Mental Health
Coordinating Council

NSW Suicide Prevention Strategy 2010 – 2015
Public Consultation Submission

July 2010

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NSW Suicide Prevention Strategy – Public Consultation
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The Mental Health Coordinating Council thanks the NSW Department of Health for providing us with the opportunity to comment on the NSW Suicide Prevention Strategy 2010-2015: Public Consultation Draft.

The Strategy identifies the six strategic directions which are:

1. Improving the evidence base and understanding of suicide prevention
2. Building individual resilience and the capacity for self help
3. Improving community strength, resilience and capacity in suicide prevention
4. Taking a coordinated approach to suicide prevention
5. Providing targeted suicide prevention activities
6. Implementing standards and quality in suicide prevention

Under these strategic directions we briefly add the following comments to the outcomes/ actions identified in the detail of the directions:

1. It is important to identify the barriers to access and equity for people with disability. The literature has provided evidence that people with physical disabilities are five times at higher risk of suicide than the general population. It is critical that suicide prevention initiatives address the needs of people with disability and chronic illness who may develop coexisting mental health difficulties. Those particularly at risk have been identified as people with acquired brain injury (ABI) and spinal cord injury (SCI).

   People of all ages with mental illness and coexisting disability experience social exclusion, stigma and discrimination, which place them at greater risk of suicide. Equal consideration must be paid to all people with disability at risk across all six strategic directions of the Strategy. This must include the high risk category of young people between 18 – 25 who have ABI and SCI (the stage of life that the majority of people sustain such injuries). Older people with chronic illness and disability, and particularly men are at greater risk of suicide.

   It is also necessary to identify the barriers to access on the basis of gender, and investigate appropriate avenues that acknowledge gender difference so that men find services accessible.

   People with mental illness frequently endure the negative effects of medication such as weight gain and loss of sexuality. This may well lead to a significant impact of quality of life and mood, putting a person at greater risk of suicide. People with disability frequently experience similar negative effects from the medication that they may take to manage pain, which likewise increases the risk of suicide.

   Similarly, people with mental illness and disability frequently describe the ‘cure’ as bad as the illness or injury – so many choose to endure unremitting illness or pain rather than the side effects of medication. Clearly, the Strategy must highlight the need for research into how people are impacted by their medication which may undermine their quality of life and lead to suicide.

2. Some of the activities do not mention the whole population group to which the corresponding Action refers, for example: GLBT and CALD communities are mentioned in Outcome 2.2, Action ii. i., but the corresponding Activity only mentions Aboriginal programs and a Rural Drought Assistance package.

   The needs of a wide range of trauma survivors need to be identified, i.e. survivors of childhood abuse; Indigenous, refugee and migrant groups; people with co-existing mental illness and intellectual disability; people with disability ; veterans and people released from the criminal justice system.

   Outcome 2.2., Action ii, needs to identify the NSW Men's Health Plan and other relevant strategies to connect and align with help seeking mechanisms through other frameworks.

3. Many of the risk factors associated with suicidal behaviour such as mental illness; drug and alcohol misuse and abuse; a history of childhood abuse; poverty; an inability to participate in meaningful and sustainable employment; in addition to social isolation are especially relevant to people with disability, whether lifelong or acquired through illness or trauma. These risk factors require emphasis throughout the strategy.

   Under this strategic direction see further comments in focus area A, B, C below.

4. The document does not specifically identify the activities of CMOs (Community Managed Organisation, otherwise known as NGOs). There needs to be a focus on how agencies will link with the activities of CMOs. Whilst this is mentioned in Outcome 4.2, Objective ii. - making reference to a "Communities of Practice" Framework, there needs to be stronger activity around the interfaces between Agencies and NGOs.

   People with disability, particularly those with ABI and SCI, who are at high risk of developing depressive illness frequently experience difficulty in accessing mental health services. There is a lack of coordination between service delivery and mainstream psychiatric services that rarely have the skills, knowledge and capacity to work with people with ABI. Specialist ABI services have limited scope for psychiatric and therapeutic interventions and tend to target services in the context of the behavioural challenges that these clients may present with.

   Under this strategic direction please see further comments in focus area A, B, C below

   Under Outcome 4.3., there needs to be a stronger emphasis on equity across regions and outreach capacity particularly in farming areas.

5. Under Outcome 5.2., that relates to improving specialist counselling services for children and young people who are bereaved. School counsellors, pastoral care and general child services generally do not have the expertise for this work. It is necessary to promote training and education to improve workforce capacity.

   Under Outcomes 5.5., it is necessary to provide for advanced training for certain types of workers and to encourage an expectation that senior workers study suicide prevention at tertiary level; and that key roles have suicide prevention as a position requirement. There is an over-reliance on Mental Health First Aid training, which is only appropriate as a minimum level of understanding for the community in general.

There is a need to highlight 'Recovery' themes as they relate to suicide prevention. For example, health workers need to be trained to connect people to the supports in their natural environment. Health workers are important carriers of hope, and there is no mention of the word "hope" within this document.

Peer Support, an important strategy within Recovery Oriented Practice, only has a brief mention in this document. The value of peer support in a broad context should be applied in the Strategy.

In Outcome 5.4., whilst there is mention of access to EAP (Employee Assistance Programs) i.e. counselling for the professions, there is no reference to compulsory supervision for workers in the field - a critical strategy for maximising safety and good outcomes for consumers and the professional development and protection of workers.

Strategic Outcome 5.5., needs to place a stronger emphasis on cultural change regarding discharge planning - promoting that it commence at admission: building knowledge and connecting to community care and support networks and minimising risk of discharging to homelessness and risk of suicide.

6. We would like to see an emphasis on Recovery Orientated Practice in the implementation of standards and quality in suicide prevention.

In order to provide further comment to this draft strategy, MHCC propose to take the opportunity to highlight 3 key areas of concern as our primary focus for people at risk of suicide as a consequence of mental health difficulties. These are focus areas that we identified in our two submissions and presentation to the Senate Community Affairs References Committee: Inquiry into Suicide in March 2010.

These three areas do not fit specifically into the strategic directions as defined in the NSW draft document, but extend across some or all of the strategic directions. The key areas are:

A. Stigma and discrimination
B. Post discharge and post release
C. The impact of childhood abuse

A. Suicide Prevention – stigma and discrimination

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

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

These community development steps are part of creating places where people can come together. It is not as simple as just placing people together and expecting them to connect. Support and preparation is needed, and Community Managed Organisation (CMOs,

otherwise known as NGOs), peer support networks, and other community based groups and agencies are ideally placed to provide this to achieve quality social integration.[ii]

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

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

Whilst the strategic directions identify the need for community education and awareness there is no strong indication of a major campaign. Research in the UK has found that an investment in stigma and discrimination campaigns of £0.55 pence per adult can produce a cost-saving of £4.51 per person: an 800% return on investment. Reducing discrimination increases the likelihood of people seeking support and treatment and leads to improved employment and education opportunities. In the absence of a national campaign NSW must follow the lead of QLD who are developing a stigma and discrimination media campaign informed by the campaign SEE ME developed in Scotland which is particular is worth noting for its success in an evaluation process recently undertaken.

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

Under strategic directions 4 and 5 that take a coordinated approach to suicide prevention; and provide targeted suicide prevention activities it is important to include community campaigns and awareness people in rural areas at risk particularly from stigma and discrimination as a consequence of their sexuality.

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

The model draws on a community managed model whereby the organisation partners or collaborates with other community orgs; public services (i.e. Centrelink type services); clinicians and other allied professionals, in addition to providing a range of services, many of which are available in-house, such as: health and nutrition; sexual health; mental health, counselling and psychology; parenting; legal advocacy; housing; training and employment; living skills and recreation.

B. Risk of Suicide post discharge and post release

Post Discharge

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

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

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

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

The transition between hospital and home needs to take into account the provision of 'step down' facilities. A consumer may not need hospitalisation but may not be well enough to cope in the community. Early intervention services that use existing partnership models with CMOs have a strong evidence base. MHCC recommend an example of this model which is the Victorian Prevention and Recovery Care (PARC) service model, a partnership between community managed mental health services and 24-hour clinical services. This model aims to intervene early, prevent risk of suicide or prevent admission or re-admission to acute mental health inpatient care. PARC presents a step-up and step-down alternative to hospitalisation that is Step-up' occurs when a person is becoming unwell, minimising risk of suicide or self-harm.

It is important that the strategic direction 4 emphasises care coordination and the role of CMOs in providing services in addition to the HASI program, designed to assist people with mental health problems requiring accommodation support to participate in the community, maintain successful tenancies; improve their quality of life and most importantly to assist in their recovery from mental illness and reduce the risk of suicide.

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

PHaMs aims to increase opportunities for recovery for consumers, providing the flexibility in service delivery people need. Under the PHAMS program people can, for example access support to help them manage everyday tasks or assistance finding alternative or more appropriate accommodation; support to access clinical care and access to employment, education or training opportunities; help to reconnect with family and friends and increase social networks and community involvement. For those at risk of suicide these services may be the critical circuit breaker of social exclusion. The Program focuses on **recovery** - demonstrating that people with a mental illness can lead a fulfilled life in the community with the same opportunities as other people.
Lapses in continuity of care, especially after discharge from Emergency Departments and inpatient psychiatric units, contribute significantly to suicide-related morbidity and mortality.

Furthermore, individuals experiencing mental illness are at the greatest risk of suicide immediately following discharge from prison and immigration detention centres.

Post Release

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

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

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

C. Thirdly - Victims of Childhood Abuse and Trauma

Sexual, physical and emotional abuse, neglect and exposure to domestic violence have significant mental health repercussions. Adult survivors of childhood abuse and trauma victims consistently manifest high rates of mental illness and suicidality; depressive and anxiety symptoms; substance abuse disorders; eating disorders; post-traumatic stress disorders, as well as poor physical health. Child sexual abuse was responsible for 0.9% of the total burden of disease and injury in Australia in 2003. Ninety-four per cent of this burden was due to anxiety and depression; suicide and self-inflicted injuries and alcohol abuse. [vii]

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

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

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

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

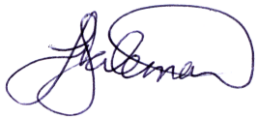
We recommend that in order to address this gap in service delivery CMOs must be supported to provide practical assistance such as: establishing an income; counselling; sustainable accommodation; clothing and other resources; healthcare, legal and providing for children's needs and well as programs that address DV; gambling; substance abuse; eating disorders as well as counselling services.

Some women's health centres and refuges already provide a diversity of support services through linkages to other CMOs but these services are scarce and under-resourced. There is a need to support CMOS to build skills to enable the workforce to better engage with this client group, and this must be evident in providing targeted suicide prevention activities under strategic direction 5.

The only recent attempt to address this gaping hole in service provision is that in July 2009, the NSW Government enhanced funding to NSW Rape Crisis (in partnership with Women's Health) to enable one FTE counsellor to provide face to face counselling for adult survivors across several Women's Health Centres in NSW. The NSW Suicide Prevention Strategy must target this area for women abuse survivors, and target men at risk for whom virtually no services exist at all.

MHCC thank the NSW Department of Health for their interest and express our willingness to participate in any future consultations. We look forward to the final strategy document and action plan.

Yours sincerely,



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