RICHMOND FELLOWSHIP OF NEW SOUTH WALES
- SUBMISSION TO SENATE INQUIRY
INTO SUICIDE IN AUSTRALIA
(Term of Reference (c))

NOVEMBER 2009

INTRODUCING THE RICHMOND FELLOWSHIP

The Richmond Fellowship NSW (RFNSW) is a non-profit, non-religious, incorporated non-government organisation, which has been providing high level support to people with mental illness in New South Wales for 33 years. RFNSW has extensive experience in delivering services to people with serious mental health issues and is committed to enhancing the lives of people with a mental illness. RFNSW has a strong infrastructure; sound management practices and embraces a culture of continuous improvement.

Richmond Fellowship of NSW is one of several not-for-profit organisations in Australia providing support for people living with a mental illness. The Richmond Fellowship was established in the United Kingdom in 1959 and commenced operations in Australia in the 1970s. There are now Richmond Fellowships in each State and Territory of Australia, with the exception of Victoria and South Australia where the Fellowship recently changed its name to Mind Australia. In addition, the State and Territory bodies have established Richmond Fellowship Australia to promote a national approach on issues of common concern.

The not-for-profit sector makes a major contribution to the support of people with a mental illness and to the prevention of suicide in Australia. This role needs to be formally acknowledged.

Organisations such as The Richmond Fellowship also have a demonstrated capacity to innovate and to offer a greater diversity of services to respond to the needs of those at risk of suicide.

The strength of the RFNSW approach is the capacity of our skilled and experienced staff to engage with people with a mental illness with a positive strengths-based focus, offering practical support with the demands of daily living and a pathway to rebuilding connection with the community.

RFNSW recognises the importance of direct care staff having up-to-date training in Suicide Prevention. As such, RFNSW currently contracts MHCC (Mental Health Coordinating Council) to deliver Suicide & Self Harm training to all direct care staff. This training is a VETAB accredited module from the Cert IV Mental Health Work Non Clinical qualification. This is a 2 day training course which covers :

- warning signs of increased risk of self-harm or suicide and how to assess

- the level of risk
- how to gain information about an individual's thoughts of suicide or self
- harm
- recognising where and when to arrange assistance from available resources.

The Richmond Fellowship Policy and Procedures assists support and rehabilitation workers to make informed judgements and decisions in response to a service user at risk of suicide. The policy and procedures have been taken from standardised 'best practice' procedures for assessing and managing suicidal risk.

The policy provides clear guidelines to the warning signals that suggest suicide risk, response to a service user who is expressing suicidal ideations, and response where an attempt to suicide has occurred. It also includes a comprehensive reference of key publications on suicide risk assessment and management.

RFNSW works closely with the NSW Government (Area Health Services and Social Housing providers) in the delivery of government funded programs such as the Housing and Support Initiative (HASI), which has been a major initiative in New South Wales. We also work in partnership with Commonwealth agencies in the delivery of mental health support services such as the Personal Helpers and Mentors Program (PHAMS) which is funded by the Department of Families, Housing, Community Services and Indigenous Affairs.

These programs are providing significant support to people with a mental illness across NSW and Australia. These programs support people in different ways including:

- helping people to better manage their daily activities like housekeeping, shopping budgeting and using public transport;
- (in the case of HASI) providing and supporting long-term housing tenure;
- working with people to reconnect to their community;
- helping people get relationships with family and friends back on track;
- accessing appropriate clinical support;
- providing direct and personalised assistance through outreach services; and
- helping people connect with other services or programs that can help like drug and alcohol, housing or medical support.

The recent evaluation of the HASI 1 Program found that for all entrants of the program, the following positive outcomes were achieved:

- 90% of clients have a reduction in hospitalisations in the first year
- 85% of clients maintained their tenancy
- 72% of clients made new friends since joining the program
- 92% of clients were regularly seen by their case manager

- 89% were still in contact with their psychiatrist[1]

While the growth of new Commonwealth programs for people with a mental illness is to be applauded, there are risks of inconsistency and service breakdown where new programs are not well-integrated into regional and local service planning. It is also vital that these programs are well-linked to the work of General Practitioners at the local level, given that GPs are the primary source of support for 30-40 per cent of sufferers with schizophrenia. [2]

SUICIDE PREVENTION

The reasons for suicide or intentional self-harm are complex and multi-faceted. However, the evidence is that mental health factors are the strongest predictors of suicidal behaviour in young people at least. [3]

Suicidal behaviour represents a crisis point in the experience of living with a mental illness, whether diagnosed or not. The crisis point may arise for a number of reasons as a result of a change in the person's situation or mental state or loss of a source of support.

In our experience, people living with a mental illness need a continuum of support (both clinical and non-clinical). Within this continuum of support, it is possible to provide additional support at a point of crisis, which can prevent suicidal or self-harmful behaviour. Social isolation or lack of basic practical supports such as housing can be a significant trigger for self-harm.

Intervention by emergency services such as Police and Ambulance, at a point of crisis, needs to be complemented by the immediate availability of clinical and non-clinical supports, provided by a clinical mental health service and a mental health support service such as RFNSW.

PRIORITY AREAS FOR SERVICE GROWTH

Resources for discharge planning

It is widely understood that the point of discharge from an acute mental health service is one of the most vulnerable times for a person with a mental illness. This represents a particular crisis point for those at risk of suicide or self-harm. There is substantial documentation [4] about the importance of

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[1] A new direction in Mental Health, NSW Department of Health, 2006

[2] Meadows, G. N. (2003) Overcoming barriers to reintegration of patients with schizophrenia: developing a best-practice model for discharge from specialist care. *Medical Journal of Australia*, 178 (9) Suppl 5, S53-S56.

[3] Beautrais (1999) Risk Factors for Suicide and Attempted Suicide Among Young People, in Setting the Evidence-Based Research Agenda for Australia (a Literature Review), National Health and Medical Research Council and the Mental Health Branch, Commonwealth Department of Health and Aged Care, Canberra 1999, p 247

[4] See for example, the NSW Health Policy Directive 16 January 2008, Discharge Planning Policy: Adult Mental Health Inpatient Services, at www.health.nsw.gov.au/policies

integrated discharge planning which commences at the point of admission and brings together clinical care and non-clinical community support and wherever possible family members to develop a supportive transitional and post-discharge plan. Supported housing such as is provided in the NSW HASI model, by agencies such as RFNSW, is critical in this process.

While the commitment and policy base exists for this integrated approach, acute inpatient mental health services are under-resourced for this purpose. Instances of poor or non-existent discharge planning still occur and rely on the mental health support organisations for urgent intervention to rescue people from harm or homelessness. The Area Health Services in NSW also struggle to meet their commitments to provide community case management within the HASI partnership.

In recent times the role of support provider non-government organisations in the identification and ongoing support for clients likely to be in the higher risk groups has grown considerably. Recognition needs to be given to the burden of care provided by this sector.

Support Provider/NGO's must be included in care planning and delivery. Better coordination of services can be achieved through existing structures such as the Joint Guarantee of Services and the Human Services Accord (NSW examples). Improved communication between Health, Housing and Support providers especially during the critical time of immediately pre and post discharge cannot be stressed highly enough. Non-government support Providers, when involved, generally have much more frequent contact with the clients and are invariably at the front line for identification of increased risk. The clear requirement for appropriate communication is crucial to a sound continuum of care and support. Non-government services can actively coordinate these varied services to provide a more targeted response and develop express pathways to acute care for those who require urgent clinical assistance.

Involved support providers must be actively included in the discharge planning from the outset and new referrals for support must be made as early as possible. Risk management strategies for those clients identified as at significant risk of suicide need to be clearly defined in referrals ensuring support providers are aware and understand the responsibilities.

While Memoranda of Understanding and Service Level Agreements can spell out the broad categories of responsibilities a more defined "matrix of responsibilities" could be instituted to ensure clear understanding of the identified risks which will provide the key to bridging the gap between clinical and non clinical services. The matrix of responsibilities would include actual identified risks and a clear plan of whom in the continuum of care is accepting which responsibility. When responsibilities are clearly defined then the subsequent heightened sense of attention will provide additional protection for those clients at significant risk.

Community mental health support services such as Richmond Fellowship have the skills and experience to provide a specific discharge and transition planning and support role, to assist the acute mental health system with these issues. This could be provided through expansion of the HASI models, including outreach models such as "HASI in the Home" and with the provision of brokerage funds to obtain additional support.

Specific programs for high risk groups

Aboriginal people with a mental illness

The Richmond Fellowship is also a partner with NSW Health in the pilot of a specific HASI model for Aboriginal people with a mental illness. The Aboriginal community is identified as high risk for suicidal behaviour and development of services which can effectively engage with Aboriginal communities is a major priority.

RFNSW is also working closely with Greater Western Area Health Service and the Aboriginal community in Bourke in Far Western NSW to offer mental health support through a family and wellness model which is based on cultural competency and community knowledge. This work is at a very early stage and requires careful, community based evaluation.

Young people

RFNSW is able to demonstrate that by early contact and outreach with people who are at risk of mental illness or have early symptoms of a mental illness, it is possible to prevent suicide or self-harm and rebuild the person's connections with the community to the maximum extent possible.

RFNSW has been providing a Young People's Residential program in Western Sydney since 1997 in partnership with the former Wentworth Area Health Service and the Department of Housing. The Program is a residential psychosocial rehabilitation facility for young people who are experiencing serious mental health problems. It is a unique program, providing medium-term, multi-level support to young people within a collaborative care framework.

The program can accommodate up to 13 clients across three levels of support – intensive, medium and outreach. Clients are provided medium-term accommodation and rehabilitation support (to a maximum three years) as well as transitional assistance when moving into independent or other accommodation. The Young People's Program also provides informal advice and support services to former users of the service.

Clients wishing to enter the program undergo an extensive assessment process in collaboration with health and other partners. Psychosocial rehabilitation and support is offered in an environment of self-determination,

underpinned by the principles of informed choice and the need for assertive encouragement. Our program seeks to support young people to develop living skills, gain insight and develop positive strategies around living with a mental illness.

The emphasis which RFNSW places on rebuilding and maintaining family and social connections (a "social inclusion" focus) is supported by the extensive literature [5]on adolescent mental health and also adolescent suicide, which identifies the existence of positive social networks as a major protective factor.

As an example of the positive outcomes of this program, during the year 2005/06:

- 25 clients used the service
- 1 client attended university
- 11 clients found jobs and returned to, or commenced in the workforce
- 6 clients undertook TAFE courses
- 8 clients were referred to specialist employment services and were actively seeking employment during the reporting period
- 20 clients accessed drug and alcohol services
- 9 clients moved into independent accommodation
- 90% of clients remained drug free

The role of this Program in preventing suicide among young people can be seen anecdotally in the three de-identified vignettes attached to this submission.

The key to this program is the competent staff and the ongoing focus on building networks and agreements amongst the relevant service providers. The program does not intend to duplicate any existing service; rather, we seek to encourage stability in a client's circumstances by facilitating services and encouraging a partnership approach. This program could easily be duplicated, given reasonable proximity to existing services and willingness by all services concerned to engage in harmonious collaborative care.

Given the importance of early intervention in the management of mental illness, we have recently initiated a pilot program in Western Sydney in partnership with the Area Health Service and a local Youth Service. The Young People's Outreach Program (YPOP) is reaching young people with a mental illness and providing practical and emotional support before a crisis point is reached. This program is also being evaluated with the assistance of the University of Western Sydney.

This program provides support to achieve the goals identified by the young person, including

- living skills development;
- skills in self-management and crisis management;

[5] See for example, Garland, A and Zigler, F, Adolescent Suicide Prevention: Current Research and Social policy Implications, American Psychologist February 1993

- support to re-engage with developmental tasks, especially education and training;
- relationships with family and friends; and
- help to access other services such as income support, employment, drug and alcohol and other health services, accommodation, recreation etc.

These programs have also built good partnerships with local Police and GPs. These partnerships are crucial to ensure the continuum of care for those with a mental illness and to ensure an effective response at a point of crisis.

Women with a mental illness and their children

The Richmond Fellowship provides a unique service for women with a mental illness and their children in partnership with the local mental; health service. This service, known as Charmian Clift Cottages, is a six-bed facility in Western Sydney funded through NSW Health and the Supported Accommodation Assistance Program (SAAP). It provides a state-wide service to women with a mental illness who are homeless or at risk of becoming homeless with dependent children in their care
As the literature describes [6], there is a strong psychological and social rationale for early intervention to support mothers with a mental illness and their children. This includes the importance of effective parent-child bonding and attachment for the child's development, the need to maintain the relationship for this to occur at all, the importance of the mothering role as a meaningful life experience for the women, and the social and psychological cost of maternal-child separation and substitute care.

There is also literature on suicide as a cause of maternal death. [7] Although the equivalent Australian data is not known to RFNSW, the issues of effective diagnosis and early support are highly relevant.

The model of recovery and psychosocial rehabilitation provided at Charmian Clift Cottages includes support groups, parenting skills training and parent education, and one-on-one support to promote bonding, as well as a range of supports to develop life skills, find permanent accommodation and link to ongoing clinical and non-clinical support. The services are now also offered on an outreach basis to young mothers with a mental illness in the local community.

We are keen to undertake a formal outcomes evaluation of this service with a view to its replication as a prevention and early intervention model.

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[6] See for example, Nicholson, J and Henry A (2003), Achieving the Goal of Evidence-based Psychiatric Rehabilitation Practices for Mothers with Mental illnesses, Psychiatric Rehabilitation Journal, Fall 2003, pp122-130

[7] See for example, Oates, M, Suicide: the leading cause of maternal death, Editorial, British Journal of Psychiatry, (2003), 183: 279-281

Similarly RFNSW sees the potential to develop a broader range of family-oriented prevention and early intervention mental health services, for example, for women & men being released from gaol, with a mental illness/dual diagnosis, with or without children.

These programs have the potential to deliver important social outcomes, for example:

- Reduction of intergenerational cycle of mental illness.
- Healthy child development
- Increased resilience in children
- Good enough parenting
- Increased self efficacy in living, social and vocational skills.

Drought-affected rural communities

The incidence of suicide and intentional self-harm among farmers and others living in rural communities affected by drought has been widely documented and the importance of this issue has been recognised in the Suicide Prevention Strategy and other government initiatives.

Programs such as the PHAMS program (FaHCSIA) have significant potential to provide outreach to people at risk in these communities and expansion of this program is recommended.

These communities are often poorly serviced in terms of clinical mental health services and community mental health support services such as RFNSW generally do not have the resources to establish and maintain local infrastructure for continuing support.

RFNSW has made a commitment to the establishment of services in central and western NSW and is currently exploring new opportunities to provide community based support and to work with the drought-affected community in Condoblin.

CONCLUSION

RFNSW can demonstrate the importance of not-for-profit non-government mental health support providers as part of the continuum of support needed by people living with a mental illness.

This continuum of care has an important role in the prevention of suicide particularly if there are strong partnerships between clinical services, support services and the emergency services. These partnerships can become a strong protective factor for people who are at risk of suicidal behavior.

Flexible funding to enable support providers to respond to local need, and funding for innovation and research will be essential to continue to build the capacity to respond to growing need in our community.

RFNSW SUBMISSION TO SENATE INQUIRY INTO SUICIDE IN AUSTRALIA

ATTACHMENT

Vignette 1
R was a young man aged 17 when he was referred to the service. Before coming to the program R had been exhibiting symptoms of psychosis for several months, he had been using cannabis and alcohol on a daily basis and had long ceased any educational or vocational activities.

Soon after moving to the program it became apparent to support staff that R was suffering with low mood. As the support staff talked with R he disclosed that he had made plans to end his life by jumping in front of a train. R explained that he had been making these plans for several months and had intended to carry out the plan that evening. The support workers arranged an immediate clinical assessment and he was admitted to hospital where he received treatment for a mood disorder.

R later returned to the program where he enrolled in a TAFE course. He no longer uses cannabis and is mentally stable. Without the detection and intervention of the support workers that evening R may have followed through with his plan and taken his own life.

Vignette 2
J is a young man now aged 26. He has been receiving support from RFNSW since 2004 when he was referred by hospital staff for support. Before this J was homeless, he slept on trains and in parks. He regularly was admitted to inpatient units where he was treated for psychosis and eventually was diagnosed with schizophrenia. (J also has been diagnosed with a mild intellectual impairment and ADHD). J had not seen his parents or any family for many years.

One of J's symptoms is auditory hallucinations or voices. The voices J hears speak about him in a derogatory manner and frequently instruct him to kill himself. Prior to his last admission in 2004 J had been found on train tracks near a major regional city. He reported that he had received instruction from the voices in his head to stand on the tracks so that he would be hit by a train.

Since receiving support from RFNSW J has not been back to hospital. He tells support workers when he is hearing "bad voices" and support staff assist him to seek clinical support. J now has a community housing flat and is seen everyday by community support workers. He works part-time and has recently made contact with his father whom he had not seen since he was 15.

Support workers have prevented J from responding to these command hallucinations to kill himself on many occasions. The daily contact that he has with these workers means that his wellbeing can be monitored and he can be assisted to get clinical treatment when required.

Vignette 3
D is a man aged 26. He is diagnosed with schizophrenia and now lives in a community housing property. D has suffered from mental illness since he was 15 and has been hospitalised countless times in psychiatric wards up and down the east coast of Australia. He was a heavy user of many drugs from sniffing petrol through to heroin. D had attempted suicide many times and had spent a lot of time in locked observation wards due to his level of suicidal ideation.

D has been supported by the RFNSW since 2005. In the past 4 1/2 years he has been admitted to hospital only once. After support staff were unable to make contact with D at his home last year police were called to enter D's unit for a "welfare check". D was found in the unit acutely psychotic. He was paranoid and suicidal.
The support from the RFNSW has helped D to break a cycle of drug use, psychosis and suicidal ideation. Though D is not currently working there have been time where he has maintained employment for periods of several months at a time. He is contact with family and he has not been homeless since 2004.