CHAPTER 4

ROLES AND TRAINING

Introduction

4.1 This chapter will address two related terms of reference. The first term of reference (c) is 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. The second term of reference (e) is the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk. In the view of the Committee the appropriate roles, effectiveness and training of frontline personnel assisting people at risk of suicide are clearly linked issues.

Suicide prevention roles

Health professionals and primary care

4.2 Primary health care and general practitioners (GPs) were recognised as important for identifying and supporting people who are at risk of suicide and for the provision of postvention support to people who have attempted suicide.[1]

4.3 The Australian Medical Association (AMA) observed that about 88 per cent of Australians visit a GP at least once a year, providing significant opportunities for suicide prevention risk assessment and treatment. They noted that research indicates that those who complete suicide are likely to have seen a GP in the weeks and months prior but rarely communicate their intentions. They are reliant on the GP recognising their risk and providing treatment. While GPs were well placed to identify patients at risk of suicide, the AMA argued that this activity relies on the availability of speciality follow up services patients can be referred to. They stated:

> Specialised out-patient and acute care services need to be immediately available to ensure patient safety. Any delays or problems with accessing these services may undermine the initial efforts to prevent suicide.[2]

4.4 Similarly the Australian General Practice Network (AGPN) highlighted the importance of GPs having the skills to identify and respond to people at risk of suicide or self harm as well as patients at risk of suicide having access to specialised suicide prevention services from psychologists, psychiatrists and social workers.[3] They

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1 AGPN, *Submission 213*, p. 6.

2 AMA, *Submission 55*, p. 8.

3 AGPN, *Submission 213*, p. 7.

emphasised the importance of patients building relationships with a single doctor or practice over time '…which provides a critical foundation for primary health care and encourages GPs and patients to take a long-term approach to care'.[4]'

4.5 However GPs and nurses were perceived as having minimal education and training regarding suicide and suicide prevention.[5] RANZCP recommended that ongoing education regarding identification and appropriate treatment of depressive disorders should be provided to GPs and all those training as health professionals should be given suicide prevention education to ensure good literary early in their careers.[6]

Police and ambulance officers

4.6 Police officers are generally regarded as having a number of roles in assisting people at risk of suicide:

- in cases of attempted suicide, seeking the intervention of health professionals, including by utilising legislative provisions, such as detaining persons pursuant to mental health legislation where appropriate;
- assisting health workers when there are issues of safety in dealing with a person who has attempted or is contemplating suicide, to reduce the risk to a safe level to enable intervention; and
- acting as a referral service to health agencies.[7]

4.7 The Committee received mixed evidence regarding the role and effectiveness of police assisting people at risk of suicide. For example Lifeline Australia noted that while in its experience the response by police to people at risk of suicide had been good, 'individual officers may lack the necessary training, experience and skills to adequately assess and assist someone at risk of suicide'. They commented that in '…some instances police response have been described as "heavy handed" by individuals requiring assistance (particularly those with chronic mental illness) and the treatment they have received from police has further traumatised them'. Lifeline argued this demonstrated the need for universal training in suicide awareness and appropriate responses to people at risk of suicide for police and other emergency services.[8] The Salvation Army also suggested that after analysing the feedback they received '… it could be observed that police in major cities appear to have the

4 AGPN, *Submission 213*, p. 8.

5 Ms Dawn O'Neil, Lifeline Australia, *Committee Hansard*, 1 March 2010, p. 8.

6 RANZCP, *Submission 47*, p. 16.

7 South Australia Police, *Submission 245*, p. 1.

8 Lifeline Australia, *Submission 129*, p. 40.

resources and training to respond appropriately and compassionately and more needs to be done to train and support police operating in rural and regional areas'.[9]

4.8 There were also indications police and coronial investigations could impose further trauma on the bereaved families following a suicide. This could occur in situations where there is initial uncertainty as to whether the cause of death was suicide or homicide. Standard police procedures such as questioning family members and treating the location of a suicide as crime scene 'can often be perceived as insensitive and distressing'.[10]

4.9 The NSW Consumer Advisory Group Mental Health told the Committee:

> Police are often the first called to respond to a person experiencing a crisis due to a lack of after-hours crisis services or because of a perceived danger to community mental health clinicians. Consumers have talked about their concerns about marked cars and uniformed police involved in a mental health crisis intervention and how this can be misconstrued as a criminal matter by other members of the community. This can result in feelings of humiliation and shame for the person who is actually in crisis, which can have a very real and long-term effect.[11]

4.10 There were other views expressed that police officers should be allowed to concentrate on law enforcement rather than functioning as 'front line mental health officers'. The challenges that police officers face in dealing with people at risk of suicide were also recognised. The Private Mental Health Consumer Carer Network Australia stated:

> 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.[12]

4.11 The SPA submission commented that there is limited information available about 'first responders' such as police in terms of their training and impact on those at risk of suicide. [13] The Committee understands the majority of police receive limited suicide prevention training as part of their training for dealing with people who may have mental health issues.

4.12 The NSW Government noted the success of the pilot NSW Police Mental Health Intervention Team (MHIT) which was developed to reduce the risk of injury to

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9 Salvation Army, *Submission 142*, p. 20.

10 SPA, *Submission 121*, p. 37.

11 Ms Rebecca Doyle, NSW Consumer Advisory Group Mental Health, *Committee Hansard*, 3 March 2010, p. 44.

12 Private Mental Health Consumer Carer Network Australia, *Submission 10*, p. 4.

13 SPA, *Submission 121*, p. 37.

police and people with mental health illnesses. It aims to improve awareness by frontline police of risks involved in dealing with people with mental illness and provide strategies to reduce injuries to police and consumers; improve collaboration with other government and non-government agencies in the response and management of mental health crisis events; and to reduce the time taken by police in the handover of people with mental illness to the health care system. The MHIT has now been established as a fulltime unit and been given the target of training a minimum of 10 per cent of all frontline NSW Police Force staff by 2015.[14]

4.13 Ambulance officers were also highlighted as a group with an important role in assisting people at risk of suicide. Where the consequences of a suicide attempt require medical attention an ambulance is often called to the scene. Ambulance officers usually have basic mental health training. The SPA Position Statement on Crisis Response notes:

> Ambulance staff need the skills to assess suicide risk and provide immediate management, but they also need support and training to safeguard their personal needs and to deal with the trauma associated with crisis response. Knowledge of local mental health legislation, involuntary admission laws and mental health or support services, facilitates ambulance workers' decision-making about suicidal patients.[15]

Emergency departments

4.14 A large amount of evidence was received regarding the responses of hospital emergency departments to persons who had attempted suicide or were at risk of suicide. The Salvation Army had 'grave concerns about the response of many emergency departments to people who are in immediate crisis'. They commented it appeared that many emergency departments are so stretched because of lack of resources and increasing demand that people in crisis do not receive the attention and support they need.[16] They also noted serious concerns with the risk assessments conducted before a person is discharged from hospital.

> Whilst the Mental Health protocols state that suicidal people should not be discharged from hospital without a Risk Assessment being conducted, people quickly learn how to respond to the questionnaire.[17]

4.15 The NSW Consumer Advisory Group described hospital triage systems as not identifying mental health as a priority.[18] RANZCP noted that acutely suicidal persons

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14 NSW Government, *Submission 136*, p. 13.

15 SPA, *Position Statement: Crisis Response and the Role of Emergency Services and First Responders to Suicide and Suicide Attempts*, June 2010, p. 11.

16 Salvation Army, *Submission 142*, p. 81.

17 Salvation Army, *Submission 142*, p. 81.

18 Ms Rebecca Doyle, NSW Consumer Advisory Group Mental Health, *Committee Hansard*, 3 March 2010, p. 43.

can be made to wait for inappropriately long periods of time. They argued that emergency departments need to be able to respond both to the psychological and emotional needs of suicidal persons as well as any physical consequences of a suicide attempt. RANZCP outlined Australian research which found '…about one third of suicide attempt survivors described their satisfaction with their hospital treatment as ‘mixed’ and one fifth as ‘poor’ or ‘very poor’'. Similarly, 28 per cent of suicide attempt survivors described the attitudes of health care professionals in the hospital environment as ‘mixed’ and 33.5 per cent as ‘poor’ and ‘very poor’.[19]

4.16 SPA suggested that persons at risk of suicide may benefit from improved widespread training of all emergency department staff in current suicide risk assessment protocols. They argued that:

> When a person who has attempted suicide comes to the attention of an emergency department, a prime opportunity opens up for intervention. However, the majority of those who do come to attention following a suicide attempt do not receive any subsequent help.[20]

4.17 A number of witnesses and submissions emphasised the importance of taking seriously any situation where someone is talking about suicide. Many related personal stories when they had difficulty in receiving assistance from emergency departments, particularly where a person had suicidal ideation but had not attempted suicide. Ms Carla Pearse from the Community Action for the Prevention of Suicide commented:

> I have got a great deal of respect for our public health system, our public mental health system, but they are absolutely snowed. They simply cannot respond to people… My experience with my clients is that they might go to A&E. If they are accepted into the system they will be sitting there for hours and hours unless they have made an attempt. But if they are going to A&E with suicidal thoughts then they are sent home.[21]

4.18 The Committee understands that guidelines and protocols exist in most jurisdictions for healthcare staff to undertake suicide risk assessment of patients. The NSW Government noted that the *Framework for Suicide Risk Assessment and Management for NSW Health Staff* provides detailed information for health staff on conducting suicide risk assessments, and includes specifics on the roles and responsibilities of generalist and mental health services. The Framework states:

> People with possible suicidal behaviour must receive preliminary suicide risk assessment and, where appropriate, a referral for a comprehensive mental health assessment including a detailed suicide risk assessment. The

19 RANZCP, *Submission 47*, p. 14.

20 SPA, *Submission 121*, p. 56.

21 Ms Carla Pearse, Community Action for the Prevention of Suicide, *Committee Hansard*, 2 March 2010, p. 42.

> goal of a suicide risk assessment is to determine the level of suicide risk at a given time and to provide the appropriate clinical care and management.[22]

4.19 However the Psychotherapy and Counselling Federation of Australia reported that its practitioners who support staff working in emergency departments of hospitals report that these personnel feel unsupported in assessing suicide risk.[23]

4.20 Some State and Territory governments appear to be responding to the difficulties for persons in crisis attending hospital emergency departments. The NSW Government reported it had established nine psychiatric emergency care centres (PECC) for patients with acute mental health needs. The ACT Government also noted an initiative it was undertaking to assist in the referral of persons at risk of suicide.

> Recognising the crucial role that Emergency Departments (ED's) play in assisting people at risk of suicide, the ACT is currently constructing a Mental Health Assessment Unit (MHAU) which will be attached to the ED of the Canberra Hospital. The MHAU will be a 6 bed mental health assessment unit that will provide specialised mental health assessment, crisis stabilisation and treatment for all people presenting to the ED with an acute mental illness or disorder.[24]

Other services

4.21 The Committee also received evidence that other government agencies as well as commercial services often need to display more tact and discretion in their transactions with people who may be at risk of suicide. For example the Psychotherapy and Counselling Federation of Australia commented:

> Many Centrelink workers do not have skills in adequately responding to the needs of at risk clients. It was noted that when discussing depression with their clients staff may not be sensitive to the needs of the individual.[25]

4.22 The NSW Government noted Mental Health First Aid training would also be rolled out to RailCorp station staff in 2010 as part of an initiative 'to address the risk and incidence of suicide in the NSW rail system'.[26]

Stigma

4.23 The Committee heard many stories from people who felt that they had not been treated appropriately by frontline personnel after an attempted suicide or completed suicide. Mr Alan Woodward of Lifeline related an experience of one of the

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22 NSW Health, *Framework for Suicide Risk Assessment and Management for NSW Health Staff,* 2004, p. 1.

23 Psychotherapy and Counselling Federation of Australia, *Submission 72*, p. 2.

24 ACT Government, *Submission 44*, p. 4.

25 Psychotherapy and Counselling Federation of Australia, *Submission 72*, p. 6.

26 NSW Government, *Submission 136*, p. 13.

Lifeline managers where a man was not treated appropriately by hospital staff after attempting suicide. He noted:

> Lifeline believes that whatever else is provided to suicidal persons, whatever else is done to keep suicidal persons safe, whatever else is done to prevent the onset of suicidality, there must be genuine, non-judgmental caring in our response.[27]

4.24 The Lifeline submission also noted that some emergency service personnel, health, and other community support workers who are the first responders to a suicide incident can suffer from 'compassion fatigue', and at times can have misinformed attitudes towards suicidal behaviours and risk factors.[28] Similarly Salvation Army stated there was a perceived lack of empathy or concern for patients who are suicidal and a perception health professionals often believe the person who has attempted suicide is attention seeking.[29]

4.25 Submitters and witnesses, including those who have worked as health professionals, gave evidence to the Committee that health care services are not always free of stigmatised views of suicide, and that people presenting with suicide attempts have had experiences of punitive and dismissive attitudes from health care professionals.[30]

4.26 The Committee was disturbed to receive evidence of practices in hospitals and by doctors whereby patients who presented following an attempted suicide or self-harm were treated badly or even 'punished'. This included publicly scolding them for their actions and treatment such as stitches for self inflicted injuries without anaesthetic. Professor Graham Martin linked these practices to the stigmatisation of people who self-harm by medical professionals.[31]

4.27 SPA also submitted the following descriptions of personal experiences which patients had contributed:

> The nurse informed me that I was both selfish and stupid to have done what I did and that her nephew had also done something similar that week and was equally selfish and stupid. I lied to every medical person who came to see me in order to get out of the hospital quicker. The experience I had in hospital meant I didn't go and see a GP for quite a few years.

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27 Mr Alan Woodward, Lifeline Australia, *Committee Hansard*, 1 March 2010, p. 3.

28 Lifeline Australia, *Submission 129*, p. 41.

29 Salvation Army, *Submission 142*, p. 22.

30 For example Dr John Crawshaw, Department of Health and Human Services Tasmania, *Committee Hansard,* 20 May 2010, p. 60; Associate Professor Ione Lewis, Psychotherapy and Counselling Federation of Australia*, Committee Hansard,* 25 March 2010, p. 12; Lifeline, *Submission 129*, p. 20

31 Professor Graham Martin, *Committee Hansard*, 2 March 2010, pp 84-86.

> I found that ambulance workers, nurses and doctors (both from ER and ICU) were judgmental of me as if I had brought my sickness on myself and was wasting the resources available for deserving sick people.
>
> Some hospital staff are still under the impression that suicide and self harmers are attention seekers. This is far from the case, and needs to be recognised without prejudice.[32]

Support for frontline personnel

4.28 The support available for those frontline staff dealing with suicide and attempted suicide was frequently raised. Their experiences were seen as resulting in 'vicarious trauma' causing stress-related anxiety, depression and post traumatic stress disorders. As an example Professor John Mendoza related the circumstances of two Queensland Ambulance Service officers who were deeply traumatised by their experience of assisting a young man to an emergency department and then being subsequently called to attend the scene of the man's suicide a few hours later.[33] SPA commented:

> The vicarious trauma and impact of suicide (particularly where the deceased was a patient or client) on first responders, clinicians, general practitioners and other health professionals (including coronial staff), and also volunteers, work colleagues and whole communities more broadly, should not be underestimated.[34]

4.29 The SPA Position Statement on Crisis Response recommended:

> First responders who are exposed to crisis situations and suicide attempts as part of their job should have formal structures of support and debriefing embedded in their work practices….
>
> Strategies for debriefing and support embedded in organisational practice should safeguard the professional’s own needs to reduce distress and burnout.[35]

Discharge and follow up support

4.30 The time following discharge from hospital or inpatient psychiatric care was identified as a period of particular risk for people who were at risk of suicide. DoHA commented that studies have estimated that the rate of suicide in people with a mental illness following discharge from inpatient psychiatric treatment could be over 200 times the rate of death by suicide in the general population. They stated:

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32 SPA, *Submission 121*, p. 40.

33 Professor John Mendoza, *Committee Hansard*, 1 March 2010, p. 92.

34 SPA, *Submission 121*, p. 38.

35 SPA, *Position Statement: Crisis Response and the Role of Emergency Services and First Responders to Suicide and Suicide Attempts*, June 2010, p. 17.

> The elevated risk of suicide is highest immediately following discharge, with 12.8% of deaths by suicide after discharge occurring on the day of discharge, 28.4% in the week following discharge, 47.7% in the month following discharge and 80% within one year of the last episode of inpatient psychiatric treatment.[36]

4.31 Despite this period being recognised as a time of risk for suicide Lifeline Australia noted that discharge from hospital 'does not always include a workable discharge plan, and a person at risk of suicide can return home with limited or no supports in place'.[37] Similarly the MHCA noted that it was 'commonplace for a person to be discharged from a mental health service following an attempted suicide and disappear into the community, without any arrangements for follow-up care in the community'.[38] They argued:

> There needs to be a compulsory follow-up plan for people discharged from hospital or other services after attempting suicide. There is currently no requirement upon hospital and frontline staff to ensure that individuals at high-risk of suicide are given the necessary follow up care and ongoing case-management.[39]

4.32 The NSW Consumer Advisory Group Mental Health argued that 'discharge planning needs to extend beyond the current minimum of making sure the individual has somewhere to go or that someone has been informed of there discharge…[t]here needs to be a process in place to ensure a continuity of care…'.[40] RANZCP commented that the majority of those who do come to attention following a suicide attempt do not receive any subsequent help.

> Non-attendance of suicide attempt survivors at follow-up interviews is alarmingly high with some researchers estimating this non-compliance to be as high as 50 to 60 per cent.[41]

4.33 The Private Mental Health Consumer Carer Network Australia recommended 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 as well as a 3 monthly review in community settings.[42]

4.34 The NSW Government noted that the period following discharge is a period of increased risk for mental health patients and stated this was recognised in the

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36 DoHA, *Submission 202*, p. 60.

37 Lifeline Australia, *Submission 129*, p. 39.

38 MHCA, *Submission 212*, p. 4.

39 MHCA, *Submission 212*, p. 12.

40 Ms Rebecca Doyle, NSW Consumer Advisory Council Mental Health, *Committee Hansard*, 3 March 2010, pp 43-44.

41 RANZCP, *Submission 47*, p. 19.

42 Private Mental Health Consumer Carer Network Australia, *Submission 10*, pp 4-6.

Discharge Planning Policy for Adult Mental Health Inpatient Services. This policy 'provides direction on the principles and practices that mental health clinicians must follow to promote the safe transition to the community for patients leaving mental health units'.[43]

4.35 Research which indicated that follow up procedures with patients after their discharge could reduce their rate of suicide was frequently mentioned in submissions. The MHCA commented that enough evidence exists to demonstrate that an appropriate discharge follow-up care plan and management by appropriately trained staff cannot only prevent future attempts, but assist in rebuilding the lives of people.[44] SPA outlined a range of interventions after discharge through which contact with the person at risk of suicide could be maintained. They noted:

> Recent studies have shown that maintaining contact with suicide attempt survivors or other high risk groups (e.g. psychiatric inpatients refusing follow-up) after discharge significantly reduces their risk of subsequent attempt and death.[45]

4.36 The Suicide is Preventable submission also emphasised that studies have demonstrated that simple letter or postcard interventions, where postcards are mailed to persons discharged from acute care mental health units inviting them to stay in touch at regular intervals, have been effective in reducing repeat episodes of self-harm and also death by suicide.[46]

4.37 DoHA highlighted two programs relevant to this area of support. The first was the Consumer Activity Network operated Community Connections project in Sydney which provides peer support and practical assistance to mental health consumers in the community for the first 28 days following discharge from psychiatric inpatient units. The service also offers a national telephone peer support non-crisis line for mental health consumers.[47]

4.38 DoHA also highlighted the Access to Allied Psychological Services (ATAPS) Suicide Prevention Pilot which aims to provide better support for people at high risk of suicide after presentation to an emergency department or general practitioner following a suicide attempt or self-harm. It facilitates priority access to referral pathways to specialised allied psychological services for people who have self-harmed, attempted suicide or who have suicidal ideation.[48] Funding is also given to Crisis Support Services to provide 24 hour telephone support.

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43 NSW Government, *Submission 136,* p. 14.

44 MHCA, *Submission 212*, p. 14.

45 SPA, *Submission 121*, p. 56.

46 Suicide is Preventable, *Submission 65*, p. 87.

47 DoHA, *Submission 202*, p. 60.

48 DoHA, Submission 202, p. 61.

4.39 The AGPN provided the Committee with further details about the operations of this pilot project.

> A pilot extension of ATAPS called Specialist Services for Consumers at Risk of Suicide is allowing provision of intensive, prioritised services for people at risk of suicide delivered in 19 GPNs [general practice networks]. It includes treatment for people discharged from hospital to GP care, people who have presented to a GP after an incident of self harm, and people who have expressed strong suicidal ideation to their GP. The GP is then able to refer the person to an experienced psychologist for immediate, intensive counselling (within 24-72 hours, for up to 2 months). The GP maintains responsibility for ongoing clinical case management, ensuring continuity of care. The person receives priority access to care, is followed up actively by the psychologist and receives care through a flexible model of face to face and telephone consultations.
>
> The Interim Evaluation Report for this program indicates the services have been positively received, are attracting increasing numbers of referrals and are providing services to a different group of consumers to those normally seen by ATAPS services, hence complementing the general ATAPS program.
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> As part of the pilot, participating allied mental health professionals were required to complete a suicide prevention training course developed by the Australian Psychological Society (APS) and delivered through participating GPNs.[49]

4.40 DoHA told the Committee the ATAPS suicide prevention pilot would not be expanded but that it would be 'continuing for another two years' incorporating a comprehensive evaluation. However DoHA indicated it was giving other Divisions of General Practice the capacity to opt into the program. Ms Colleen Krestensen of DoHA stated:

> We are building into our additional funding for ATAPS some additional service capacity for the rest of the divisions, which is about 100 divisions, to enable them to boost their capacity to provide more services to people who have presented to a GP or have been referred to ATAPS post a suicide or a self-harm attempt. [50]

Stepped care and accommodation services

4.41 The lack of appropriate accommodation for those at risk of suicide was frequently highlighted. The Psychotherapy and Counselling Federation of Australia described the number of ‘secure’ or gazetted beds available in ‘acute’ publicly funded residential facilities for adolescents as 'extremely inadequate'. They reported acutely suicidal adolescents have sometimes been admitted to adult psychiatric units. The AMA also noted the while people who are receiving (acute or inpatient) mental health

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49 AGPN, *Submission 213*, p. 10.

50 Ms Colleen Krestensen, DoHA, *Proof Committee Hansard*, 18 May 2010, p. 29.

care for suicidal risk may improve in supported accommodation there was a lack of available spaces. This made the appropriate referral of persons at risk of suicide by treating GPs difficult.[51]

4.42 A common observation during the inquiry was the need for alternative and graded accommodation for people at risk of suicide or having a mental health crisis. For example AGPN argued that there was growing evidence that a 'stepped care' approach to mental health service delivery improves mental health outcomes, reduce costs and increases access to care.

> Stepped care models are those in which there are interventions of different levels of intensity, and consumers are assigned to the level of intervention that matches their needs. Care ranges from low to high intensity interventions… Stepped care can better tailor care to meet patients' needs and minimise unnecessarily intensive or invasive treatment.[52]

4.43 One of the projects proposed by the AISRP was for a full residential care facility where clinical specialists and support workers will care for people who have made an attempt at suicide. They described the 'Life House' as filling an important gap by '…offering a coordinated service, outside of the hospital setting, specifically designed to treat people who are suicidal and assist their families'. They commented:

> Research strongly suggests that individualised and coordinated care for first-time attempters in an appropriate environment is critical to providing an effective response and recovery. By providing at least 14 days of care at no charge, the Life House will fill the significant gap between hospital-based care and emergency room or outpatient care for people who are suicidal.[53]

4.44 SPA noted that services which provide one-off short-term accommodation in a supported non-medical environment can allow '…people with a mental illness who require urgent/emergent need to receive crisis stabilisation services in a staff-secure, safe, structured setting that is an alternative to hospitalisation'.[54]

4.45 Similarly a key recommendation of Mr Jim Snow was for the provision of flexible graded services for the mentally ill with alternatives based on care in the community, accommodation in houses, accommodation in larger supervised hostels with respite care arrangements, and accommodation in psychiatric hospitals depending on need. In particular supervised hostels could benefit those people who are able to live in the community but need occasional respite. He argued:

> Properly done, the cost of a flexible system of care for mental health patients would be reduced by greater efficiency, the avoidance of high

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51 AMA, *Submission 55*, p. 8.

52 AGPN, *Submission 213*, p. 11.

53 AISRP, *Submission 237*, p. 112. The Life House is discussed further in Chapter 8.

54 SPA, *Submission 121*, p. 56.

> police, hospital and other costs associated with suicide, suicide attempts, violence, family breakdown and delayed corrective action.[55]

4.46 The need for alternative accommodation options has also been recognised by community organisations. For example the Launceston-based Youth Suicide Action Group (YSAG) has created Time Out House which provides secure accommodation to young people from the age of 14 to 28 years of age at risk of suicide and self harm.[56]

4.47 The Mental Health Coordinating Council noted the Victorian Government funding for Prevention and Recovery Care services (PARC) which provide access to step-up/step-down bed based alternatives to hospital inpatient care showed the '…potential for step-up programs to reduce some of the impact on the acute inpatient services'.[57] Queensland Alliance also highlighted the recent state funding for a Time Out House youth initiative.

> That is about funding community organisations to offer safe, friendly and welcoming spaces. The whole purpose of that is an early intervention response, and the whole purpose of the place is that it is safe, friendly and welcoming—a mental health service that people actually want to access rather than one that you drag people to and that they then get a really bad experience of.[58]

4.48 DoHA noted that $1.6 billion was made available through COAG commencing next financial year to support the 1300 sub-acute beds. The range of target groups for these subacute beds included people with mental health needs coming in and out of hospital.[59]

Coordination of care

4.49 The coordination and continuity of care was seen as essential for persons at risk of suicide to prevent them 'falling between the gaps'. Repeatedly the Committee received personal stories which highlighted a lack of coordination of care between services. The Integrated Primary Mental Health Service of North East Victoria observed that difficulties 'routinely' arise in cross-jurisdictional activities involving emergency services and mental health services and assisting people who are at risk of suicide.[60] Similarly Lifeline Australia noted:

> Lifeline has seen examples of where a lack of coordinated care between services such as drug and alcohol, mental health, and hospitals can mean

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55 Mr Jim Snow, *Submission 17*, p. 3.

56 Ms Verity Tunevitsch, YSAG, *Proof Committee Hansard*, 20 May 2010, pp 1-2.

57 Ms Jenna Bateman, Mental Health Coordinating Council, *Committee Hansard*, 3 March 2010, p. 9.

58 Mr Jeffery Cheverton, Queensland Alliance, *Committee Hansard*, 2 March 2010, p. 20.

59 Ms Rosemary Huxtable, DoHA, *Proof Committee Hansard,* 18 May 2010, p. 43.

60 Integrated Primary Mental Health Service of North East Victoria, *Submission 26*, p. 5.

> that people at risk of suicide do not receive appropriate and holistic care and intervention. Such a lack of cohesion in the health sector can mean that people requiring help 'fall through the gaps' and the onus of responsibility and care is left to friends, family, or carers.[61]

4.50 The Psychotherapy and Counselling Federation of Australia stated that where their members were already involved with a patient they 'report not being included in plans for support following discharge and, for example not being copied into discharge plans and not receiving advice regarding the follow up care that is needed'. They noted:

> Patients can be discharged quite suddenly without the hospital notifying families or the counsellor/psychotherapist involved. This is not effective and discourages clients from seeking further help.[62]

4.51 Mr John Dalgleish of Boystown stated that the reasons for lack of coordination appear varied:

> In the community sector and health sector there still seem to be artificial silos and barriers to coordination. People have different frameworks for intervention, people have different language and different culture. People do not know what services exist in their local community. All those things add up to a lack of coordination.[63]

4.52 The Suicide is Preventable submission highlighted the results of the *Tracking Tragedy* report which included the examination of suicide deaths of patients in community mental health settings. Concerns were raised in this report regarding gaps in assessment documentation, deficient duration and continuity of care, and poor ongoing risk monitoring.

> The implication arising from such findings is that improved integration at critical transitions of inpatient and community-based care may well reduce the risk of suicide among mentally ill individuals.[64]

4.53 The SPA Position Statement on Crisis Response noted that GPs generally refer suicidal patients needing acute or community care to emergency departments rather than directly to rather than directly to inpatient or community services.[65] SPA suggested one way of ensuring greater continuity of care may be to develop working partnerships between emergency mental health services and crisis hotlines.

> Such care extends beyond the boundaries of the traditional health and mental health care systems. Crisis hotlines also provide relatively low-cost,

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61 Lifeline Australia, *Submission 129*, p. 38.

62 Psychotherapy and Counselling Federation of Australia, *Submission 72*, p. 4.

63 Mr John Dalgleish, Boystown, *Committee Hansard*, 2 March 2010, pp 2-3.

64 Suicide is Preventable, *Submission 65*, p. 83.

65 SPA, *Position Statement: Crisis Response and the Role of Emergency Services and First Responders to Suicide and Suicide Attempts*, June 2010, p. 10.

> effective services to individuals seriously contemplating suicide and are available to all regardless of geographical barriers, appointment availability, or ability to pay.[66]

4.54 The AGPN argued there should be better greater efforts to link people who have attempted suicide to community based primary mental health care following discharge from tertiary services to avoid patients at risk of suicide 'falling into the gaps' between services. They highlighted two key programs: the *Better Outcomes in Mental Health Care* initiative and the *Better Access to Psychiatrists and General Practitioners through the Medicare Benefits Schedule* program. The AGPN stated:

> These programs have increased the capacity of primary health care professionals to more effectively respond to and treat mental health problems by driving uptake of mental health education and training, providing additional referral channels from general practice to mental health specialists, and access to psychiatrist advice.[67]

4.55 It was noted that the transport of suicidal patients by police to psychiatric services or emergency departments can be difficult due to a lack of clarity regarding responsibility for patient safety and supervision. 'Handovers' were seen as a time of particular risk for patients at risk of suicide. The SPA position statement on crisis response highlighted the memorandum of understanding between the NSW Health, the NSW Ambulance Service and the NSW Police as an example of an effective measure to promote safe and coordinated systems of care.[68]

4.56 The Committee also heard of good examples of cooperation and coordination between public agencies and community organisations. For example Ms Dulcie Bird of the Dr Edward Koch Foundation told the Committee:

> The life bereavement service has a memorandum of understanding signed with the Queensland Police Service. It incorporates a faxback referral system, which requires that a Queensland police officer who is attending any unexpected death offers the support of our life bereavement support service to the person bereaved. A person agreeing to this signs the faxback referral assistance request, the police officer faxes it to us and we are able to go out and see these people.[69]

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66 SPA, *Submission 121*, p. 41.

67 AGPN, *Submission 213*, p. 7.

68 SPA, *Position Statement: Crisis Response and the Role of Emergency Services and First Responders to Suicide and Suicide Attempts*, June 2010, p. 11.

69 Ms Dulcie Bird, Dr Edward Koch Foundation, *Committee Hansard*, 2 March 2010, p. 31.

Patient information and privacy

4.57 An issue frequently raised in submissions related to the level of access family members should have to the patient information of a person at risk of suicide.[70] Often bereaved family members were frustrated they had not been informed of significant events, for example when a patient had been discharged from a healthcare facility or if the medication of a person had been altered. Lifeline Australia noted that when privacy policies prevent contact with other members of a patient's family '…important information which could be vital to the treatment of the patient is lost'.[71] Similarly Ms Fatima Clark of the White Wreath Association argued:

> Confidentiality and privacy must not be allowed to cause loss of life. Commonsense, natural justice and good professional practice dictate that the preservation of life is of paramount consideration. Doctors and psychiatrists must involve families and use their knowledge and opinion to help fight this epidemic as they would with any other life-threatening condition.[72]

4.58 The balance between patient privacy, family access and risk is reflected in a number of areas. The AMA Code of Ethics states that doctors have an obligation to maintain a patient's confidentiality and exceptions to this must be taken seriously. These include where '…there is serious risk to the patient or another person… or where there are overwhelming societal interests'.[73] The National Privacy Principles also provides that organisations which provide health services must not disclose the health information of an individual. Exceptions include where the organisation reasonably believes that the use or disclosure is necessary to lessen or prevent a serious and imminent threat to an individual's life, health or safety.[74] The Committee was also referred to the NSW *Mental Health Act 2007* which includes recognition that carers and family members need greater access to information about the consumer and also giving some control to the patient regarding who can be provided with information.[75]

4.59 Mr Michael Barnes, the Queensland Coroner, also highlighted the refusal of mental health practitioners to involve families in treatment decisions for patient as an area of concern. He suggested greater use be made of advanced health directives and

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70 For example Mr Jim Snow, *Submission 17*, p. 1; SOS Survivors of Suicide Bereavement Support Association, *Submission 106*, p. 2.

71 Lifeline Australia, *Submission 129*, p. 19.

72 Ms Fatima Clark, White Wreath Association, *Committee Hansard*, 2 March 2010, p. 25.

73 *AMA Code of Ethics*, 2006, 1.1 (l).

74 *National Privacy Principles*, Principle 2.1.

75 Mr Peter Dodd, Public Interest Advocacy Centre, *Committee Hansard*, 3 March 2010, p. 73.

other standing powers of attorney to authorise the disclosure of patient information to family members.[76]

4.60 Poor information sharing practices between healthcare services and practitioners was also often highlighted during the inquiry. The Suicide is Preventable submission recommended that the Commonwealth, through the National e-Health Strategy, lead efforts to improve collaboration and information sharing and surveillance between and among systems of care for all patients but particularly for those with severe or persistent mental illness (SPMI). They stated:

> Poor communication and lack of information sharing between social service agencies, law enforcement, justice, education, health care and mental health care providers and others precludes key opportunities to advance suicide prevention efforts for persons with SPMI.[77]

Pharmacological issues

4.61 Different forms of medication were seen as an important method of reducing suicides during the inquiry, particularly antidepressants. In 2005, Professor Robert Goldney's review of recent studies into suicide prevention included positive assessments of effectiveness of psychotropic drugs in decreasing rates of suicide and suicidal behaviour for patients with a range of mental health conditions. These included anti-depressants, mood stabilisers and antipsychotic medication.[78]

4.62 The importance of closely supervising patients with a mental illness commencing or changing medications was highlighted during the inquiry.[79] This was seen as a particular period of high risk. The Suicide is Preventable submission noted that ' available research confirms that individuals may experience an increased risk of suicidal behaviour in the early stages of starting antidepressant medication, given that this treatment may not be immediately effective'.[80]

4.63 The Committee also received conflicting evidence regarding the dangers and efficacy of patients being prescribed two forms of antidepressants simultaneously. Professor David Horgan argued that despite overseas practices in relation to combination antidepressants the practice in Australia '…is to take the patient off that antidepressant, which, unfortunately, means the illness is going to come back again, and to start them on the next one in the hope that the next one will lock on'.[81] However

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76 Mr Michael Barnes, *Proof Committee Hansard* , 18 May 2010, p. 52.

77 Suicide is Preventable, *Submission 65*, p. 27.

78 Robert Goldney, 'Suicide prevention: A pragmatic review of recent studies', *Crisis: Journal of Crisis Intervention and Suicide Prevention*, 2005, vol. 26, no.3, pp 133-134.

79 Mr Jim Snow, *Submission 17*, p. 2.

80 Suicide is Preventable, *Submission 65*, p. 86.

81 Professor David Horgan, Australian Suicide Prevention Foundation, *Committee Hansard*, 4 March 2010, p. 7.

Dr Watson from RANZCP commented the all medications have side effects and 'combinations of drugs have combinations of side effects'. He stated '…the research around combination antidepressants and its relative safety is markedly limited'.[82]

Suicide awareness and assistance training

4.64 The Committee received many recommendations during the inquiry for suicide prevention training to be more wide spread amongst healthcare professionals, government agencies and the general community. Recommendations were also received which suggested mental health first aid and suicide prevention training should be subsidised to encourage broader participation and access.[83] The Suicide is Preventable submission stated that suicide prevention and intervention training and education for frontline workers or 'gatekeepers' (for example. emergency workers, health care workers, GPs.) has been shown to reduce suicide rates.[84] It recommended the development of 'accredited and fully evaluated training programs for front line staff in a range of settings… to better enable staff to identify and support those who are vulnerable or at risk'.[85]

4.65 RANZCP and others also identified 'gatekeepers' in the communities '…whose contact with potentially vulnerable populations provides an opportunity to identify at-risk individuals and direct them to appropriate assessment and treatment'. These included include clergy, first responders, pharmacists, geriatric caregivers, personnel staff, and those employed in institutional settings, such as schools, prisons, and the military. Large scale evaluations of gatekeeper training in institutional settings such as the US Air Force suggest this approach can be an effective in lowering suicide rates.[86]

4.66 Ms Jacinta Hawgood of AISRP noted the education and training of GPs was one of the demonstrated ways of preventing suicide. She stated:

> Training usually takes the form of targeting, at a gatekeeper level, allied health professionals, community workers, including emergency workers, and/or targeting GPs. Since there is evidence about the effectiveness of this particular initiative, we often ask the question: why do we not invest more in this initiative?[87]

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82 Dr Darryl Watson, RANZCP, *Committee Hansard*, 4 March 2010, p. 75.

83 For example MMHC, *Submission 93*, p. 11; Ms Verity Tunevitsch, YSAG, *Proof Committee Hansard*, 20 May 2010, p. 5.

84 Suicide is Preventable, *Submission 65*, p. 82.

85 Suicide is Preventable, *Submission 65*, p. 26.

86 RANZCP*, Submission 47*, pp 13-14.

87 Ms Jacinta Hawgood, AISRP, *Committee Hansard*, 18 May 2010, p. 12.

4.67 Lifeline Australia argued that competence in role appropriate suicide intervention knowledge and skills should be a foundational requirement for front-line health and community workers providing services to persons at risk of suicide. However it noted that 'systematic suicide intervention training to agreed standards across sectors, among emergency services personnel, and within professions has yet to be realised'.[88]

4.68 The Salvation Army stated 'there is no doubt' that suicide prevention training raises the confidence of frontline and community workers in intervening to support people who are at risk of suicide. They considered it was imperative that all workers in community services are able to understand and recognise warning signs and know how to take action to get people the assistance they need.[89]

Suicide prevention training programs

4.69 A range of different models of suicide prevention training were outlined during the inquiry. Some focused on health care professionals or community workers while others were aimed at members of public.

4.70 The Lifeline Australia LivingWorks program delivers both safeTALK and the ASIST (Applied Suicide Intervention Skills Training). They commented:

> Whereas ASIST prepares people to engage more fully with suicidal persons to review their risk and develop and mobilise a safety plan, safeTALK enables a briefer engagement – recognising risk, reaching out and enabling referral. These two programs can potentially work together within an organisational or community setting.[90]

4.71 The AGPN recommended the SQUARE education and support package as a useful resource for GPs and other frontline workers providing services to people at risk.[91] DoHA stated:

> ….important work has been done to increase the capacity of primary care clinicians to work with patients who are experiencing suicidality, most notably through the development and dissemination of the SQUARE (Suicide QUestions, Answers and REsources) resources developed by the South Australian Division of General Practice and Relationships Australia SA with joint funding from the NSPP and the South Australian Government.[92]

4.72 The Kentish Regional Clinic also outlined their CORES (Community Response to Eliminating Suicide) training program which has provided services to 25

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88 Lifeline Australia, *Submission 129*, p. 47.

89 Salvation Army, *Submission 142*, p. 37.

90 Lifeline Australia, *Submission 129*, p. 52.

91 AGPN, *Submission 213*, p. 9.

92 DoHA, *Submission 202*, p. 61.

communities around Australia. The CORES model is based around a community package which delivers one-day suicide intervention training to members of different communities with local volunteer team leaders trained to deliver the program and 'champion' the training locally. Communities are then responsible for shaping the way the program is delivered in the future.[93]

4.73 The Salvation Army referred to the online suicide prevention training course which they deliver called QPR (Question, Persuade, Refer). The one hour QPR training includes myths and facts about suicide, warning signs of suicide, applying QPR and how to offer hope and support.[94]

4.74 It was also recommended that suicide awareness training should be as accessible and promoted as First Aid courses for the public.[95] A Lifeline telephone counselling trainee told the Committee about her significantly increased ability to provide appropriate support to a friend who was considering ending their life after completing an ASIST suicide intervention course:

> This leads me to two points: one, is that having recently been made aware of a practical model for responding to this distressing and confronting situation gave me infinitely better resources for coping, and hopefully helping, than I would have had a month previously…. Secondly, I wondered at the time if my friend sought me out to talk to about their situation because they knew I was doing the suicide intervention course…Perhaps they thought that I would be not afraid to talk about this confronting topic. Most people would have few or no people in their life that they would feel comfortable openly sharing pain this dark with, as it changes the nature of a relationship, and talk about mental illness and death by suicide is highly stigmatised…Any strategies that lead to people having a greater number of safe avenues for dialogue with someone else about how they are feeling can only be positive.[96]

Conclusion

Suicide prevention roles

4.75 The role of staff in primary care, law enforcement and emergency services and care was seen as vital to the detection and treatment of persons at risk of suicide and care for bereaved families. The Committee considers it is necessary for staff in these areas to receive broad suicide prevention training which is assessed, updated and maintained.

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93 Kentish Regional Clinic, *Submission 40*, p. 3.

94 Salvation Army, *Submission 142*, p. 9.

95 Frances, *Submission 18*, p. 2; Professor Nicolas Allan, *Committee Hansard*, 4 March 2010, p. 98.

96 Frances, *Submission 18*, p. 2.

4.76 Any person who seeks assistance because of suicidal ideation or following a suicide attempt should be taken seriously and treated appropriately. In the view of the Committee is important that there is at least one person in each emergency department with the mental health training and capacity to conduct suicide risk assessments and referral for persons who may be suicidal.

4.77 Front line staff often encounter confronting and stressful situations which involve suicide and attempted suicide. Adequate support, debriefing and counselling services should be made available to these key personnel to access.

Recommendation 8

4.78 The Committee recommends that Commonwealth, State and Territory governments ensure that staff in primary care, law enforcement and emergency services receive mandatory and customised suicide risk assessment, prevention and awareness training as part of their initial training and ongoing professional development.

Recommendation 9

4.79 The Committee recommends that Commonwealth, State and Territory governments mandate that hospital emergency departments maintain at least one person with mental health training and capacity to conduct suicide risk assessments at all times.

Recommendation 10

4.80 The Committee recommends that Commonwealth, State and Territory governments review debriefing procedures and counselling support available to frontline workers regularly exposed to suicide and attempted suicide related incidents.

Discharge and follow up

4.81 The period following discharge from mental health services or hospital following psychiatric care or an attempted suicide was recognised as critical during the inquiry. Discharging persons who have attempted suicide or are at risk of suicide without providing follow up support or referral to appropriate services appears to the Committee a breach of duty of care. The Committee considers everyone should have a well resourced and supported care plan when being discharged from hospital or psychiatric care if they are assessed as having been at risk of suicide.

Recommendation 11

4.82 The Committee recommends that Commonwealth, State and Territory governments establish mandatory procedures to provide follow up support to persons who have been in psychiatric care, have been treated following an attempted suicide or who are assessed as being at risk of suicide.

Coordination of care

4.83 The Committee heard many personal stories of people at risk of suicide 'falling through the gaps' between services because of lack of coordination between agencies and service providers. The coordination and collaboration of agencies and services such as law enforcement, emergency care, mental health services, primary care, telephone crisis support services and community organisation is essential in providing continuity of care for people at risk of suicide.

Recommendation 12

4.84 The Committee recommends that Commonwealth, State and Territory governments provide funding for programs to identify and link agencies and services involved in the care of persons at risk of suicide. These programs should aim to implement agreements and protocols between police, hospitals, mental health services, telephone crisis support services and community organisations and to improve:

- **awareness by different personnel of suicide prevention roles and expectations; and**
- **handover procedures and continuity of care for persons at risk of suicide.**

Stepped accommodation

4.85 The need for graded or stepped accommodation and alternatives to acute inpatient care for people at risk of suicide and people with severe mental illness was emphasised during the inquiry. The Committee notes some governments are providing some funding for subacute accommodation and other alternatives. However the Committee considers further investment in this area is necessary and has the potential to significantly assist people who have attempted or who are assessed as being at risk of suicide. The Committee also received evidence that closely supervised accommodation may be necessary where patients change their medication as this was a period of increased risk for suicide.

Recommendation 13

4.86 The Committee recommends that Commonwealth, State and Territory governments provide additional funding for graded accommodation options for people at risk of suicide and people with severe mental illness.

Patient privacy

4.87 The Committee recognises the difficult balance that must be maintained between persons at risk of suicide (who can often suffer from a mental illness) and rules regarding the privacy of patient information. There does not appear to be an easy solution to this problem. Any significant changes to patient privacy could potentially lead to patients not feeling comfortable or able to entrust medical information to their doctors. The Committee considers that medical practitioners should recognise the

benefits of family involvement in the treatment and care of patients as well as the possible use of waivers of privacy where the patient is willing to give consent.

Recommendation 14

4.88 The Committee recommends that the Australian governments oblige health care staff to offer prior consent agreements, such as advance health directives and standing medical powers of attorney, to patients at risk of suicide.

Training

4.89 Training issues have been recognised in the *Fourth National Mental Health Plan.* One of the Prevention and Early Intervention National Actions is to 'provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors'. It states:

> Supporting these groups to better understand and recognise mental illness and to know how to react to individuals during an acute episode of illness or suicidal behaviour will improve earlier intervention and bring better outcomes for individuals and their families. Workers that are particularly important include police, ambulance, child protection workers, correctional services staff, employment support officers, pharmacists, residential aged care workers and teachers.[97]

4.90 The Committee considers it is appropriate for Australian governments to provide leadership in this area through providing suicide prevention training to their frontline staff. This would also function to improve understanding and awareness of suicide in community.

Recommendation 15

4.91 The Committee recommends that Commonwealth, State and Territory governments provide accredited suicide prevention training to all 'front line' staff, including those in heath care, law enforcement, corrections, social security, employment services, family and child services, education and aged care.

4.92 Increasing the number of persons with suicide prevention training was seen as having a number of benefits during the inquiry. These benefits included the improving the opportunities for someone at risk of suicide to be detected and assisted and building community awareness and understanding about suicide. Better training is a suicide prevention strategy with a supportive evidence base.

4.93 The NSPP already grants funding to a number of projects which provide suicide prevention training such as the CORES program. The Committee considers there is scope for this access to suicide prevention and awareness training to be

97 DoHA, *Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009- 2014*, p. 35

extended. Several community organisations noted the cost of suicide prevention training and mental health first aid training was a disincentive to participation.

Recommendation 16

4.94 The Committee recommends that the National Suicide Prevention Strategy promote and provide increased access for community organisation and the general community to appropriate suicide prevention training programs.