Submission to the Senate Community Affairs Reference Committee

Inquiry into Suicide in Australia

October 2009

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Committee Secretary
Senate Community Affairs References Committee
PO Box 6100
Parliament House
Canberra ACT 2600

To whom it may concern

Re: Senate Inquiry into Suicide in Australia

The NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG) is the peak, independent, state-wide organisation representing the views of mental health consumers at a policy level, working to achieve and support systemic change. Our vision is for all mental health consumers to experience fair access to quality services that reflect their needs

NSW CAG is pleased to have the opportunity to express our views regarding the incidence of suicide in Australia.

Mental illness "is a significant risk factor for suicide" (Living Is For Everyone, 2007). People in NSW who experience mental illness frequently report that the current mental health system fails to provide support to them when they need it. Instead, services frequently only become available when people reach a point of crisis.

Our submission speaks very specifically to the role and effectiveness of mental health services and others involved in the provision of mental health services in assisting people at risk of suicide, such as police and emergency departments. We aim here to highlight a number of gaps in the mental health services offered to consumers in NSW that, in our view, increase the risks of people living with mental illness experiencing feelings of suicidality.

To present this information we address terms of reference (c) and (d) in this submission.

Please do not hesitate to contact me on any questions that you may have.

Yours sincerely,

Karen Oakley
Executive Officer

Basis of this advice

NSW CAG exists to ensure that policy makers hear the perspectives of mental health consumers across NSW. The basis of this advice derives from information obtained through our core work, including regular interaction and consultation with people who use mental health services across NSW including:

- Over 900 people on our Network who are accessible via the internet;
- Face to face consultations with consumers in each Area Health Service across NSW; and
- Our knowledge base derived from consulting with consumers of mental health services in NSW over the last 17 years.

Summary of NSW CAG's recommendations

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

Police and law enforcement agencies

- Crisis intervention teams.
  Crisis intervention teams need to include both mental health professionals and police located in each Local Area of Command (LAC). Police interventions which include police in uniforms and marked cars should only be used when absolutely necessary.
- Intensive mental illness training.
  Intensive mental illness training for all police officers, including new recruits, is critical to ensure that police are equipped with the skills to de-escalate situations involving people who experience mental illness. It is vital that this is rolled out across the state and incorporated into the core training of new police recruits.
- NSW Health Transport Service.
  NSW Health needs to assume the responsibility for the transport and escort of persons who have a mental illness where a person is not a threat to the safety of themselves or others. A mental health ambulance service for the purpose of transporting consumers to and from hospitals is most viable.

Emergency Departments (ED)

- More PECC Units.
  Pilot studies of the PECC model conducted in NSW have been successful. NSW CAG now advocates for PECC units to become part of the continuum of care available in areas where there is both a demand and a need. We also encourage consumer consultation into the development and setup of PECC units to ensure services that are meeting consumer needs.
- Increased mental health training for ED triage staff.
  Staff members responsible for triage in the ED provided with training in mental health in recognising and providing support to consumers who may be suffering from acute symptoms of mental illness.
- Enhanced community services.
  There is a serious need for ongoing development and funding in the community sector to adequately support people living with mental illness. Of particular concern is the significant gap in step up and step down services which enable people who experience mental illness to increase and decrease their level of clinical and non-clinical support. Programs like HASI have clearly demonstrated the benefits and success of providing innovative community based support to people and strongly need to be expanded beyond the target groups of the HASI

program. These services need to be implemented and/or expanded to ensure that consumers receive the right support they need to help them stay well in the community.

- Mental health first aid training.
  All staff members in front-line support to partake in mental health first aid training.

Mental health services

- Adequate discharge planning.
  - Clear protocols that ensure that consumers discharge summaries are forwarded to the relevant team of clinicians, whether it is GPs, psychiatrists or both, to ensure continuity of care in the community;
  - Staff ensure that consumers have safe means of travel on discharge from an inpatient facility or hospital;
  - Post-discharge follow-up care by relevant community services is provided to consumers within the 7 day period from discharge. To ensure that this occurs, NSW CAG recommends that a discharge community officer be appointed to ensure that the connection between discharge from an impatient facility and care in the community happens (whether it be GP, psychiatrist or other relevant community service);
  - Consumers are provided with a case manager or referral to a GP where they can access psychologists through the Better Access Scheme;
  - Consumers are a key participant in their discharge planning, which includes consultation with the consumer about their needs to remain well in the community. This can include the development of a wellness plan or advanced directive, and adequate psychosocial support.
- Step up / step down services.
  - Establish step up and step down community mental health services which enable consumers to increase or decrease their level of clinical and non clinical care in the community following a hospital admission or during periods of increased symptoms.
  - Ensure options to fluidly move in between different levels of care.

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

National anti-stigma campaign

This would need to address the causes of suicide and create greater knowledge about how suicide can be prevented in every day life. It would need to include accurate information about mental illness and attempt to reduce the false or negative perceptions of mental illness to enhance help seeking. The anti-stigma campaign would also need to promote help and support services that are available within the community setting.

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

i) The role and effectiveness of police and law enforcement agencies

Law enforcement agencies such as police continue to play an important role in the care of people who experience mental illness. According to NSW Police, officers attend around 34,000 incidents a year where mental health is a contributing factor, which is almost 93 incidents per day (NSW Police 2009). Police are often the first called to respond to a person experiencing crisis, and have been referred to as 'front line mental health practitioners' (Senate Select Committee on Mental Health 2006). Police are heavily relied upon to respond to crises due to the lack of community after hours crisis services, or because mental health professionals will not attend due to the perceived danger. In regional and particularly remote areas in NSW, the only emergency service likely to be available to respond to a crisis is police (Senate Select Committee on Mental Health 2006, p.340).

The increased role and involvement of police in the care of people who experience mental illness has had many significant implications for mental health consumers. NSW CAG is particularly concerned about the increased criminalisation of people who experience mental illness; and how ineffective police practice has often led to escalation of crisis and increased stigma of mental illness:

<u>Criminalisation of mental illness</u>

The shift from deinstitutionalisation to community based care for people who experience mental illness has led many consumers to experience increased contact with law enforcement agencies, particularly police. While police are perceived to be 'front line mental health practitioners', this is not well reflected in consumer's experiences, as they continue to raise concern over the lack of mental health awareness and training evident in police behaviour. Consumers state that police involvement and treatment often makes them feel "like a criminal", due to their inability to recognise symptoms of mental illness.

> *"Why do they treat us like criminals? You get put in a police car like we are not innocent. The police should have different rules. They need to treat us with respect. The problem is they don't know we have a mental illness"* (Consumer, 10th September 2009).

The process of increased contact with police has often been referred to the "criminalisation of mental illness", where consumers are processed through the criminal justice system instead of being referred to appropriate mental health treatment (Sced 2006).

Ogloff and colleagues (2007) indicate that police officers have choices when confronted by a person who is acting in an erratic manner and demonstrating symptoms of mental illness. Police can attempt to resolve the issue; they can call a crisis team; they can take the person to hospital, or they can arrest them. The overrepresentation of people who experience mental illness in the criminal justice system suggests that, at least in the past, arrest has been the most prominent choice by police. In this regard, NSW CAG strongly advocates that police be supported in receiving adequate and intensive mental health training which educates police officers on how to improve the recognition of mental illness symptoms and how to develop appropriate responses to mental health crises, including referral to relevant community mental health services.

<u>Escalation through police involvement</u>

Our core work with consumers at NSW CAG indicates that people who experience mental

illness often feel threatened by the presence of police officers. The show of force and authority exerted by police officers can lead to the escalation of their symptoms at the point of crisis. The fatal shooting by police of Elijah Holcombe, a 24 year old from Armidale who was chased by police despite earlier family warnings that he was experiencing a mental health crisis and had become fearful of police (Welch 2009) is an excellent example of this.

Stigma and mental illness

Consumers have also reported feeling a sense of shame and humiliation when police have been called to assist them in crisis. Consumers have talked about their concern about marked cars and uniformed police in a mental health crisis intervention and how it can be misconstrued as a criminal matter by other members of the community. Some consumers have explained how police involvement has destroyed their reputation and had a detrimental impact on their mental and emotional wellbeing, leaving mental and emotional scars long after the event. One consumer explained:

> *"I haven't done anything wrong and they do it to me* [arrest] *in front of my friends and neighbours, and they completely destroyed my reputation and life"* (Consumer, 10th September, 2009).

In our view, it is paramount that consumer's privacy, dignity and self-respect are maintained at the highest level by police. Greater care is needed to ensure that mental health interventions are not confused with criminal behaviour and do not further contribute to the stigma associated with mental illness. Crisis intervention teams need to include both mental health professionals and police located in each Local Area of Command (LAC). Police interventions which include uniforms and marked cars should only be used when absolutely necessary.

Transportation by police vehicles

Under section 81 of the NSW Mental Health Act (2007), police have obligations to transport, or assist in the transport of, a person to a health care or custodial facility. In the Memorandum of Understanding between NSW Health, the Ambulance Service of NSW and NSW Police (2007), police vehicles should only be used in extreme circumstances to secure safety or as last resort.

However, through our core work at NSW CAG, we have heard consumers continually express that police vehicles are used regularly to transport them to, from and in between mental health facilities. This is of great concern to consumers, where police vans (also known as 'divvy vans') significantly contribute to the stigma associated with mental illness and place the consumer's physical safety at risk:

> *"The police handled me badly* – [there were] *no seatbelts in back of* [the] *divvy van. I was thrown around in the back with no seatbelt in the vehicle. I was treated like my life was worth nothing, like a criminal being taken to hospital"* (Consumer, 12th May 2009).

NSW CAG strongly advocates for more suitable options for transporting people who experience mental illness to, from and in between mental health facilities. We support recommendation 98 of the NSW Legislative Council Select Committee on Mental Health (2002) which proposed that NSW Health initiate and maintain a mental health patient transfer service for the transport of people with mental illness. To date, this recommendation has not been implemented in NSW.

Police training

While all NSW police officers now receive basic mental health training, only 166 officers to date have received the more intensive training in how to de-escalate potentially violent

situations involving people who experience mental illness (McDermott 2009). The aim to have 10 percent of all frontline officers receiving the training over the next five years is, in our view, grossly inadequate, particularly as there are currently 12,646 field operation officers in NSW (NSW Police 2009a). It is crucial that the methods used to respond to people who experience mental illness are different to a typical criminal emergency situation, and this training is critical to ensuring that police do not further contribute to the crises already being experienced by this vulnerable population group.

NSW CAG strongly advocates that this intensive training be rolled out across the state to all front line police officers over the next five years, and incorporated into the core training for new police recruits.

What's needed

Crisis intervention teams.
Crisis intervention teams need to include both mental health professionals and police located in each Local Area of Command (LAC). Police interventions which include police in uniforms and marked cars should only be used when absolutely necessary.

Intensive mental illness training

Intensive mental illness training for all police officers, including new recruits, is critical to ensure that police are equipped with the skills to de-escalate situations involving people who experience mental illness. It is vital that this is rolled out across the state and incorporated into the core training of new police recruits.

NSW Health Transport Service

NSW Health needs to assume the responsibility for the transport and escort of persons who have a mental illness where a person is not a threat to the safety of themselves or others. A mental health ambulance service for the purpose of transporting consumers to and from hospitals is most viable.

ii) The role and effectiveness of Emergency Departments (ED)

Hospital emergency departments have a major role in the care of people who experience mental illness. As there are often limited or no community services available consumers, particularly in rural and remote areas, EDs are in many cases the only option for consumers seeking mental health related services. They are an initial point of contact for people accessing mental health related services for the first time, and are often the only option available for mental health care to after hours.

However, many consumers continue to express that the ED is particularly non-therapeutic, stressful and inadequate environment where in many cases, treatment may not eventuate:

> *"*[The] *emergency department is not a receptive, helpful or useful way of getting treatment"* (Consumer, 28th May 2009).

Consumers have reported experiencing the following problems with ED:

1. Poor triage of mental health. Consumers report that mental illness related issues are generally considered as a low priority when they attend the Emergency Department:

   > *"Human judgement has been taken out of triage, with computers dictating what level of triage a person is. On the triage list, mental health is at the bottom of the list because we are not considered to be 'in pain'. They have to abide by the computer which tells them what level of emergency it is"* (Consumer, 21st September 2009).

Consumers attribute poor triage to a lack of understanding about mental health:

> *"Emergency* [department staff] *don't understand that you can be in as much pain experiencing psychosis as with a broken leg" (*Consumer, 21st September 2009).

NSW CAG believes that staff in the ED: 1) need to be supported to better understand the pain that consumers may be experiencing; and 2) that they would benefit from receiving mental health first aid training and/or access to relevant mental illness awareness programs.

2. Long waiting times. Consumers report that they spend inappropriately long waiting periods in EDs while waiting for an acute mental health bed to become available, or that they are discharged from the ED before one becomes available. This is particularly evident in the experience of consumers from rural and remote areas where community mental health services do not exist, and in other areas where after hours community crisis services are not available. Consumers often report to NSW CAG that lengthy waiting periods can exacerbate their symptoms and psychiatric distress. In some cases, consumers become so frustrated with the waiting time and lack of attention given to mental illness that they leave without being attended to. These experiences lead to feelings of hopelessness in people seeking assistance, and can be critical for someone who may be experiencing suicidal ideation and then leaves a hospital facility without a risk assessment and service support.

   NSW CAG strongly believes that timely access to emergency mental health services is appropriate to minimise the risk of harm consumers may face to themselves or to others.

3. Referral to alternative services. In many cases treatment may not eventuate for people experiencing mental illness who present to the ED. Often, consumers who are considered not to be acutely unwell are sent away from the ED without given explanations why their situation has not met the requirements of an 'emergency' situation and or referral to more suitable services within the community. This considerable gap in service delivery has meant that many people who may have been in the early stages of a mental health crisis have been turned away without any mental health support.

   NSW CAG advocates that if consumers presenting to the ED are not considered to be in crisis and an admission is not required, staff need to explain to the consumer why they are not being admitted, and refer the consumer to an appropriate mental health service in the community.

4. Staff attitudes. Consumers frequently discuss their impressions of staff attitudes in emergency settings and how these impact on the way they are understood and responded to in the community setting.

   > *"Emergency department attitudes are so appalling and I've heard them say that people with mental health were taking away time from the 'real work'"* (Consumer, 21st September 2009).

   One consumer explained how his level of care at the ED changed once staff became aware that he had the experience of mental illness:

   > *"I was a nursing student. I was cleaning linen, and I got really sick and had to go to the emergency department. I was vomiting and I had really bad diarrhoea. When I first presented to emergency they were really accommodating to me and were trying to help my situation, but as soon as I told them that I had schizophrenia that*

level of treatment stopped. It was that bad that I felt as if I wasn't getting the level of help that I needed and I had to leave and go home and look after myself" (Consumer, 21st September 2009).

Consumers should never be made to feel that their acute symptoms of mental illness are inferior to acute physical pain. Emergency Department staff need to be supported to attain a better understanding of mental illness and consumer experiences by receiving adequate mental health first aid training.

The problems experienced by consumers in the ED would significantly reduce if there were more adequate mental health support services available in the community. This would lead to a reduction in the strain placed on EDs and relieve the revolving door syndrome of re-admissions into inpatient units, and provide greater assistance to consumers to maintain their wellbeing in the community setting.

Psychiatric Emergency Care Centres (otherwise known as PECC units) are a new service model of care co-located with an ED that aim to provide rapid access to specialised mental health care, as well as helping to improve the capacity of the ED. The PECC unit offers two functions: mental health assessment and discharge planning for all those referred; and observation and short term care (less than 24 hours) for those seen as benefiting from such a stay. PECCS provide quick access to specialist mental health care and play an important role in providing adequate responses to people in need of emergency mental health care. Despite initial concern from consumers about segregation from mainstream health services, consumers report that they continue to be impressed with the services and care they receive at PECCS. Consumers who have used the units have found them to be a less stigmatising option with less waiting time, greater support from staff and a quieter environment separate from the activity of the ED.

What's needed

More PECC Units

Pilot studies of the PECC model conducted in NSW have been successful. NSW CAG now advocates for PECCS to become part of the continuum of care available in areas where there is both a demand and a need. We also encourage consumer consultation into the development and setup of PECCS to ensure services that are meeting consumer needs.

Increased mental health training for ED triage staff

Staff members responsible for triage in the ED need to be provided with training in mental health in recognising and providing support to consumers who may be suffering from acute symptoms of mental illness.

Enhanced community services

There is a serious need for ongoing development and funding in the community sector to adequately support people living with mental illness. Of particular concern is the significant gap in step up and step down services which enable people who experience mental illness to increase and decrease their level of clinical and non-clinical support. Programs like HASI have clearly demonstrated the benefits and success of providing innovative community based support to people and strongly need to be expanded beyond the target groups of the HASI program. These services need to be implemented and/or expanded to ensure that consumers receive the right support they need to help them stay well in the community.

Mental health first aid training

All staff members in front-line support to partake in mental health first aid training.

iii) The role and effectiveness of mental health services

Through the core work conducted by NSW CAG, it is evident that consumers prefer to receive treatment for their mental illness within the community. However, limited community mental health services often prevent consumers from accessing services prior to an acute episode, particularly if they do not associate with being, or are not considered to be, suicidal.

> *"I had a bad attack of depression and suicide, and I couldn't work out how to get help. A member of this group encouraged me to go to the hospital…they told me to walk. I nearly stepped in front of a truck... I was terribly stressed. They asked me if I was suicidal, and I said 'no' I was just distressed. They then said they couldn't help me. Where is the help for people who aren't suicidal? I was surprised that the service couldn't help me because I didn't want to commit suicide"* (Consumer, 18th June 2009)

NSW CAG strongly believes that inadequate discharge planning from an inpatient stay and lack of suitable step up and step down services prior to and following a hospital admission significantly contribute to the role and effectiveness of mental health services delivered in the community. These issues are addressed below.

a) Discharge planning

Research indicates that the highest risk of suicide amongst people who experience mental illness is in the first 28 days after discharge from an inpatient or hospital setting following an acute episode of illness (Senate Select Committee on Mental Health 2006, p.200; NSW Health 2008). Australia's National Suicide Prevention Strategy, the *Living is for Everyone* framework acknowledges that the risk is most imminent following discharge from a psychiatric unit if there is a history of suicide attempts or where person was involuntarily admitted, lives alone or is exposed to work stress (Living Is For Everyone 2007). The framework stipulates that mental health consumers need thorough treatment post discharge from hospital which includes addressing the circumstances which led to the admission; trauma which may have been experienced during admission (particularly if admission was involuntary); management of stresses; and improved follow up and ongoing suicide risk assessments. NSW Health's policy directive *Discharge Planning for Adult Mental Health Inpatient Services* (2008, p.18) acknowledges that the first 28 days after discharge are a period of increased risk, and that discharge planning needs to take this into consideration to ensure the continuity of care.

Despite this policy context, consumers are often discharged back into the community with little or no discharge care planning at a time when they still consider themselves to be unwell and in need of support. Consumer's concerns about inadequate discharge planning and post-care support include the following:

1. Poor clinical handover. Consumers are concerned about the lack of discharge summary paperwork that is forwarded to clinicians providing detailed notes about medication and treatment, and what services may be needed. Consumers report being handed their discharge papers without any referral to support services in the community setting, and NSW CAG considers this detrimental to ensuring the continuity of care for consumers in the transitional period back into the community.

2. Need for mandatory risk assessments. We have heard through our committee work that there is a gap in formal risk assessments conducted with consumers on discharge. Formal risk assessments must be conducted prior to leave/discharge for consumers who have been clinically indicated to be at risk of suicide/harm to themselves or to others.

3. Poor medication review. Consumers often report being on high doses of medication which impacts on their ability to function well in the community. For consumers in rural and remote areas, poor access to GPs and lack of private psychiatrists can often lead to

months of waiting before their medication is reviewed. Consumers report that this can make them feel too medicated to function, or that they make the choice to stop taking medication altogether, which triggers a return of symptoms.

> *"In this area, you can wait 3 months to see a psychiatrist – I needed to get my medication changed due to the high dose that I was on when I was discharged, but I had to wait 3 months"* (Consumer, 21st September 2009).

4. Lack of community transport. The limited availability of acute beds often means that consumers can be transferred long distances from their home to ensure that they can receive timely mental health care. However, this poses as a significant problem for consumers, particularly in rural and remote areas, who are left to their own devices to find their own way home with limited or no knowledge of local transport networks or even money to pay for fares.

> *"You are left to your own devices when you are let out of hospital – i.e. sent to Sydney then released with no way to get home* [to Bega]*. There is just no discharge planning"* (Consumer, 12th May, 2009).

NSW CAG has heard on numerous occasions that consumers have had to rely on hospital staff to provide them with money to pay for their transport fares home.

> *"Nurses often have to pay for transport because consumers can't afford to get home. They need community transport or shuttle buses so people can return home"* (Consumer, 21st September, 2009).

> *"There is a real issue for people going into hospital with no money and clothes. There is a need for coordination of services and there needs to be a discharge plan"* (Consumer, 21st September 2009).

The stress of having to find appropriate and safe ways of travelling home may cause unnecessary distress and a return of symptoms. It is inadequate the current system is relying on the good will of nurses to ensure that consumers can get home safely on discharge. Consumers must not be left to their own devices to find transport home, particularly if they have been provided with acute care in a hospital long distances/in another down from their home. In our view, this again supports the need for community transport to be provided for consumers to, from and in between mental health facilities.

5. Poor follow up care after discharge from the hospital and/or inpatient facilities. Some consumers have reported receiving no communication from mental health services in their transitional period back into the community. Many consumers and/or their carers have had to self-initiate their post-hospital care, and others report receiving phone calls rather than face to face follow up.

> *"We get thrown out back into the community and we are not able to organise ourselves – they need to make discharge planning compulsory"* (Consumer, 10th September, 2009).

Inpatient facilities and emergency departments need to ensure that appropriate referrals are made and community services need to ensure that consumers receive face to face follow up within one week of discharge from a mental health facility, irrespective of the risk rating given to the consumer. There needs to be a clear delineation of responsibilities between hospitals and community services for ensuring this follow up care.

6. Lack of available case managers. The shortage of case managers is particularly detrimental to consumers' health and wellbeing following discharge from hospital. Through

the post discharge period, consumers need to be supported to address their psychosocial needs which may include accommodation, income assistance, food, parenting needs, psychological support, education, employment, family and social connectedness. There is also a need to understand why hospitalisation occurred in the first place.

> *"Hospital facilities are good for acute care, but when you're sent home there is a need to find out why you got into that position so you can avoid getting into that position again"* (Consumer, 24th April 2009).

7. Lack of consumer involvement in the discharge process. Discharge planning needs to be undertaken in partnership with consumers, and where requested, carers and family members. Consumers often report that their involvement often involves being *told* what their treatment is, rather than being *asked* where they need support. Discharge planning needs to ensure that treatment is tailored to the individual and is within an environment which is conducive to recovery.

> *"On discharge, I wanted structure in my life and the doctor wasn't interested in what I wanted, which was help with access to employment. I was given no discharge planning except for offering me to come back to the hospital"* (Consumer, 4th August 2009).

Consumers also need to be supported in relapse planning through the development of advanced directives, where consumer's documented instructions are drawn on by health professionals in the event that the consumer becomes unwell and loses capacity to make decisions for themselves. Consumers also need to be provided with adequate information about how to maintain wellness in the community, and the local services which are available to them, should they become unwell.

Consumers indicate that the systemic failure to provide this adequate follow up care often results in increased symptoms and the 'revolving doors syndrome' of readmission to hospital. The gap in support structures between inpatient facilities and the community needs to be met with adequate step down or comprehensive primary care support services that assist consumers in the transitional period back into independent living. To consumers, the failure to provide this adequate discharge planning indicates that the mental health system has failed in its obligation to ensure that they experience a safe and successful transition back into the community. Discharge planning needs to extend beyond the current minimum of making sure that the consumer has somewhere to go, or that someone has been informed of their discharge.

b) Developing flexible community service models that prevent hospitalisation and keep people in their communities

NSW CAG strongly advocates for the development of a range of step up and step down services available to enable consumers to increase and decrease their level of support and care in the community. We believe that this is a critical component of suicide prevention for this vulnerable population priority group.

Currently the lack of enhanced support and interventions available to consumers prior to and following a hospital admission means that consumers have to wait until they are acutely unwell before they can receive (or return to) treatment. Consumers, both in our consultations as well as in local and international research (NSW Health 2008: Goldsack et al 2005; Hobbs et al 2002) continue to express their preference to be treated in the period prior to hospitalisation, within the community setting:

"There is a lack of community services for consumers as opposed to hospitals – we could do heaps of things and early intervention instead of ringing the crisis team, before people become unwell" (Consumer, 4th August 2009).

"Prevention is so important – we shouldn't be getting to this point [hospitalisation] *and we should be stopping them before they end up in hospital!"* (Consumer, 21st September 2009).

Early intervention / step up services

Early intervention in the form of step up services enables the consumer to receive more intensive care while still remaining in the community, which can lead to a reduction in the level of hospital admissions. As highlighted earlier in this submission, many consumers present to EDs due to a lack of alternative options available, but are denied admission because they are not considered to be in acute distress. Appropriate step up services would enable people to receive this support before they reach the point where suicide may be contemplated. NSW CAG strongly advocates that people who experience mental illness be provided with support at a stage when they say they need it.

Post-vention / Step down services

Step down services provide much needed support to consumers making the transition back to the community. For consumers who have strong social support in the community, discharge often comes too early without adequate post care planning to support their transition back in the community. Early discharge can often result in increased or returned symptoms and possible readmission. For other consumers who do not have social support or accommodation options, their inpatient stay is often longer than necessary due to a lack of options to provide care in a less restrictive environment. Longer inpatient stays and high readmission rates contribute to the shortage of acute bed availability and block the availability of hospital services for new admissions when they are truly needed.

As consumers prefer to remain in the community setting, which is fundamental to recovery, consumers need to be provided with options to increase and decrease their level of clinical and non-clinical support within the community. Such community services are essential to reducing suicide, so that consumers

- Are supported to continue their lives in the community;
- Remain socially connected;
- Experience minimal disruption to their life;
- Maintain a recovery focus.

Options to move in between levels of care

In conjunction with step up and step down services, consumers need to be provided with the opportunity to access different levels of care. Currently in NSW, consumers cannot readily increase their level of care within the community should they become unwell again without re-entering through the triage system. This often involves presenting to hospital, speaking to a mental health intake service or using the mental health access line. One consumer explained:

"The community mental health team and their policy has done a total back flip. Now they are only seeing you when you come out of hospital. Unless you keep close contact with them, they take you off the books" (Consumer, 28th May 2009).

Consumers report that they cannot return to their case manager or service where rapport has been established, and again, consumers struggle to find support until they reach a point of crisis.

"I had no contact with any area health service for 12 years - how could they intervene at an early intervention stage? You ring the crisis team and they tell you come back when you are sicker – but we need services now and not at that later stage" (Consumer, 4th August 2009).

These services are needed to ensure that consumers get help and support before they reach a point of desperation, or suicidality.

What's needed

Adequate discharge planning

- Clear protocols that ensure that consumers discharge summaries are forwarded to the relevant team of clinicians, whether it is GPs, psychiatrists or both, to ensure continuity of care in the community;
- Staff ensure that consumers have safe means of travel on discharge from an inpatient facility or hospital;
- Post-discharge follow-up care by relevant community services is provided to consumers within the 7 day period from discharge. To ensure that this occurs, NSW CAG recommends that a discharge community officer be appointed to ensure that the connection between discharge from an impatient facility and care in the community happens (whether it be GP, psychiatrist or other relevant community service);
- Consumers are provided with a case manager or referral to a GP where they can access psychologists through the Better Access Scheme;
- Consumers are a key participant in their discharge planning, which includes consultation with the consumer about their needs to remain well in the community. This can include the development of a wellness plan or advanced directive, and adequate psychosocial support.

Step up / step down services

- Establish step up and step down community mental health services which enable consumers to increase or decrease their level of clinical and non clinical care in the community following a hospital admission or during periods of increased symptoms.
- Ensure options to fluidly move in between different levels of care.

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

Research from Australia and overseas has indicated that media reports which portray suicide in a negative way can lead to imitation acts and increase the incidence of suicide within society (Pirkis et al 2009). While the Mindframe National Media Initiative has encouraged responsible, accurate and sensitive reporting of suicide in the Australian media, suicide continues to be a taboo subject for public discussion in the community. In our view, the lack discussion and limited knowledge available about suicide leads to unfounded beliefs about the causes of suicide, decreases people's willingness to seek help and limits access to helpful information.

At consultations run by NSW CAG, we have heard how poor public discussion about suicide has compounded the experience of people who may be experiencing suicidal thoughts or those that have lost someone to suicide. One consumer explained:

> *"I have known 100 people committed suicide. It's the 30% rule - 30% will get better, 30% will kick on, 30% will commit suicide. With suicide, everyone here knows someone that has committed suicide, but they don't talk about it, or about grieving. We need support in dealing with grief. How do you prevent suicide? What assists?"* (Consumer, 30th June 2009).

We believe that a national anti-stigma campaign which includes sensitively managed discussions about suicide is essential to normalise the human experience of difficult emotional times, and reduce the incidence of suicide. It is paramount that the discussion focuses on the experience of difficult circumstances rather than suicide as a way of responding to such circumstances. This campaign would need to emphasise that there is no shame in experiencing feelings of hopelessness, helplessness and despair, and that there are services which can offer support in the community.

NSW CAG advocates that the anti-stigma campaign address the causes of suicide, and create greater knowledge about how suicide can be prevented in every day life. That it provide accurate information about mental illness, and attempt to reduce the false or negative perceptions of mental illness, as a way of enhancing help seeking. Finally, the anti-stigma campaign would need to promote help and support services that are available within the community setting.

It is our view, an anti-stigma campaign could play a powerful role in addressing the stigma associated with help seeking when experiencing strong emotions and difficult circumstances, particularly for those who experience suicidal ideation.

What's needed

A national anti-stigma campaign which addresses:

- the causes of suicide;
- suicide prevention strategies;
- accurate information regarding mental illness;
- reducing false or negative perceptions of mental illness, as a way to enhance help seeking; and
- provides reference to help and support services that are available in the community.

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