Mental Health
Coordinating Council

Submission to the Senate Community Affairs Reference Committee

Inquiry into Suicide in Australia

November 2009

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The Mental Health Coordinating Council

MHCC is the state peak body for non-government organisations (NGOs) working for mental health throughout NSW, representing the views and interests of over 200 NGOs. Member organisations specialise in the provision of services and support for people with a disability as a consequence of mental illness. MHCC provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services to the community.

Facilitating effective linkages between government, non-government and private sectors, MHCC participate extensively in public policy development. The organisation consults broadly across all sectors in order to respond to legislative reform and sits on National, State (NSW) and State Government Department (NSW) committees and boards in order to affect systemic change. MHCC manages and conducts research projects and develops collaborative programs on behalf of the sector, and is a registered training organisation, delivering mental health training to the workforce.

The sector in which MHCC operates provides us with a unique opportunity to gain insight into the lived experience of people with disability as a consequence of mental illness who interface with mental health services. Consultation with the sector has consistently shown that many people challenged by mental health disability are unable to access the services they need, exacerbated by the stigma and discrimination that further limits social inclusion. Sadly, too many people only come to the attention of the community when the story of their death by suicide appears in the media.

MHCC is a signatory to the Submission to the Senate Inquiry initiated by Lifeline Australia; Suicide Prevention and the Mental Health Council of Australia which very comprehensively covers the main areas of concern to us.

Nonetheless, we take this opportunity to emphasise three areas of particular concern to our members and the sector:

1. Pathways for building resilience – suicide prevention

It is important to recognise where suicide prevention activities are likely to be most effective, ensuring that funds are targeted at areas where they will have the greatest impact. It is critical that approaches are community based, developed to bring about cultural change in attitudes regarding mental illness.

School teachers and those in training to be teachers; a range of service providers, including Indigenous community organisations; community service and health sector workers in contact with community based projects need to be targeted for mental health awareness training to reduce stigma and discrimination.
Similarly, to bring about a cultural shift in community awareness for future generations, increased understanding of mental health issues among secondary school students needs to be built into the curriculum.

MHCC stress the need to build capacity at an individual and service level, through increased access to, and utilisation of mental health and suicide prevention training and resources. The objective is to increase the ability of service providers to identify and respond to people at risk of suicide and self harm. A focus for these initiatives should include, for example: junior and senior school teachers; school counsellors and psychologists; vocational community staff working with children and young adults (i.e. sport, scouts; dance and drama etc); child support agency staff; GPs and allied health professionals; emergency department staff and Indigenous and CALD community workers.

These initiatives must provide a pathway to resilience for life by aiming to increase the coping skills of target populations by involving them in projects that: increase emotional literacy; improve communication and peer interactions; improve responses to cultural diversity and improve responses to bullying in school and other areas of children and young people's lives.

A particular aspect that MHCC wish to highlight is the need for teachers, school / pastoral counsellors and psychologists and others working with children and young people, to understand the dynamics and prevalence of childhood trauma: so that they understand and respond to challenging behaviours; eating disorders; self-harming and risk taking behaviours such as alcohol and other drugs; drops in performance or truancy with a consideration of the relationship between trauma and behaviour, and respond with more than behavioural interventions.

2. Risk of suicide or self-harm post-release

MHCC draw attention to the evidence of risk to people who have already engaged with mental health services but suicide or non-fatally injure themselves shortly following discharge from acute care.

Lapses in continuity of care, especially after discharge from emergency departments and inpatient psychiatry units, contribute significantly to suicide-related morbidity and mortality. Furthermore, individuals experiencing mental illness are at the greatest risk of suicide immediately following discharge from psychiatric inpatient care (and some detention settings—e.g. prisons and immigration detention centres).

Discharge planning must take into account the provision of a seamless transition from acute care to community living. This requires communication within and between agencies. There are many examples of lack of communication between agencies. The danger of poor communication between agencies cannot be understated, and action should be taken to enhance communication between agencies.

There is a need for adequate numbers of mental health case managers to be available in every public mental health facility or unit. These case managers need to be part of a multidisciplinary team, working in collaboration with NGOs in the community to coordinate services so as to provide holistic care for the individual. Coordination also needs to include GPs and other allied health professionals.

Linkage to mental health workers needs to be made prior to hospital discharge; and the connection must be maintained to support consumers develop plans that meet their changing needs in the community so as prevent risk of suicide, for up to at least 3 months after discharge.

Opportunities to develop a follow – up plan that includes coordination of community services should be provided to voluntary patients discharging themselves from hospital against the advice of the treating team, to minimise risk of suicide.

Centralised approaches to reform of mental health services implemented over the past 15 years in Australia have failed to achieve the widely shared aim of comprehensive, coordinated systems of care. Investment to date has focused on the development and integration of specialist mental health services and primary medical care. Whilst some progress has been made, substantial inadequacies remain in the comprehensiveness and continuity of care received by people affected by mental health problems, particularly in relation to social and psychosocial interventions which are some of the most effective ways of minimising risk of suicide and self-harm.

The transition between hospital and home also needs to take into account the provision of 'step down' facilities. A consumer may not need hospitalisation but may not be well enough to cope in the community. MHCC support the funding of early intervention sub-acute services that use existing partnership models with NGOs that have a strong evidence base. An example of this is the Victorian Prevention and Recovery Care (PARC) service model. This model aims to intervene early, prevent risk of suicide or prevent admission or re-admission to acute mental health inpatient care. PARC presents a step-up and step-down alternative to hospitalisation that is a partnership between NGO community mental health services with 24-hour community clinical services. 'Step-up' occurs when a person is becoming unwell. The client will enter PARC and receive early intervention services to avoid a hospital stay. 'Step-down' provides short-term transitional support after discharge from an acute admission, providing supported discharge, to minimise risk of suicide or self-harm.

3. Recognition of 'at risk' trauma victims

Sexual, physical and emotional abuse and neglect have significant mental health repercussions. Research studies consistently demonstrate that adult survivors of all forms of childhood abuse manifest high rates of mental illness and suicidality; depressive and anxiety symptoms; substance abuse disorders; eating disorders; post-traumatic stress disorders, as well as poor physical health.

Suicidality has been associated with childhood abuse in a number of studies.[1] In one, 16% of survivors had attempted suicide compared to 6% of their non-abused

cohorts.[2] Self-mutilation is consistently described among survivors (Lindberg et al., 1995). [3] In one study, 70% of survivors with a history of child sexual abuse who suffered from anorexia or bulimia had self-harmed by overdosing, poisoning, cutting or burning themselves or by head-banging.[4]

> *Child sexual abuse was responsible for 0.9% of the total burden of disease and injury in Australia in 2003. Ninety-four per cent of this burden was due to anxiety and depression; suicide and self-inflicted injuries and alcohol abuse. Of the 14 risk factors examined, child sexual abuse was the second leading cause of burden in females under the age of 45. Just over four-fifths of the burden from child sexual abuse was experienced by females and 14% was due to mortality. The burden from child sexual abuse, both in terms of rate per head of population and in absolute terms, peaked at around 40 years-old then declined with age. The contribution from anxiety and depression dominated at this age after which contributions from suicide and self-inflicted injuries and alcohol abuse became increasingly important.* (Begg at al., 2007). [5]

An abundance of international and Australian evidence identifies the barriers to service delivery survivors almost universally experience. The complex needs of adult survivors often overwhelm the capacity of mainstream services.

MHCC take this opportunity to draw the Senate Committee's attention to the plight of this 'at risk' group. Research confirms that adult survivors need access to long-term counselling/psychotherapy. The availability of short term access to psychologists and social workers through the MBS scheme (6-12 sessions) generally does not meet the psychotherapeutic needs of most survivors. We strongly urge the Inquiry to acknowledge the mental health needs of this long neglected group of clients and advocate for service provision to minimise risk of suicide and self-harm.

Central to removing long-term barriers to access, is a need for adult survivors to have the option to be referred directly to community services rather than via clinical services. We propose that in line with the Government's social inclusion agenda and a strong theme of prevention and early intervention, there needs to be an unambiguous acknowledgement of the necessity to provide a wide range of coordinated services providing holistic care for people with mental illness in the community who experience complex personality and behavioural problems as a consequence of childhood abuse, and are at high risk of suicide.

A good example of a wrap around service model is one provided by the Salvation Army to women escaping domestic violence throughout Australia. This includes emergency and medium-term accommodation; and support assisting women to identify needs and goals, formulate a plan and provide practical assistance which includes: establishing an income; counselling; sustainable accommodation; clothing and other resources; healthcare, legal and providing for children's needs. Many other smaller women's refuges also provide a diversity of support services through linkages to women's health centres providing i.e. social networking, counselling, psycho-education, employment and training; legal and childcare services.

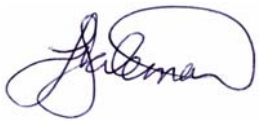
Similarly Shopfront Youth Services provide a range of services to deal with physical, emotional and social health problems that affect young people or their families. Services include: advocacy for youth health issues; counselling; drug diversion programs; harm minimisation program; health education, information and referral;

internet access; pregnancy testing; legal services and more. Likewise, services provided through STARTTS (Service for the Treatment and Rehabilitation of Torture and Trauma Survivors) is a broadly connected service model which helps refugees recover from their experiences and build a new life in Australia.

Services include counselling, group therapy, group activities and outings, camps for children and young people, English classes and physiotherapy.

MHCC thank the Senate Community Affairs References Committee for inviting us to provide a submission to the Inquiry into Suicide in Australia, and express our willingness to be consulted in the future. We look forward to the Committee's report to Government.

Yours sincerely,



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