Private Mental Health
Consumer Carer Network (Australia)

engage, empower, enable choice in private mental health

29 October, 2009

SENATE COMMUNITY AFFAIRS COMMITTEE - INQUIRY INTO SUICIDE IN AUSTRALIA

We thank the Senate Community Affairs Committee for the opportunity to provide comment on the consultation to the Inquiry into Suicide in Australia.

The *Private Mental Health Consumer Carer Network (Australia)* (hereafter Network) represents Australians who have private health insurance and/or who receive their treatment and care, and those that care for them, from private sector settings for their *mental illnesses or disorders.* As our title implies, the Network is the authoritative voice for consumers and carers of private mental health settings.

The Network is committed to working with the Government and would be pleased to work with the Senate Community Affairs Committee and relevant others in addressing the needs of people and their families who contemplate suicide, attempt suicide or commit suicide. We bring to the Inquiry a private mental health consumer and carer perspective.

Mental health brings with it many challenges. As a consumer and carer organisation we are in a position to provide direct lived experiences to the Senate Community Affairs Committee and would welcome the opportunity to engage in further consultations, either independently or with other relevant organisations.

The Network has made the following seven recommendations.

Recommendation 1
The Network recommends greater targeted prevention strategies for men.

Recommendation 2
The Network recommends the reporting protocols of deaths within 28 days of discharge from a mental health facility be linked to coronial reporting requirements.

Recommendation 3
The Network recommends the reporting of any death within 28 days from consultation with a health professional for a mental health issue, be linked to coronial reporting requirements.

Recommendation 4
The Network recommends greater clarity in public awareness programs targeted towards suicide.

Recommendation 5
The Network recommends suicide prevention training is provided to health and community workers who provide services to individuals with a mental illness.

Recommendation 6

i) The Network recommends the urgent mandatory introduction and use of a clinician rated and validated suicide risk assessment tool, within public and private mental health sectors, at *admission* and *discharge* from inpatient settings and within a 91-day *review period* in community settings.

ii) The Network recommends the introduction and routine use of a clinician rated and validated suicide risk assessment tool for all people in contact with community mental health support organisations.

Recommendation 7

The Network recommends this Senate Community Affairs Committee – Inquiry into Suicide in Australia support as a matter of urgency, the actioning of the previous Senate Community Affairs Committee Report – *Toward recovery; mental health services in Australia.* Recommendation 25 of the Report of 25 September, 2008. (Please see Page 6 for full text of this Recommendation)

Submission

The focus of this Submission is on people living with a mental illness or mental health issues. These people are at a high risk of suicide. Suicide is a topic most people find difficult to discuss and to understand. However, people with a mental health disorder may often live day by day with suicidal thoughts - it may be a central factor of their mental illness and/or the issues associated with their struggle. These issues may include (but not be limited to) social isolation, a deep sense of failure, neglect by themselves and others or a profound grief at the loss of many important things in their lives as a consequence of their mental illness - not the least being, the normal functioning and recognition as an individual of worth.

We would like to address the Committee's Term of Reference individually.

a) The personal and social costs of suicide in Australia

The Network recognises the enormous costs of suicide in Australia. The personal, social and emotional costs left after the suicide of someone close are immeasurable.

In addition to grief, emotions of guilt, blame, anger and frustration are all felt by families, friends and work colleagues. People find it hard to fathom why someone chooses to take their own life. Both grief and guilt are often heightened for those left after a suicide because of their belief that the death could have been avoided and that in some way some responsibility rested with them and their inaction. Research shows that people affected by the death by suicide of someone close to them are at a greater risk of suicide themselves.

Suicide is a topic the Australian community does not openly discuss as a general rule and seems more comfortable in avoiding the matter. Families will report that following death by suicide of a family member, people i.e. friends, neighbours etc tend to react in a negative manner toward them, often avoiding them or avoiding talking about the death (or life) of their loved one.

Many of us exposed to the mental health area know people who have chosen this path as a solution to their suffering, or know their families. Suicide within mental health is a reality - with some people living with suicidal thoughts on a daily basis.

When an individual chooses to take their own life, it is generally a reflection of their inner torment to which they see no end or no escape.

b) The accuracy of suicide reporting in Australia

We believe there are a number of factors which impede accurate identification and recording of possible suicides in Australia.

i) Single person fatal vehicle accidents

It is well known that the suicide rate in young males especially in rural communities is higher than in the cities. The Network questions if many single vehicle deaths in the road toll are actually accidents, but may instead be acts of suicide by men.

ii) Rural and regional areas

The Network is concerned about the increased rate of suicide in rural and regional areas of Australia. It is common knowledge that these areas, although having a much higher rate of suicide than metropolitan areas, continue to have fewer mental health services. Increasingly, the results of drought, natural disasters, loss of properties held in families for generations, lack of employment and social networks all compound on the health of people, particularly men, in these areas.

Stigma also plays a huge part in impeding mental illness identification and treatment in rural and regional areas. Both men and women in small communities often seek assistance from health professionals outside of their local community, especially for mental health issues, for fear of the reaction of others within their small social environ.

iii) Suicide rate higher in men

Men often refuse to get help and treatment for mental health issues, failing to either recognise a problem exists or to admit there may be something wrong. Data detailed in the Australian Bureau of Statistics Report of 2007 shows that the age-standardised suicide rate in 2005 was 16.4 per 100,000 for males against 4.3 per 100,000 for females. The Report therefore vividly illustrates that through the 10 year period to 2005, male suicide death rate remained roughly four times higher than for females.

Clearly, men must be a more highly targeted group for suicide promotion strategies.

Recommendation 1.
The Network recommends greater targeted prevention strategies for men.

iv) Suicide whilst an inpatient of a public and private mental health service.

All suicides whilst in the care of inpatient health services are madatory reporting requirements classified as a sentinel event. These are the subject of coronial inquiries.

iv) Discharge from a mental health service and suicide

It is acknowledged that a number of people suicide within a short period of discharge from a mental health facility. This could be deemed to imply that either discharge has been premature, recognisable risk factors at the time of

discharge are not taken seriously or that there is insufficient community referral and support provided following discharge.

We understand that a reliable collection of information of this nature would require linkage of health service data collections with coronial data collection.

The Network further understands that it is *not mandatory* for public mental health services to collect this information as part of the national data collection protocol.

Similarly private mental health services are *not required* to follow up, support or provide services in the community. Any consequential cases of suicide occurring post-discharge can go undetected – or at least, unrecorded. All admissions to private sector mental health facilities are mostly via a private psychiatrist, though in some instances by a GP or other referral and the private psychiatrist, GP or other referrer *discharge the consumer into their own care*. The private hospital is *not required* to initiate any process by which to follow the consumer after discharge As a result, private mental health facilities are precluded from mandatory reporting of information of this nature.

The Network considers that **the lack of** suicide reporting for mental health services is of major concern. The Network understands that the collection of this kind of follow-up information is hampered by the difficulties imposed by privacy legislation. Whilst a person is in a service's care the service is obliged to collect and report certain information. Once a person is discharged, it becomes very difficult for health service providers including individual practitioners to be aware of this important information.

The Network concludes that efforts must be made to collect, report and review all occasions of death by suicide following discharge from mental health services.

Recommendation 2.
The Network recommends the reporting protocols of deaths within 28 days of discharge from a mental health facility be linked to coronial reporting requirements.

Recommendation 3.
The Network recommends the reporting of any death within 28 days from consultation with a health professional for a mental health issue, be linked to coronial reporting requirements.

c) The appropriate role and effectiveness of agencies

Different agencies can and do play a vital role in effectively preventing suicide. We acknowledge the critical role of police and/or emergency services in de-escalating attempted suicides, risking their own safety and wellbeing. Mental health is a challenging area when people with florid psychotic symptoms, who are at risk of harm to themselves, prove very difficult to manage.

d) The effectiveness of public awareness programs

There are currently *many* public awareness programs around seeking help for a mental health issue. There are also *well publicised crisis help lines* available 24 hours per day 7 days per week. Yet, even these 'talk' more about seeking support in general terms rather than actively seeking help to specifically address thoughts of suicide. The wording is implied yet does not specifically talk about suicide and/or suicide avoidance.

There is only limited public awareness programs directly targeted at suicide. The fear being that if suicide were openly discussed, people who are particularly vulnerable could be unconsciously swayed into attempting to end their life in a 'copy cat' type manner.

Recommendation 4.
The Network recommends greater clarity in public awareness programs tarted at suicide.

e) The efficacy of suicide prevention training and support

The Network believes that specific suicide prevention training needs to be introduced to health and community workers providing services to people with a mental illness.

The Network also strongly supports the introduction of a suicide risk assessment screening process on a regular basis for all people contacting health services or health professionals regarding a mental health issue. Further, we strongly support the introduction of an identical process into community organisations supporting consumers with a mental illness.

Recommendation 5.
The Network recommends suicide prevention training be provided to health and community workers who provide services to individuals with a mental illness.

f) Targeted programs and services that address high-risk groups

(i) We have addressed a number of high-risk groups in (b) above - namely young men, men generally, those from a rural or remote areas and those with a mental illness.

A number of reports over the past 10 years have found strong evidence that mental health problems are a major contributor to suicidal behaviours. It has been suggested that up to 90% of people who had committed suicide were suffering some form of mental illness. Further, research suggests that people with a diagnosed mental illness are 10 times more likely to take their own life than the general population.

We have put forward recommendations we believe will address some of the issues. However, there are a number of people with specific diagnoses within mental health that are particularly prone to the risk of suicide.

Those individuals diagnosed with depression, schizophrenia, substance abuse and borderline personality disorder are particularly at risk of suicide. *Schizophrenia* has a suicide rate of around *8-10%* of sufferers, and *borderline*

personality disorder around the same. It is estimated that up to *one third* of youth suicides have been the result of the existence of borderline personality disorder. Clear evidence suggests that having a mental illness or problem puts a person of whatever age or gender at a much higher risk of suicide than the general population.

Currently, in both public and private mental health settings, part of the routine national data collection requires the completion of a clinician rated outcome measure (HoNOS) and a consumer self reporting outcome measure (Kessler-10, Basis-32, MHI-38 and in the private sector the MHQ-14) at admission and discharge from inpatient settings, and routinely at 91-day intervals within community settings. The Network considers that, as part of this collection and reporting suite of outcome measures, it would be appropriate to implement a clinician rated and validated suicide risk assessment measure. The main concern the Network has is the reliable collection of these instruments on a routine basis.

The Network therefore believes that a routinely administered suicide risk assessment measure be introduced as mandatory, for **all** mental health consumers at admission, discharge from **all** inpatient settings, and at ninety-one day reviews of mental health consumers in **all** community settings.

Recommendation 6.

i) The Network recommends the urgent mandatory introduction and routine use in public and private mental health sectors of a clinician rated, validated suicide risk assessment tool at admission and discharge from inpatient settings and 3 monthly review in community settings.

ii) The Network recommends the introduction and routine use of a clinician rated, validated suicide risk assessment tool for all people in contact with community mental health support organisations

(ii) A particular high-risk group – Borderline Personality Disorder

As mentioned above, having a mental illness pre-disposes people to suicidal behaviours. It is well recognised that people with depression, schizophrenia and substance abuse are at greater risk of suicide than other mental illnesses.

The failure to conduct assessment, analysis and/of research into suicide by and suicide prevention for people with the diagnosis of *borderline personality disorder* - and indeed even any recognition or focus on people with this mental illness - can only be considered a national disgrace. The suicide rate of people with this diagnosis is estimated to be around 10%. These deaths can be prevented if appropriate and designated services are provided, access and entry to those services are available and people are not further discriminated against.

In an unprecedented move within mental health in Australia, a coalition of the peak consumer and carer national advocacy organisations, together with the clinical and key non government organisations brought this issue to national prominence by lobbying the *Senate Community Affairs Committee – Inquiry into Mental Health*. This resulted in a clear recommendation (*number 25)* in the Report tabled in the Australian Senate on 25 September, 2008 that a national borderline personality disorder initiative, overseen by a Taskforce is undertaken.

The Recommendation is as follows:

Recommendation 25

The committee recommends that the Australian, state and territory governments, through COAG, jointly fund a nation-wide Borderline Personality Disorder initiative. The committee recommends that the initiative include:

- *designated Borderline Personality Disorder outpatient care units in selected trial sites in every jurisdiction, to provide assessment, therapy, teaching, research and clinical supervision;*

- *awareness raising programs, one to be targeted at adolescents and young adults in conjunction with the program in Recommendation 19 (Chapter 8) aimed at improving recognition of the disorder, and another to be targeted at primary health care and mental health care providers, aimed at changing attitudes and behaviours toward people with Borderline Personality Disorder; and*

- *a training program for mental health services and community-based organisations in the effective care of people with Borderline Personality Disorder.*

The committee recommends that a taskforce including specialist clinicians, consumers, community organisations, public and private mental health services and government representatives be convened to progress and oversight the initiative.

The Network strongly supports this recommendation.

At the time of writing this Submission, no action on this recommendation has taken place.

Recommendation 7.
The Network recommends this Senate Community Affairs Committee – Inquiry into Sucide in Australi support as a matter of urgency, the actioning of the previous Senate Community Affairs Committee Report – Toward recovery; mental health services in Australia, Recommendation 25 of the Report of 25 September, 2008.

h) The effectiveness of the National Suicide Prevention Strategy

The *National Suicide Prevention Strategy* supports a number of national projects and initiatives as well as those delivered within the community for the whole of the Australian population. The projects are targeted to individuals to enhance their capacity to access vital information and seek support for their emotional and social wellbeing and to increase the identification, referral and treatment of at-risk individuals. A recent Australian Institute of Health and Welfare Report, released on the statistics used to report suicide rates in Australia, found that some cases had been misclassified due to the difficulties the ABS experienced in accessing completed and full information from Coroners.

The Network questions the effectiveness of the Strategy in light of the statistics, whether complete or not. The Australian Bureau of Statistics Report showed that death by suicide for the period 2005 was not significantly different from the previous year. The ABS Report also showed the suicide rate for the Northern Territory as greater than any other jurisdiction. This is attributed to Aboriginal people, identified as

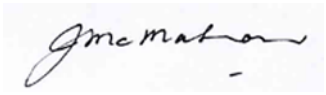
being at greater risk of suicide. It would seem from face value, and presented for distribution reliant on the data collected to 2005, that the National Suicide Prevention Strategy may not have had the desired impact.

Conclusion

Significant monies 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. Very significant funding indeed!

In terms of suicide prevention within **mental health**, the Network draws the Committee's attention to our seven Recommendations outlined above, and in particular, *Recommendation 6 (i) and (ii)* regarding at-risk individuals within the mental health sector. We believe such a practical measure will go a great way in identifying and reducing suicide to these vulnerable individuals.

We thank the Senate Community Affairs Committee and would welcome the opportunity of further discussions on this very important issue from a private mental health consumer and carer perspective.



Ms Janne McMahon OAM
Chair
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