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Submission for the Inquiry into Suicide in Australia

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To:

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The Victorian Mental Health Carers Network Inc. (Carers Network)

The Victorian Mental Health Carers Network is the peak body for mental health carers in Victoria. We encompass over 20 key organisations within Victoria that support and work with Carers. The broad aims of the Carers Network are:

- Carer involvement in planning and decision making about treatment and care
- Carer participation in systems change, service and policy development
- Advocating for service and system developments to meet carer support needs

Preamble

Thank you for the opportunity to make comments in relation to this inquiry. Our Carer Research and Evaluation Unit (CREU) ha*s* recently conducted a study of carers of people who have a mental illness and have attempted or completed suicide. The qualitative research included 15 family carers (9 female, 6 male) who are in a variety of caring roles e.g. wife, husband, etc; from a variety of geographical and socio-economic areas e.g. rural and metropolitan; one male of aboriginal descent was involved.

We have included results of our findings under the various headings given under the terms of reference for the Inquiry.

a. The personal, social and financial costs of suicide in Australia;

Research shows that while the human costs of suicide are hard to measure, the financial costs are estimated to be in the millions of dollars each year. Not only are the immediate family and friends affected – offspring, siblings, parents and grandparents – there is also a rippling effect across the broader community.

In our research, personal, social and financial issues were identified by carers as potential risk factors, ie likely reasons why their family members attempted or completed suicide.

Personal social and economic circumstances can contribute to the likelihood of a person attempting suicide. Out study found that breakdown in social circumstances, such as parental divorce and disrupted family upbringing, intimate relationship breakdown and separation from children can increase the risk of suicide.

Change in economic circumstances can also translate into higher suicide risk. Loss of or changes in employment circumstances and employment-related stressors and workplace bullying are other triggers for suicide

Inadequate funding for the mental sector can contribute to increased risk for suicide. Our study revealed that the carers considered the following as increasing the risk for person attempting suicide: untreated increased psychiatric symtpoms e.g. paranoia, depressive thoughts, anxiety; brief treatment interventions for severe psychiatric symptoms; early or high risk (while still suicidal) discharge from general hospital or MHS; inadequate follow-up post discharge from in-patient psychiatric unit and lack of step-down units for transitioning back into family/community setting.

b. The accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk)

This issue was not canvassed in our research.

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;

Our research gathered information on carers' experiences of services. Below are the main points.

1. Our research found that carers' experiences of services was varied. These were:

- Carers largely found GPs empathic to their situation and supportive of their seeking specialist psychiatric care. Those with previous experience within the mental health system contacted their local Crisis Assessment Team or Youth Access Team, the consumer's case manager, mental health clinician, or local mental health service (MHS) seeking further assessment and treatment for their relative. These agencies were generally unknown to family members without prior MHS experience, as one mother stated "Orygen I found by mistake…I didn't know it existed". With minor exceptions, carers found the CAT/YAT teams to be unresponsive to or dismissive of their needs in a crisis situation, as captured in this participant's satirical characterization: "CAT – Can't Attend Today team, Call Again Tomorrow team".
- The police were generally considered an unsafe option (because of police shootings of mentally ill people in Victoria) and/or uninformed resource for assisting families in the management and care of consumers presenting with symptoms of psychosis and violence.
- Family carers who presented at small rural hospital emergency departments with a consumer who had overdosed or self harmed, often reported being refused medical treatment based on various grounds, for example: the service does not treat young girls who self harm; the family is draining the service's resources; or as one husband was informed when he presented at the ED with his wife: "we don't do walk-ins, call an ambulance". he went out into the 'middle of the highway' to call an ambulance. Carers were frequently required to transport their distressed or unwell consumer between 2 to 4 hours to the only hospital in the region with an acute psychiatric unit. Carers reported ambulance response times in regional areas ranging from 10 to 45 minutes, with only one unit being on call after-hours for the whole Wimmera region.

2. Our research found that the quality of care with services needs to be improved.

- There was an insufficient provision of activities and programmes of a positive and therapeutic nature for consumers while in acute psychiatric units. For example, “My wife has been in the acute unit twice and I’ve found she is worse when she comes out than when she has gone in. In there, there is nothing for them to do, they are left to their own devices, there aren’t even any art classes, you have the depressed/bipolar people in with the psychotic people, and there’s a lot of bullying”.

- The duration of stay was frequently seen as too brief and characterised by the lack of an ongoing comprehensive psychiatric or risk assessment, or the development and/or implementation of a psychological and/or pharmacological treatment plan. The care emphasis was on discharge rather than the provision of treatment or developing a sense of commitment to the consumer. For example “…with all these suicide attempts he ended up in the hospital. They were very short of beds so were doing their best to get rid of him all the time. ‘You take him home’. Well we’d had about four times of this and we said ‘no we’re not taking him home till he gets some help’”.

3. Our research found in addition to this previous point that there was a difference in quality of care within services depending on where they were based and what training the workers had been given. In particular there was a marked difference between the same type of service in metropolitan and rural regions.

- Where there was an attempt via overdose and the ED was large and well equipped, care quality was enhanced. For example, carers presenting a consumer to an ED following an overdose or other form of suicide attempt, received physical, ‘life saving’ care which was of a high standard in the immediate aftermath of the attempt.
- By contrast, families seeking immediate local attention in rural areas presented to a small ED only to be refused care or re-directed to another service some hours away. For example, “I’ve driven her up to hospital several times with her unconscious in the car [after an OD] and she’s always been transferred because they have no doctors or anything at Warracknabeal, she’s always ambulanced down to Horsham”.
- The assessing doctor’s psychiatric knowledge/expertise and ability to establish rapport and develop a therapeutic relationship with the consumer was generally viewed as poor and varied greatly depending on the individual practitioner and particular care venue.

4. Our research found that carers were repeatedly ignored by services, often to the detriment to the consumer. However, adolescent services were often the exception to this rule.

- For example, “they didn’t have the means and the skills I believe to assess my husband. I told them my husband was paranoid, ¾ hr assessment, he made some phone calls…they were quite happy for him to stay at home that was their opinion… the Doctor didn’t have a clue, he looked exhausted…I was there to get my husband admitted and he ended up dead”. This very distressed wife was simply not listened to although she knew her husband better than anyone.

- The lack of ‘listening’ to family members was perceived as contributing to their loved one’s subsequent suicide, through an incomplete/inaccurate formulation of the consumer’s level of suicide risk and need for in-patient admission and ongoing assessment. For example: “I presented to [local hospital], but they didn’t think he was paranoid, I knew that he was well and truly on the way…my situation wasn’t listened to…we had worked for months and months on early warning signs to no avail, none of them were heeded, none of the history was heeded, and the fact that I was his carer for 28yrs – I had no weight, no power at that moment of admission.”

- There was a lack of ongoing suicidal risk assessment and consultation with carers by MHS staff. For example, when a husband heard from his wife that she was being discharged: “I spoke to the psychiatrist and said ‘are you mad sending her home on the bus’, he said ‘why?’ I said ‘she is still suicidal’. He said ‘is she really?’… ‘She is still suicidal’…‘oh…okay we’d better not send her home then’. I said ‘if you’d rung me and spoken to me you would have found this out, because she told me she was still suicidal’…she would have OD’d on the way home on the V-line bus”.

- Carers also felt excluded from the ongoing psychiatric assessment and treatment planning/management of their loved one when they were admitted to an in-patient psychiatric unit, as this account describes: “ .....never been involved in the consultation or development of her management plan”.

5. Our research found that carers can experience stigma by services, which often led to isolation and further trauma.

- Rurally located MHS staff frequently treated family carers in a patronising manner. For example, “As a carer I’m treated with disdain, I feel frustrated, and I still feel patronised-sort of as if I’m some kind of blight on…that’s how I feel as a result of the body language and the kinds of things that are said” and “But the hospital itself, you don’t get support from them, they still treat me like I’m an idiot”.

- Those with a mental illness and their families regularly felt stigmatised by staff in small regional hospitals. For example, “you’ve got the small hospitals who don’t understand people with mental illness and don’t understand families and don’t want to, and families are being stigmatised for bringing them there – families can’t even use their local hospital, it’s wrong and we’ve tried to address that for years, and we still can’t get those things addressed – it’s about stigma, it’s unequitable, just to be treated”.

- Parents often felt blamed by hospital staff for their children’s repeated presentations at ED after a suicide attempt or incident of self-harming behaviour. As these parents stated, “Mothers and fathers are blamed for lacking parenting skills if their child turns out this way [having a mental illness] – health care professionals imply, “what have the parents done?” – it is shifting, but it’s still around”.

6. Our research found that there was a lack of, or inadequate support for carers and consumers post hospitalisation.

- There was a lack of assessment of the psychosocial needs of consumers and their carers by hospital and MHS staff. No interventions were planned or implemented to assist consumers to better cope with their psychosocial stressors, and in many cases no referrals were made to appropriate community agencies (e.g. grief counselling) to meet the consumers' or carers' social support needs.
- There was a consistent lack of communication (both verbal and written) between crisis assessment teams, community based MHS, ED staff, in-patient psychiatric services, and general practitioners regarding the presentation, risk assessment, treatment/management planning, and discharge planning for those presenting with suicidal behaviour. This lack of communication led to a discontinuity in the care of consumers and a lack of timely and appropriate monitoring, ongoing risk assessment, and follow-up post discharge.
- In-patient psychiatric care post-survival for those who had made a suicide attempt was less than optimal. Admission to the in-patient psychiatric unit was a disappointment and sat in stark contrast to the physical management received in ED.
- Consumers were regularly discharged home alone or without carers being informed post a presentation of attempted suicide. For example, "they discharged her in the am when they knew nobody was home to care for her" and "Family weren't notified of son's impending discharge from [the hospital]".
- In rural regions there was no appropriate provision for the transition of consumers from an acute psychiatric setting back into their local communities, such as a step-down unit.

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;

Family carers frequently reported not knowing where to go to seek the necessary assistance for their distressed loved one, or alternatively identified approaching a range of medical agencies for help including their family general practitioner, local hospital emergency department, or calling an ambulance in the case of a suicide attempt or serious attempt at self harm.

e. The efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk;

Our research found that there is a lack of knowledge and understanding of mental illness in staff of small regional hospitals, and a resistance by staff to gain such skills. For example, "There is no step-down unit in [our region], so when they come out of hospital it's straight home into the stresses…To save the family stress we've kept my wife in the local base hospital, but that is not really a great option, as the nurses are bush nurses…My wife was put into a ward and the nurse who delivers babies said: 'Now come on darl, pull your socks up'. My wife has acute bipolar, very brittle, treatment resistant, so the understanding of the base hospital is very ordinary".

f. The role of targeted programs and services that address the particular circumstances of high-risk groups;

Carers and their family members who have either attempted or completed suicide are at higher risk due to an increase of risk factors. The following points provide a summary of carers' experience of services once their family members have either attempted or completed suicide.

- Carers generally felt abandonned and neglected within the acute care setting after presenting with a family member to ED post a suicide or self-harming attempt.
- Family carers were not offered any immediate or ongoing emotional support despite having been involved in a traumatic and distressing event with their loved one. For example, "there's nothing for parents, you're so in shock, there's nobody for you to talk to" and "I was left to rot in my own juices". Similarly, one mother whose daughter experienced a rapid-onset acute psychotic episode following her brother's suicide, re-contacted her son's regional MHS but was refused an assessment or any immediate assistance by the CAT team with "oh we're too busy…no one can come and see her".
- Family carers (in adult settings) were generally not provided with information about suicidality, what to look out for post discharge, who to contact if concerned, and how to care for a loved one who has recently attempted suicide or again become suicidal. For example, "Son discharged…went to a friend's home, he gave away possessions. Son went to mother's home …also gave away possessions – we [parents] had not been informed of signs to look out for suicidal behaviours" and "my sister is currently suicidal – all I need is a bit of encouragement how to deal with the fact that she's threatening suicide – skills about how to cope with someone who is suicidal".
- While family carers reported a range of follow-up care in relation to the consumer, the overwhelming majority of participants experienced less than satisfactory contact. Inadequacies in follow up contact were linked by participants to their relatives' subsequent suicides.
- Four family carers reported that follow-up care arrangements (3 psychiatrists, 1 MH clinician) had been made for their consumer, however their sons or husband had committed suicide prior to these appointments. Two of these consumers were reported to have received recent medication changes with a subsequent one month follow-up, one had been recently discharged from an acute psychiatric unit for the third time in eleven days with a 1-2 month follow-up, and another had been refused hospital admission despite warning signs of suicidality with a 5 day follow-up.
- A consumer had been seen twice in a month by a psychiatrist post his suicide attempt and then told he did not need to return, only to go on and suicide.
- On a positive note, three carers stated that their loved ones received regular (ranging from bi-weekly to three-weekly depending on what was required), free, and ongoing support from a psychologist, whose care and treatment they found helpful.

g. The adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy

We believe more research needs to be carried out on support by Hospital/MHS staff for family cases of bereavement, and best practice postvention interventions. Below are examples of some carers' experiences.

- In the majority of cases reported in the two focus groups, little to no support was offered to bereaved families, either by hospital or MHS staff. The most supportive instance reported involved a family whose teenage daughter had suicided post-discharge from an acute psychiatric unit, where it was reported there was "some attempt to work with family [parents]", however "her sisters didn't get to debrief with workers". In this case the consumer's father perceived the family's bereavement needs as secondary to concerns by MHS staff regarding negligence suits and legal deficiencies, as this comment reflects: "a couple of nurses were terrific but they closed up shop when she died…this wall of silence".
- One family sought private individual and family group counselling after their son suicided following a referral by a family friend who was a health professional. This family reported the professional support was beneficial as the mother recounts: "he [counsellor] saw each of us separately (thereby allowing each family member to privately express their grief) and then together (to support each other) – that was fabulous". One wife for whom the regional MHS did not provide direct follow-up support after her son's death reported accessing a mental health clinician through the support of the regional carer consultant.

h. The effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress

Our recommendation is that projects funded under the NSPS guidelines need to be explicit about including families/carers in project reference groups. In the article, 'A review of 156 local projects funded under Australia's national suicide prevention strategy: overview and lessons learned'[1], it provides a useful evaluation of a number of projects funded under the NSPS – some of which are projects that support family and friends re: suicide prevention and postvention. However, in its recommendations, while it states the importance of including key stakeholders within NSPS project reference groups; earlier in discussing the key stakeholders families/carers are specifically not referenced within this group.

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[1] Heady, A *et al.* 2006, A review of 156 local projects funded under Australia's national suicide prevention strategy: overview and lessons learned, Australian e-Journal for the advancement of mental health (AeJAMH), Vol. 5, Issue 3, accessed 6/10/09, http://www.auseinet.com/journal/vol5iss3/headey.pdf

As a result of our study with carers on the topic of suicide prevention we offer the following recommendations:

Medical staff in ED/MHS would benefit from some training in suicide risk assessment. These clinicians also need to be provided with clear assessment and management guidelines for those having attempted or at risk of suicide, and adherence to this plan needs to be documented within the medical file. In cases of bereavement, an audit of adherence to guidelines would assist in maintaining care quality, and promoting clinical accountability.

When conducting a suicide risk assessment medical staff need to be mindful of co-morbid mental illness, in particular diagnoses associated with increased risk such as depression, schizophrenia, substance abuse, or borderline personality disorder. In addition, a comprehensive assessment ought to incorporate an evaluation of short- and long-term risk factors including psychosocial stressors and interpersonal problems or conflicts.

Corroborative sources such as family carers should be accessed wherever possible in the initial and ongoing assessment of suicide risk, and asked if they are aware of anything that would suggest suicidal intent, about any current life stressors, alterations to their loved one’s usual behavior, and regarding the consumer’s current social supports. Family carers need to be consulted and kept informed about the ongoing treatment/ management planning, discharge planning, and follow-up/monitoring arrangements of consumers presenting post a suicide attempt or with increased psychiatric symptoms. Information (verbal and written) about suicidality, crisis resources, and how to cope with someone who is suicidal, needs to be routinely provided to carers of those presenting to ED or acute MHS post suicide attempt or at risk of suicide.

Family carers require the provision of emotional support in the ED or acute MHS when presenting with a loved one post suicide attempt or following bereavement. All family members (parents, siblings) require their ongoing psychosocial support needs to be assessed and an appropriate referral made to an internal (e.g. pastoral care, psychology/ social work, carer consultant) and/or external (e.g. community grief service, private psychology/counseling, community MHS clinician) support service.

Thankyou

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