family, and/or the perpetrator may have used tactics to convince them that they are responsible for the abuse through their consent or initiation. One victim described the social pressures toward silence by saying:

'I learnt to shut up. If you want to keep your friends, don't say anything.'

Ultimately, this places survivors in a dilemma of wanting others to know about the abuse and support them to stop the abuse, but not wanting to be judged or alienated. CSA can produce shame, humiliation, secrecy and social isolation that all contributes to suicide risk. Workers must be trained to understand the effects of CSA in relation to suicide risk.

Domestic violence

Up to 77% of women who have experienced domestic violence, report suicidal ideation (Golding 1999). Taft (2003) shows that women in domestic violence situations are up to 4 times more likely to report suicidal ideation than women who are not abused. As with CSA, women in abusive relationships fear the impact that disclosure might have on others, such as their children. Furthermore, they might fear their own social isolation or judgement and, through tactics of the perpetrator, may have been made to feel that the abuse is somehow their fault. Domestic violence can result in women feeling isolated, helpless and shameful which places them at risk of suicidal ideation and behaviour.

The majority of women are never asked about domestic violence by treating health services (Hegarty & Taft 2001). Women often take ownership of domestic violence and believe it is their responsibility to manage it. Unsupportive responses from community members or services can reinforce these feelings. It is essential for effective suicide prevention, that community workers understand the dynamics of domestic violence and feel competent to discuss it with women. If workers avoid, or fail to identify DV, then their capacity to determine a woman's suicide risk is compromised.

Gambling

Problem gambling is often associated with legal, financial and relationship problems (Battersby et al. 2006) which leave people vulnerable to the law, without financial resources and with few social relationships. People with a gambling problem have often been implicated in crime through theft and fraud, in order to fund their addiction. Fear of

prosecution and unemployment compound the stresses of financial insecurity. The LIFE framework (Commonwealth Department of Health and Aged Care, 2000) identifies legal problems or 'behaviour that brings people into conflict with the law or society' (p. 28) as significant risk factors for suicide.

Despite fear of prosecution, problem gamblers may avoid disclosing their problem to preserve their social relationships. Studies have shown how important social relations are to health (Wilkonson & Marmot 1998) and that, especially for men, suicide often follows the breakdown of personal relationships (Baume et al. 1998). Family and friends may marginalise problem gamblers for their behaviour, particularly its effects on others from whom they have borrowed, stolen or otherwise sourced money. These factors compound so that people find themselves feeling financial and legal pressures and extreme responsibility without supportive social relationships. People with a gambling problem experience compounded risk factors for suicide. Suicide attempts or suicidal ideation are, in our experience, common presenting factors for problem gambling as an underlying issue.

Secrecy and isolation

Research shows that connectedness to family, community and society are protective factors for suicide (De Leo et al. 1999). CSA, DV and problem gambling may each respectively disconnect people from their families, their friends and society. Unless these factors are disclosed and addressed, the symptom of suicidal ideation usually persists. Training of community workers that is focused on risk factor identification must include these three factors. Without workers who are competent and prepared to explore these issues and engage with suicidal ideation, people at risk may be unwilling to disclose, which compromises the identification of suicide risk.

2. The efficacy of training community workers to identify and respond to suicide risks is compromised if this information is not taken on by acute services.

The final evaluation report on the National Suicide Prevention Strategy (Aylward & Lawler, 2006) identifies the enhanced capacity of service providers and communities to identify risk factors and take appropriate action as integral to effective efforts at suicide prevention. The following case study demonstrates how the identification of risk factors is occurring, but that its efficacy is significantly reduced by limited avenues of collaboration and information sharing between services.

Case example

Soraya first accessed our agency through our Children's Contact Service that supports separated parents with children contact and changeover arrangements. Soraya had sought a separation due to the abusive nature of her relationship with Farbod. The court ordered a shared parenting arrangement and so Soraya used the Children's Contact Service to manage contact and changeover of their children. The Children's Contact Service facilitated changeover strategies that were less anxiety provoking for their child and the process appeared stable for almost 12 months.

One day, through contacts with the Iranian community, our service became aware that Soraya was missing from work and had been seen jumping in front of cars. It later emerged that this was the expression of significant distress over her relationship with Farbod. Despite their separation, Soraya had found it hard to separate from him and they had pursued a twelve month secret affair. Members of Soraya's family felt that Farbod made her dependent upon him, which made it hard for her to end their relationship, despite their legal separation. When Farbod then became involved with another woman, Soraya had become progressively distressed. Members of the school community, Children's Contact Services and members of the Iranian community had noticed her increasing emotional stress.

Police were contacted and Soraya was hospitalised for 5 weeks.

After this time, her consulting doctor contacted our agency, suggesting that the suicide attempts were situational and a product of relationship issues rather than an organic or diagnosable mental illness. It was suggested that a return to work was in Soraya's best interests and that relationship counselling would support her in coming to terms with the end of her relationship with Farbod.

An experienced Worker worked with Soraya to this end. Soraya still held strong hopes for a life with Farbod and was struggling to resolve feelings of humiliation and betrayal. With her Worker, she identified specific instances where she felt most vulnerable, such as during contact arrangements and when driving past her child's school during Farbods time as carer. Her Worker engaged Soraya in developing a community safety plan to support Soraya to manage her vulnerability, and to serve as an indicator of suicide risk.

Soraya eventually broke this safety plan. One day she left work in distress and drove away without informing anyone of her whereabouts or intentions. A previous suicide attempt is a strong indicator of risk, which in this case was compounded by Soraya's involvement in an abusive relationship, and the sense of loss over this relationship. Her Worker recognised these as risk factors and sought to take appropriate action. She contacted Acute Crisis Intervention Service (ACIS) and the hospital at which Soraya was previously detained to alert them to these risk factors.

Neither ACIS, nor the hospital would take the information being offered. The hospital stated that should Soraya present to their service, they would assess her risk at that time. Despite having direct experience with her pervious suicide attempt - and having themselves identified this as situational - the hospital refused to acknowledge this information as significant and deferred it instead to their clinical assessment processes.

The RASA Worker had identified suicide risk factors and developed a community safety plan. However, she was left with no avenues for appropriate action. She sought only to express the contextual risk factors that affected Soraya, so as to support the hospital in their assessment. However, the hospital was interested in the information obtained through their assessment alone which focused on her mental status and included none of the relevant and compounded risk factors. The hospital interpreted the Workers contact as a request for referral and in turn, this marked a sharp division between acute and community services, their perceived responsibilities and the limits of collaboration.

This case example shows how training community workers, to identify risk factors and engage consumers about suicide, must be complemented by an acute care system that acknowledges the pertinence of this information. Without collaboration between acute and community services where knowledge about clients is mutually valued and shared, community workers are left with few avenues for appropriate action.

In Soraya's case, the hospital valued the information gained through clinical assessment, yet there is no guarantee that the suicide risk factors in operation would manifest as a diagnosable mental illness. In fact, the hospital themselves, had previously come to this conclusion. By refusing to take on the information provided in preference for that obtainable through clinical assessment, they refused any responsibility for the situation while leaving our Worker feeling overly responsible, unheard and unsupported.

There are many reasons acute services may refuse responsibility. Significant time pressures mean that intake must be monitored so as to not overburden an already stretched service. But we were not seeking referral, only the sharing of information that would have assisted the hospital in a timelier and effective assessment, should Soraya have presented to their service. The hospital first reduced the concept of inter-agency collaboration to a process handover and referral of sole responsibility for a consumer, before then defending itself against taking this responsibility by refusing the information provided.

There is a need for more sophisticated collaboration between community and acute services in order to ensure that the suicide risk factors identified by workers translate into appropriate action and acute support.

3. We advocate for each service involved in suicide risk assessment to share responsibility for consumers rather than establishing lines of demarcation to determine who has sole responsibility.

Recommendation 8.7 of the South Australian Review of Community Mental Health Services (South Australian Department of Health, 2008) states that service drivers should be determined by the consumer's needs and not time restrictions. To realise this recommendation, acute services must incorporate information provided by community service workers concerning qualitative changes in behaviour and suicidal risk status. Sole reliance on a mental illness diagnosis as the condition of admission, serves as an exclusionary mechanism to protect a stretched mental health service against increased client loads and perceived time pressures. This practice, assumes that suicidal ideation is the result of a mental state, rather than a contextual trajectory made up of compounding risk factors. Such an understanding is incompatible with the training of community workers and risks missing major suicide risk within the population.

Gambling is a risk factor that clinical assessment can easily miss. Only 1.6% of Australians are identified as pathological gamblers while 3.8% are defined as problem gamblers (Schaffer & Hall 2001, in Batterbsy et al. 2006). The term 'problem gambler' has been employed, because of the legal, financial and social implications of gambling that can cause distress and harm. They are not confined to those diagnosed as pathological (Battersby et al.). Acute services that acknowledge suicide risk only through a clinical assessment and diagnosis, fail to address over half of the problem gamblers, potentially at risk of suicidal ideation or behaviour.

Similarly, while CSA may often manifest in mental illness, those without a diagnosis may still experience social isolation, fear, stress and familial pressure that contributes to suicide risk. Reliance upon identification methods that focus solely on mental illness fails to acknowledge the compounded risk factors for suicide experienced by survivors of CSA.

A close relationship with clients, places community services workers in a strong position to identify situational factors that contribute to suicide risk and detect qualitative changes

in behaviour, mood or context that may amplify this risk. However, they are not in a position to manage acute crises and so it is to acute services that they turn for support. Services must share responsibility for suicide rather than delineating limits for their sole responsibility.

Community and acute services each have particular skills, capacities and responsibilities around suicide, but these are not exclusive. Each service must perform its role by valuing the information and skills of others, in order to provide timely and supportive care for people at risk of suicide. Community services can identify, prevent and minimise risk factors, while acute services can detain and protect those at immediate risk of harm to themselves or others. But the capacity to detect this risk of harm essentially involves an understanding of the risk trajectory for a particular consumer, and the risk factors that make up this trajectory may not appear to be clinically acute enough to raise concerns. This is primarily the case, if community services are involved, as they are perceived to be a preventive support. However, once the non-acute community based arrangements have 'broken down', it is often only a matter of time before the situation becomes acute.

It is our experience that this period between the collapse of community based arrangements and the development of an acute situation, represents an important opportunity for suicide prevention. Yet because this opportunity seems to lie between community and acute services, where the former breakdown and the latter are yet to intervene, the strategies for inter-agency collaboration to productively realise this opportunity, demands further elaboration.

Conclusion

In this submission we have illustrated three key points:

1. Child sexual abuse, domestic violence and problem gambling must be included in suicide prevention training as significant risk factors for suicide. Unless workers respond to CSA, DV and problem gambling, the symptoms of suicidal ideation and behaviour usually continue.
2. The efficacy of training community workers to identify suicide risks is compromised, if this information is not taken on by acute services.
3. Each service involved in suicide, must *share responsibility* for consumers rather than establishing lines of demarcation to determine who has *sole responsibility*.

We strongly support the importance of this inquiry and hope that our submission may contribute to greater support for suicide prevention and crisis management in Australia.

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