Private Mental Health Consumer Carer Network (Australia) Limited

engage, empower, enable choice in private mental health

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Ms Christine Morgan

National Suicide Prevention Advisor

Suicide Prevention Taskforce sent via email: SP.Taskforce@health.gov.au

Dear Christine,

Thank you for the opportunity of contributing to this critical issue of suicide in Australia. The Network recognises the enormous costs associated with someone taking or attempting to take their lives. We bring this submission to you from a lived experience and family perspective.

We know from our experiences that people often live with suicidal thoughts and this in the main results from abject hopelessness, with no hope of any future changes. People see the ending of their lives as the only option for them, and for many, see it as a requirement for those they leave behind in the belief that they will be better off without them.

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

People with mental illnesses such as borderline personality disorder self-harm in order to contain the inner pain they are experiencing. These people are at greater risk or suicide in that attempts to self-injure can go too far. These people are at a high risk of suicide. However, people with a mental health disorder may often live day by day with suicidal thoughts - it may be a central factor of their mental illness and/or the issues associated with their struggle. These issues may include (but not be limited to) social isolation, a deep sense of failure, neglect by themselves and others or a profound grief at the loss of many important things in their lives as a consequence of their mental illness - not the least being, the normal functioning and recognition as an individual of worth.

Suicide is a topic the Australian community finds difficult to discuss and to understand and does not do so openly as a general rule, and the community seems more comfortable in avoiding the matter. Families will report that following death by suicide of a family member, people i.e. friends, neighbours etc tend to react in a negative manner toward them, often avoiding them or avoiding talking about the death (or life) of their loved one. Many of us exposed to the mental health area know people who have chosen this path as a solution to their suffering or know their families. Suicide within mental health is a reality, and we are concerned that health professionals are becoming 'risk adverse' and looking to reduce the ways in which people can take their lives ie removing doors to bathrooms etc. This is not looking at the larger issues of dignity, respect etc for the majority of patients.

In 2017, 3,128 lives were lost to suicide. [1] The biggest risk factor for suicide is a prior suicide attempt. Assertive outreach approaches to integrated suicide prevention can prevent 21 per cent of suicide deaths and 30 per cent of suicide attempts[2]. Every individual who has attempted suicide and sought hospital treatment for a related injury should be followed up.

All governments have made the following commitment to Australians: "Services will actively follow up with you if you are at a higher risk of suicide, including after a suicide attempt."[3]

Despite the large amount of funding over several years, the suicide rate has increased. The Network provided Recommendations in relation to suicide to the October 2009 Senate Community Affairs Committee, Inquiry into Suicide in Australia[4]. We still believe these are relevant for the Taskforce to be aware of.

There are insufficient services to support families, carers or significant others when a person has attempted suicide or has died by suicide. This is a vulnerable time and people require the necessary mental health supports at this time. We know that it is not uncommon for a sibling, or child of someone who suicides, to also die via suicide. This is a known time of vulnerability and mental health services must be established to cater for this group.

Suicide rate higher in men

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

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

Rural and regional areas

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

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

There is good evidence to determine that it is the coming together as a community that is the most useful after tragedies or natural disasters occur. We believe that funding to support local

[1] Australian Bureau of Statistics. 3303.0 Causes of Death, Australia 2017. Table 11.1 Intentional self-harm, Number of deaths, 5 year age groups by sex, 2008-2017.

[2] Black Dog Institute. LifeSpan research. <https://blackdoginstitute.org.au/research/lifespan>, accessed 27 September 2018.

[3] Council of Australian Governments Health Council. The Fifth National Mental Health and Suicide Prevention Plan. August 2017. Page 25

[4] Submission 10: Private Mental Health Consumer Carer Network (Australia)

governments in rural and regional areas to build the capacity of the community and provide prevention, early intervention and support services is urgently required.

Single person fatal vehicle accidents

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

In terms of suicide prevention within mental health, the Network draws the Taskforce to our recommendations below together with the section on 'People at high risk, Borderline Personality Disorder' within the mental health sector. We believe such practical measures will go a great way in identifying and reducing suicide to these vulnerable individuals.

Recommendations:

i. **Introduce targeted prevention strategies for men.**
ii. **Introduce targeted prevention strategies for the rural and remote areas.**
iii. **Provide funding to local governments to offer community based prevention, early intervention and support services to build the capacity of communities as well as when faced with tragedies or natural disasters**
iv. **Fund the training and education to country staff including ambulance, police and administrative staff of suicide awareness.**

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

All suicides whilst in the care of inpatient health services are mandatory reporting requirements classified as a sentinel event. These are the subject of coronial inquiries. However any coroner's recommendations are not required to be mandated or rectified.

Discharge from a mental health service and suicide

It is acknowledged that a number of people suicide within a short period of discharge from a mental health facility. This could be deemed to imply that either discharge has been premature, recognisable risk factors at the time of discharge are not taken seriously or that there is insufficient community referral and support provided following discharge.

We understand that a reliable collection of information of this nature would require linkage of health service data collections with coronial data collection. The Network further understands that it is *not mandatory* for public mental health services to collect this information as part of the national data collection protocol.

Similarly, private mental health services are *not required* to follow up, support or provide services in the community although this is changing. Any consequential cases of suicide occurring post-discharge can go undetected by the private facility. All admissions to private sector mental health facilities are mostly via a private psychiatrist, though in some instances by a GP or other referral and the private psychiatrist, GP or other referrer *discharge the consumer into their own care*. It is our understanding that the private hospital is *not required* to initiate any process by which to follow the consumer after discharge. Many private hospitals initiate a telephone call to people a few days post discharge, but not in the long run. As a result, private mental health facilities are precluded from mandatory reporting of information of this nature.

The Network considers that **the lack of** suicide reporting for mental health services is of major concern. The Network understands that the collection of this kind of follow-up information is hampered by the difficulties imposed by privacy legislation. Whilst a person is in a service's care the

service is obliged to collect and report certain information. Once a person is discharged, it becomes very difficult for health service providers including individual practitioners to be aware of this important information.

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

Recommendations

v. **Implement reporting protocols of deaths within 28 days of discharge from a mental health facility be linked to coronial reporting requirements.**

vi. **Implement the reporting of any death within 28 days from consultation with a health professional for a mental health issue, be linked to coronial reporting requirements.**

vii. **Introduce suicide prevention training to health and community workers who provide services to individuals and to those with a mental illness.**

viii. **Implement the mandatory introduction and routine use in public and private mental health sectors of a clinician rated, validated suicide risk assessment tool at discharge from inpatient settings and 3 monthly review in community settings.**

ix. **Introduce and routine use of a clinician rated, validated suicide risk assessment tool for all people in contact with community mental health support organisations.**

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

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

People most at risk are those who have attempted suicide. Services are urgently needed to recognise and support these people.

Recommendations

x. **Provide community-based assertive outreach to people who have attempted suicide.**

xi. **Provide community-based supports for families and or significant others affected by suicide or suicide attempt.**

xii. **Fund a range of targeted community mental health supports to reduce the risk of subsequent suicide following discharge from hospital or other care. Follow up should occur through multiple channels (in person, by phone), and should not be dependent**

on the nature of any other service the person is receiving or has received, or how that service is funded (Commonwealth or State). [5]

High-risk group – Borderline Personality Disorder

Schizophrenia has a suicide rate of around *8-10%* of sufferers, and *borderline personality disorder* around the same. It is estimated that up to *one third* of youth suicides have been the result of the existence of borderline personality disorder.

There seems to be a lack of research and analysis of causes into suicide by and suicide prevention for people with the diagnosis of *borderline personality disorder* and recognition or focus on people with this mental illness is of considerable concern. The suicide rate of people with this diagnosis is estimated to be around 10%. These deaths can often be prevented if appropriate and designated services are provided, access and entry to those services are available and people are not further discriminated against.

In an unprecedented move within mental health in Australia, a coalition of the peak consumer and carer national advocacy organisations[6], together with the clinical and key non-government organisations brought this issue to national prominence by lobbying the *Senate Community Affairs Committee – Inquiry into Mental Health*. This resulted in a clear recommendation in the Report tabled in the Australian Senate on 25 September 2008[7] that a national borderline personality disorder initiative, overseen by a Taskforce is undertaken.

The Recommendation is as follows:
Recommendation 25
The committee recommends that the Australian, state and territory governments, through COAG, jointly fund a nation-wide Borderline Personality Disorder initiative. The committee recommends that the initiative include:

- designated Borderline Personality Disorder outpatient care units in selected trial sites in every jurisdiction, to provide assessment, therapy, teaching, research and clinical supervision;
- awareness raising programs, one to be targeted at adolescents and young adults in conjunction with the program in Recommendation 19 (Chapter 8) aimed at improving recognition of the disorder, and another to be targeted at primary health care and mental health care providers, aimed at changing attitudes and behaviours toward people with Borderline Personality Disorder; and
- a training program for mental health services and community-based organisations in the effective care of people with Borderline Personality Disorder.
- The committee recommends that a taskforce including specialist clinicians, consumers, community organisations, public and private mental health services and government representatives be convened to progress and oversight the initiative.

The Network strongly supports the actioning of these 4 points. Additionally, the Network undertook surveys in June 2011 and again in June 2017 around the experiences of consumers and a separate survey for carers. This was an Australian and International first. Here are the published papers relating to these survey findings.

[5] Mental Health Australia 2019 Election Platform
[6] Senate Community Affairs, Toward recovery: mental health services in Australia, Pg 168 9.57 (Submission 53, Private Mental Health Consumer Carer Network (Australia) p.4)
[7] Senate Community Affairs, Toward recovery: mental health services in Australia

Lawn, S., McMahon, J., Zabeen, S. (2017). FOUNDATIONS FOR CHANGE: PART 1 - CONSUMERS: Experiences of CONSUMERS with the Diagnosis of Borderline Personality Disorder (BPD) 2017 Update. Private Mental Health Consumer Carer Network (Australia) Inc: Marden, South Australia, Australia. (60 pages) http://www.pmhccn.com.au/
Lawn, S., McMahon, J., Zabeen, S. (2017). FOUNDATIONS FOR CHANGE: PART 2- CARERS: Experiences of CARERS supporting someone with the Diagnosis of Borderline Personality Disorder (BPD) 2017 Update. Private Mental Health Consumer Carer Network (Australia) Inc: Marden, South Australia, Australia. (95 pages) http://www.pmhccn.com.au/

McMahon, J., Lawn, S. (2011) Foundations for Change - Experiences of Consumers and Carers Supporting Someone with the Diagnosis of Borderline Personality Disorder (BPD). An Independent Report of the Data from a National Survey Undertaken by the Private Mental Health Consumer and Carer Network, July 2011 ISBN 1 920966 25 0 http://pmha.com.au/pmhccn/PublicationsResources/Surveys.aspx
Lawn, S., McMahon, J. (2011) Foundations for Change Part 1- Experiences of Consumers with the Diagnosis of Borderline Personality Disorder (BPD). An Independent Report of the Data from a National Survey Undertaken by the Private Mental Health Consumer and Carer Network, July 2011 ISBN 1 920966 26 9 http://pmha.com.au/pmhccn/PublicationsResources/Surveys.aspx

Lawn, S., McMahon, J. (2011) Foundations for Change Part 2- Experiences of Carers Supporting Someone with the Diagnosis of Borderline Personality Disorder (BPD). An Independent Report of the Data from a National Survey Undertaken by the Private Mental Health Consumer and Carer Network, July 2011 ISBN 1 920966 27 7 Peer report

The Network makes the following recommendations in regard to BPD.

Recommendations.

xiii. Fully implement Recommendation 25 of the Senate Community Affairs, Toward recovery: mental health services in Australia.

xiv. Increase the number of consultations under the Better Access initiative for people with BPD to the same as eating disorders, i.e. 40 per year.

We would be very happy to further discuss any of the content within this Submission. Please contact me on the following: Email: jmcmahon@senet.com.au Telephone 1300 620 042 Mobile 0417 893 741

Yours faithfully,

Janne McMahon OAM

Chair and Executive Director

8 November 2019