Mental Health
Coordinating Council

Submission to the Senate Community Affairs Reference Committee

Inquiry into Suicide in Australia
Submission 11

March 2010

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Sen Rachel Siewert
Chair
Senate Community Affairs References Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Re: Senate Community Affairs Committee – Inquiry into Suicide in Australia
Mental Health Coordinating Council Presentation 3/3/10 -Submission 11

Dear Senator Siewert and Committee Members,

The Mental Health Coordinating Council thanks the committee for giving us the opportunity to present to you on 3 March 2010. As agreed we are sending this follow up submission to answer the three additional questions that were put to us on the day, as well as including our presentation in full detail.

PART 1 - Three Questions

1. A National Suicide Agency.
MHCC were asked whether we would support the establishment of a dedicated authority to oversee a National Suicide Strategy rather than it remaining under DoHA.

Whilst we made the comment at the hearings that it is disappointing DoHA has not progressed the need for a National stigma and discrimination campaign, our position is that in relation to a National Suicide Strategy a separate agency would just create another level of bureaucracy and that rather than create a separate body, greater attention must be paid to coordination between national suicide prevention activities and evaluation of programs.

Considerable funds have been allocated to the National Suicide Prevention Strategy. The total funding attached is $127.1 million for the period 2006-2012 which includes an additional $62.4 million over five years towards *Expanding Suicide Prevention Programs* provided as part of the Commonwealth's component of the COAG National Action Plan on Mental Health 2006 – 2011. Nevertheless, there appears to be a lack of outcome measurement data on which to evaluate the activities undertaken by each recipient organisation.

We are unsure whether an evaluation of the *Life is for Living* suite of resources for the prevention of suicide in Australia has been conducted, as data appears to be unavailable. We are not in a position to comment until access to outcomes evidence is presented on this initiative.

We do acknowledge that the most recent data from the ABS show a reduction in suicides nationally from 1.6% to 1.3%. However, there is no evidence that this is as a result of the National Suicide Strategy, or whether there are other factors in terms of societal change; funding or service delivery approaches that enables us to ascertain the reason/s for this lower figure.

2. Care Coordination

In July 2006, the Council of Australian Governments endorsed the *National Action Plan on Mental Health* (2006-2011). In this Plan COAG stated its commitment to ensuring coordinated care for people with severe mental illness and complex needs who are most at risk of falling through the gaps in the system. The Plan established a basis for a Care Coordination initiative to be implemented in each State and Territory. This involved collaboration in each jurisdiction between Commonwealth agencies and the relevant State/Territory government agencies, and non-government and private sector organisations linking care for people with a mental illness in need of extensive support in the community.

At the Senate hearing MHCC made the point that care coordination relied on there being an adequate number and range of services in the community. However, MHCC would also like to make the point that it is very important in the mental health system to ensure that there are a range of referral pathways to care and support, and that whilst referral pathways and partnerships to maintain continuity of care must be a priority for service providers, recognition that not all consumers will connect with clinical services must be respected. Many consumers are well supported by community organisations and GPs, and would not seek help if the clinical services were the central referral point.

The PHaMs program is an example of a program which allows for a diversity of referral pathways, in that people can access support directly without a referral from clinical services. There are a number of consumers who have had negative experiences of psychiatric hospitals and clinical approaches including adverse effects of medication, poor understanding of recovery principles and collaborative care and withdrawal of rights to self-determination. The positive outcomes for consumers able to access alternative options of support by engaging with a program like PHaMs is irrefutable. PHAMS prioritizes social and community integration whilst encouraging reengagement with clinical support through GPs and community health services where appropriate,.

In addition, Care Coordination as described in the Plan has not been as effective as it might be in part because greater clarity around role delineation between Government and Non-Government service providers is required. The need for this to occur has been identified by MHCC in numerous sector and workforce development forums and consultations highlighting the risk of service duplication as clinical services expand to traditional community sector 'whole of life' involvement,(including Vocational Education, Training and Employment (VETE) in NSW), rather than maintaining focus and service delivery on clinical care to those experiencing acute mental illness .

3. **Queensland Health Emergency Follow-Up Care Pilot Project** (Pilot, Qld Health & Division of GPs)

Senator Siewart asked MHCC to comment on the care pilot project in Qld that aims to help people at risk of suicide discharged from emergency departments, connecting them to GPs. This is the trial referred to by Dr Aaron Groves in his presentation to the Committee in Brisbane (Hansard, CA97 & CA98). The detail is somewhat unclear from the transcript but we have spoken to the Alignment and Reform Team who were kind enough to provide us with some details on the project.

Research has consistently demonstrated the effectiveness of case management treatment frameworks in improving post-discharge outcomes, evidenced by increased rates of compliance with treatment, heightened consumer satisfaction with mental health services, and reduced rates of self-harming behaviours.[i]

Discharge planning must provide a seamless transition from acute care to community living. This requires communication between agencies and action should be taken to enhance care-coordination. In order to reduce levels of suicide and self-harm a case management model must be initiated that in the first instance ensures a safe pathway (for a person at risk of suicide post discharge) to supported community living.

The importance of how people are able to manage their lives in the community should not be understated in terms of risk of suicide. Recovery is dependent on a plethora of environmental and social factors which include: safe long-term housing; social networks; activities; employment etc, as well as access to clinical services. Referral to a GP for a person at risk of suicide is an inadequate response, and may be detrimental if provision of ongoing social support is not considered of equal significance in reducing risk of suicide. The 'Hospital to Home' model funded by the National Suicide Strategy is a model that provides the consumer with a support worker who can: pick them up from the hospital; take them to appointments; support and connect them to the necessary services to assist them as they reengage with their community. This role is one that is well suited to a peer support worker who has received training in mental health and suicide prevention but who also has a lived experience enabling an additional level of insight into the needs and experience of the person they are supporting.

4. MBS Psychology Services and people in prison

MHCC wish to further emphasise evidence provided at the hearing in relationship to the need for access to alternative psychological services for prisoners with high rates of mental illness and co-existing intellectual disability, drug and alcohol and other conditions at risk of suicide, to assist them work through their psychological distress and assist them to plan and explore how life after prison will be. MHCC urge the Senate Committee to take a leadership role in this long neglected matter so clearly evidenced in the NSW Justice Health Inmate Survey 2009. People in prison should be able to access psychological services via the MBS however this is not currently allowed as Corrective Services is supposed to be providing this service. The fact is access to psychological counselling in prisons is extremely low. MHCC urge the Senate to review the Health Insurance Act 1973 which currently prevents prisoners from accessing MBS items on the grounds that they have access to services provided by arrangement with a government authority – Corrections NSW in this instance. We recommend the expansion to psycho-educational groups and evidence based individual interventions to be provided in gaol, and the shortage of clinicians in Corrective Services to be supplemented by the Commonwealth agreeing to provide MBS psychological services to inmates.

PART 2 – Presentation

MHCC take the opportunity to present on 3 key areas of concern as their primary focus:

- Stigma and discrimination
- Post discharge and post release
- The impact of child abuse

1. Suicide Prevention – stigma & discrimination

Frequently, people at risk of suicide are very isolated from society. Whilst the medical profession is important in managing suicidality, MHCC emphasise the significance of adopting an approach that enhances social cohesion. This is only achievable by embedding a flexible community managed approach into service delivery that provides the social connectedness and glue that helps communities become inclusive and resilient. We support six steps for social integration that provide a practical framework to bring the idea of community integration together with service delivery, (Carling)[ii]:

1. Increase opportunities for social relationships;
2. Increase support for social integration;
3. Increase diversity of social connections;
4. Improve continuity of relationships;
5. Expand the number of freely given relationships; and
6. Increase chances for intimacy

These community development steps are part of creating places where people can come together. It is not as simple as just placing people together and expecting them to connect. Support and preparation is needed, and CMOs, peer support networks, and other community based groups and agencies are ideally placed to provide this to achieve quality social integration.[iii]

Where suicide prevention activities are concerned, it is necessary to target areas likely to have the greatest impact on building resilience, promoting social inclusion and generating attitudes of tolerance and acceptance towards people generally and particularly towards people with mental health problems. To minimise stigma and discrimination, approaches must raise awareness through media and community campaigns, and build capacity at an individual and service level.

Australian mental health consumers have identified discrimination as the single largest barrier to their recovery. Discrimination against people with mental illness is recognized as a priority issue in all English-speaking OECD countries. National campaigns on mental health exist in Scotland, England, NZ, USA and Canada. Australia has a relatively poor track record in this regard. Even the work done by Beyond Blue in relation to depression pales against campaigns in other countries which have positive social inclusion campaign approaches to high prevalence and low prevalence mental health problems.

Research in the UK has found that an investment in stigma and discrimination campaigns of £0.55 pence per adult can produce a cost-saving of £4.51 per person: an 800% return on investment. Reducing discrimination increases the likelihood of people seeking support and treatment and leads to improved employment and education opportunities. Australia must invest in a clear and positive national stigma and discrimination media campaign comparable to other western nations. The campaign developed in Scotland in particular is worth noting.

Alongside a National Media Campaign to raise awareness, it is necessary to support community initiatives specifically targeted at school students, teachers, counsellors and vocational community staff working with children and young adults; and child support agency staff. These initiatives would not be dissimilar to Road Traffic Authority Drink Driving campaigns, but instead help people identify and respond to those that may be at risk of suicide and self harm.

MHCC also recommend a Prevention / Early Intervention evidence based model based on a US Program, Family Options which takes a family-centred, strengths-based approach to dealing with mental illness, parenting and family relationships. The program partners with people with mental health problems and their family's assisting to build networks of supports and resources. The aim is to strengthen the long-term mental health, well-being and functioning of all family members. The program provides personalized support to each family member as well as the identified adult or child.

Under this model families and individuals are supported by a 'family coach' ensuring service coordination across the diversity of services they need, which will vary over time. The model draws on a community managed model whereby the organisation partners or collaborates with other community orgs; public services (i.e. Centrelink type services); clinicians and

other allied professionals, in addition to providing a range of services, many of which are available in-house, such as: health and nutrition; sexual health; mental health, counselling and psychology; parenting; legal advocacy; housing; training and employment; living skills and recreation.

2. Risk of Suicide post discharge and post release

Post Discharge

ABS (2007) data tells us that suicide deaths in Australia represented 1.3% of all deaths and that for Aboriginal people this figure climbs to 3.7%. [iv] These figures may be substantially higher for both Aboriginal and non aboriginal peoples if unexplained vehicle and other accidents were to be included.

Trends show that men aged 30 to 34 years and 40 to 44 years are now at highest risk of suicide, compared with a decade earlier when men aged 20 to 24 years, 25 to 29 years and 75 years and over were at highest risk (DoHA, 2006). [v]

Mental illness is recognised as a significant risk factor for suicide. The review of research and evidence states that: *A diagnosis of a mental disorder is among the strongest risk factors for both non-fatal and fatal suicidal behaviour, and that co existing mental health and drug and alcohol problems increases the risk even further.*

Over the past 20 years the chronic problem of post-discharge suicide remains of significant concern worldwide. One study in the UK reported suicide mortality rates are 213 fold higher than the general population in the first twelve months after discharge from inpatient care (Goldacre et al, 1993).[vi] These figures need not be so high if adequate levels of ongoing community support services were put in place.

A controlled case study in Qld in 2008 by the Australian Institute for Suicide Research and Prevention ,[vii] funded by DoHA as part of the National Suicide Strategy was undertaken in response to Goldacre's findings that showed similar suicide figure post discharge internationally. The report provides ample evidence in its extensive report that: *there appear to be remarkable benefits in case-managing patients immediately after post-discharge*.

Data from Hong Kong suggests that post-discharge suicide fatalities appear to cluster, with up to 80 % occurring within the first year; [viii] 48 % within the first month, 28 % within the first week, and 13 % occurring on the actual day of discharge. [ix] This kind of research must inform service design if we are serious about reducing suicide rates.

The transition between hospital and home 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. Early intervention services that use existing partnership models with CMOs have a strong evidence base. MHCC recommend an example of this model which is the Victorian Prevention and Recovery Care (PARC) service model, a partnership between community managed mental health services and 24-hour clinical services. 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 Step-up' occurs when a person is becoming unwell, minimising risk of suicide or self-harm.

Similarly, MHCC recommend a national expansion to the HASI program, designed to assist people with mental health problems requiring accommodation support to participate in the community, maintain successful tenancies; improve their quality of life and most importantly to assist in their recovery from mental illness. HASI has been identified as a key program under the *New South Wales Interagency Action Plan for Better Mental Health* that is a

collaborative approach to the provision of mental health services between NSW Health, Housing and Community Managed rehabilitation services.

We likewise recommend expansion to the FAHCSIA funded Personal Helpers & Mentors Program that reduces risk of post discharge and post release suicide. Initiatives must provide a pathway to resilience by aiming to increase the coping skills of target populations.

PHaMs aims to increase opportunities for recovery for people whose functioning has been impacted by mental illness, providing the flexibility in service delivery people need. Under the PHAMS program people can, for example access support to help them manage everyday tasks or assistance finding alternative or more appropriate accommodation; support to access clinical care and access to employment, education or training opportunities; help to reconnect with family and friends and increase social networks and community involvement. For those at risk of suicide these services may be the critical circuit breaker of social exclusion. The Program focuses on **recovery** - demonstrating that people with a mental illness can lead a fulfilled life in the community with the same opportunities as other people.

Lapses in continuity of care, especially after discharge from Emergency Departments and inpatient psychiatric 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 prison and immigration detention centres.

Post Release

Suicides in gaol receive considerable attention from prison authorities in Australia. Programs and policies are in place to minimise the risk of suicide during incarceration. In contrast, far less attention is paid to the post-release period, when the duty of care shifts from the custodial authorities to the community. Studies suggest that the initial adjustment period after release is a time of extreme vulnerability, particularly for men.

An Australian study of recently released prisoners found that in the immediate 6 month post-release period, the suicide rate is three times higher than in the general population, On return to the community, variables associated with suicide such as hopelessness, significant loss, social isolation, lack of support, and poor coping skills are especially significant for this group (Kariminia et al, 2007. *Suicide risk among recently released prisoners in New South Wales, Australia*).[x]

MHCC urge this Inquiry to highlight the need of access to alternative psychological services for prisoners with mental health issues, at risk of suicide to assist them work through their problems; plan and explore how life after prison will be. Whilst convicted persons are eligible for Medicare benefits whilst in goal, the Health Insurance Act 1973 precludes them from accessing these benefits on the grounds that they have access to services provided by arrangement with a government authority – Corrections NSW in this instance – however whilst some psychological services are provided through Corrections in NSW, they do not fulfil the need as evidenced by the Justice Health Inmate Survey 2009, which shows very high rates of mental illness and psychological distress. We recommend the expansion to psycho-educational group and evidence based individual interventions to be provided in gaol, and the shortage of clinicians in Corrective Services to be supplemented by the Commonwealth agreeing to provide MBS psychological services to inmates.

MHCC recommend an expansion of the HASI model to provide a home for recently released inmates with mental illness and/ or co-existing mental health and drug and alcohol problems. This would greatly reduce the risk of suicide, post release for this vulnerable group.

3. Thirdly - Victims of Childhood Abuse.

Sexual, physical and emotional abuse, neglect and exposure to domestic violence have significant mental health repercussions. Adult survivors of childhood abuse consistently 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. 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. [xi]

Suicidality has been associated with childhood abuse in a number of studies.[xii] In one, 16% of survivors had attempted suicide compared to 6% of their non-abused cohorts.[xiii] Self-mutilation is consistently described among survivors. [xiv]

Over the last two decades, both in Australia and internationally, numbers of women in the criminal justice system have increased by 260 percent. Increasingly women are going to jail for longer periods for minor crimes, most frequently related to drug and alcohol crimes or theft. The statistics for Indigenous women is even more alarming.

One study found that 80 - 85% of women in Australian gaols have been victims of incest or other forms of abuse.[xv] Another study of 27 NSW correctional centres in 1999 found 65% of male and female inmates were victims of child sexual abuse and physical assault. [xvi]

According to the 2008 NSW Inmate Census by Corrective Services NSW, women represent approximately 7.3% of inmates in NSW of which 29% are Aboriginal. [xvii] The 2009 NSW Inmate Health Survey found:

- 27% have attempted suicide
- 45% experienced domestic violence or abuse as an adult
- 20% have been admitted to a psychiatric unit or hospital
- 66% have been in a violent relationship

Source: Indig, D et al. (2009). *2009 NSW Inmate Health Survey: Key Findings Report* (in press). Justice Health.

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

We recommend that in order to address this gap in service delivery CMOs must be supported to provide practical assistance such as: establishing an income; counselling; sustainable accommodation; clothing and other resources; healthcare, legal and providing for children's needs and well as programs that address DV; gambling; substance abuse; eating disorders as well as counselling services. Some women's health centres and refuges already provide a diversity of support services through linkages to other CMOs but these services are scarce and under-resourced. There is a need to support CMOS to build skills to enable the workforce to better engage with this client group.

Research including a study MHCC conducted in 2006 confirms that adult survivors need access to long-term counselling and 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.

In line with the Government's strong theme of social inclusion, funds should be allocated to community managed programs that provide individual therapy and connect people to support and psycho-educational groups. MBS funds could be used to provide psychologists and other specialist allied professionals, if there were greater flexibility around national accreditation schemes for professionals other than psychologists to undertake this work.

Such a scheme has been initiated that provides accreditation of counsellors who are clinical members of the Psychologists & Counsellors Association (PACFA) to be WorkCover accredited in NSW.

The only recent attempt to address this gaping hole in service provision is that in July 2009, the NSW Government enhanced funding to NSW Rape Crisis (in partnership with Women's Health) to enable one FTE counsellor to provide face to face counselling for adult survivors across several Women's Health Centres in NSW.

Finally, MHCC strongly recommend the need for a targeted National Strategy as suggested in the joint submission initiated by Lifeline Australia and Suicide Prevention Australia, which MHCC endorsed:

…….in the absence of a clear national strategy, it is unsurprising that roles, responsibilities and accountabilities are poorly defined. Further, unlike in other cross-jurisdictional and cross-portfolio issues, there is no agency at a national or state/territory level with the mandate to address suicide and suicide prevention. This is in stark contrast to the infrastructure, clear strategy with targets and regular public reporting on progress and investment in road safety, which has a lower number of deaths (notwithstanding the underreporting problem with suicide data).

MHCC recommend the following additional reference material:

Post-Discharge Care in Psychiatric Patients at High-Risk of Suicide (2008): Final Report to the Commonwealth of Australia, Department of Health and Ageing, on a research project funded under the National Suicide Prevention Strategy. Available: http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/Post%20Discharge%20Care%20in%20Psychiatric%20Patients%20at%20High-Risk%20of%20Suicide%202008.pdf

Evaluation of 'see me' - the National Scottish Campaign Against the Stigma and Discrimination Associated with Mental Ill-Health (2009). Available: http://www.scotland.gov.uk/Publications/2009/01/16153921/0

MHCC thank the Senate Committee for their interest and express our willingness to participate in any future consultations. We look forward to the publication of the report to Government.

Yours sincerely,

Jenna Bateman
Chief Executive Officer

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Dhossche, D., Ulusarac, A. & Syed, W. (2001). A retrospective study of general hospital patients who commit suicide shortly after being discharged from the hospital. Archives of Internal Medicine, 161, 991-994.

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[iii] Merton, R. & Bateman, J. (2007). Social Inclusion: its importance to mental health. Mental Health Coordinating Council.

[iv] ABS (2007) 3303.0 - Causes of Death, Australia, 2007. Available: http://www.abs.gov.au/ausstats/abs@.nsf/0/F7FFC6536E191ADBCA25757C001EF2A5?opendocument

[v] DOHA (2006). Evaluation of the National Suicide Prevention Strategy – Summary Report.

[vi] Goldacre, M., Seagroatt, V. & Hawton, K. (1993). Suicide After discharge from psychiatric inpatient care. The Lancet, 342, 283-286.

[vii]AISRAP. Australian Institute for Suicide Research and Prevention (2008). Post-Discharge Care in Psychiatric Patients at high risk of suicide. Final Report to the Commonwealth of Australia, Department of Health and Ageing,on a research project funded under the National Suicide Prevention Strategy.

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[ix] Deisenhammer, E., Huber, M., Kemmler, G., Weiss, E. & Hinterhuber, H. (2007) Psychiatric hospitilizations during the last 12 months before suicide. General Hospital Psychiatry, 29, 63-65.

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[xi] Begg,S., Vos, T., Barker, B., Stevenson, C., Stanley, L., & Lopez, A. (2007). The burden of disease and Injury in Australia, 2003. Published May 2005; ISBN – 12 978 174024 648 4: AIHW cat no. PHE 82.

[xii] Bryer, J. B., Nelson, B.A., Miller. J.B. & Krol, P.A. (1987) Child sexual and physical abuse as factors in adult psychiatric illness. American Journal of Psychiatry, 144, 44-68. Briere. J.& Zaidi. L.Y. (1989). Sexual abuse histories and sequelae in female psychiatric emergency room patients. American Journal of Psychiatry, 1989,146, 1602-1606. Bagley, C. & Ramsay R. (1986). Sexual abuse in childhood: Psychological outcomes and implications for social work practice. Journal of Social Work and Human Sexuality, 4, 33-47. Briere. J. & Runtz. M. (1987). Post-sexual abuse trauma: Data and implications for clinical practice. Journal of Interpersonal Violence, 2, 367-379. In Nurcombe, B. (2005). Paper Presented at Ausinet Workshop. Brisbane. Online. Available:http://auseinet.flinders.edu.au/resources/auseinet/workshops/csapre51.php

[xiii] Saunders, B. E., Villeponteaux. L. A., Lipovsky, J. A. et al. (1992). Child sexual assault as a risk factor for mental disorders among women: A community survey. Journal of Interpersonal Violence, 7, 189 -204.

[xiv] Lindberg, F. H. & Distad, L. J. (1985). Posttraumatic stress disorders in women who experienced childhood incest. Child Abuse and Neglect, 9, 329-334.

[xv] Easteal, P. (1994). "Don't talk, don't trust, don't feel". Alternative Law Journal, 19, 2, 185-89.

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