

Psychotherapy and Counselling Federation of Australia Submission to the Senate Inquiry into Suicide

Preamble

PACFA is a national federation of 38 counselling and psychotherapy associations, which has established Professional Training Standards for the profession, provides a rigorous course accreditation process and maintains a national Register for practitioners who meet the Register standards of training, practice experience and hours of supervision. PACFA has worked with the Australian Counselling Association to set up a national credentialing system for the profession, the Australian Register of Counsellors and Psychotherapists. Counsellors and psychotherapists provide services to people at risk of suicide, and their families and carers, as well as people bereaved by suicide, across Australia. Counsellors and psychotherapists can be accessed in urban, regional, rural and remote areas.

This submission by PACFA is based on consultation with our member associations on (c), (d), (e) (f) and (g) of the terms of reference for the Senate Inquiry into Suicide as most relevant to PACFA's objectives. Feedback was received from member associations, practitioners from a range of disciplinary backgrounds, including psychiatry, clinical psychology, counselling and psychotherapy, and researchers on suicide. Recommendations arising from the feedback follow.

Recommendations

1. Suicide prevention and risk assessment training should be provided to all staff working in emergency departments and community health services. Such training should include counselling skills. Ideally, this training should be incorporated into the formal education courses for all health and community workers.
2. Training and degree courses for community workers, counsellors, social workers, psychologists, psychiatrists, psychotherapists and mental health nurses should include suicide prevention training and counselling skills.
3. First responders to a suicidal death, including police, other emergency services, hospital staff and funeral staff should receive training in how to communicate with family members sensitively following a suicide. This training should include information on how to contact support services specialising in suicide bereavement.
4. A dedicated line to a national Suicide Prevention service with a free number should be established for people at risk of suicide and family members caring for a suicidal person.
5. Clinical supervision and debriefing should be provided to all health and community staff providing services to people at risk of suicide to ensure the helpfulness of their response, to minimise the risk of detrimental responses and to assist with the emotional burden they are exposed to through their roles as health professionals.

6. Inpatient facilities for people at risk of suicide in both public and private health services need to be expanded. Adolescents require dedicated secure facilities to ensure they are not exposed to further risk, to respond to the needs of adolescents and their families, with staffed who are adequately trained in adolescent development.
7. The role of parents and carers in the care of young people at risk of suicide should be recognised by health services. Parents and carers should not be made responsible for the safety of adolescents and young people.
8. Research on suicide should include a focus on family factors both in contributing to risk and helping suicidal adolescents.

The following sections address the criteria (c), (d), (e) (f) and (g).

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

It is noted that the risk of suicide occurs across all social classes, although the extent of the risk increases with social disadvantage. There is the potential for everyone to be impacted upon at some time by grief and loss, family separations, acute crises, major depression or psychosis, all factors which may increase the risk of suicide.

Emergency departments and crisis response to people at risk of suicide

Practitioners who provide support to staff working in emergency departments of hospitals report that these personnel feel unsupported in assessing suicide risk. For example, social workers employed in hospital settings may be uncomfortable and unable to provide intensive support and/or referral to people at risk of suicide.

It was noted that the labelling of mental health conditions can be detrimental and stigmatising for consumers and may have consequences in the future, for example when applying for insurance and in disclosing health conditions to employers. While diagnosis plays a role in people being able to access appropriate services, people require a holistic assessment and response that includes areas such as self-esteem, self efficacy and living skills.

Clients' and carers' experiences of the crisis response include numerous examples where Mental Health professionals have not been professional, or are burnt out by their demanding work, or feel severely depressed themselves, and therefore pass judgment on those who have attempted suicide, or dismiss the suffering of depressed patients by comparing them to other people. For example, one client (a single parent whose 2 year old son had recently been found dead at home), was told at a hospital to take her medication and that there were many others walking around in a similar state of loss and grief.

Financial pressures on health services have reduced some services for people at risk of suicide. For example Manly Hospital in NSW used to have a 24 hour phone line

which gave useful back up support, however, in recent years this service has reduced its service to the community. has only a small number of beds and cannot keep patients for any lengthy period.

Family members find it difficult to access inpatient treatment for their suicidal relative or partner. If the person suicides, bereaved family members struggle with the loss of their previous belief that health services are available and able to help those who are mentally ill and who become suicidal (Ratnarajah, PhD thesis in progress).

Practitioners report that information about clients' admission to inpatient mental health services is rarely forthcoming. For example it took one therapist two weeks to locate a client of four years standing and to discover she had been admitted to a secure psychiatric ward. While PACFA is very aware of patients' rights to confidentiality and privacy, in most cases the lack of communication arises because there is no protocol to ask on admission about other treating health practitioners such as counsellors and psychotherapists, and to ask the patient's permission to communicate with the practitioner.

Clients' and carers' experiences of the crisis response include numerous examples where emergency department and mental health professionals have not been professional, are burnt out by their demanding work, are insufficiently resources, or feel severely depressed themselves, and therefore pass judgment on those who have attempted suicide, or dismiss the suffering of depressed patients by comparing them to other people. For example, one client (a single parent whose 2 year old son had recently been found dead at home), reported that she was told at a hospital to take her medication and that there were many others walking around in a similar state of loss and grief.

In Victoria, the Crisis Assessment Teams (CAT) are often overloaded and not able to respond immediately when a person is suicidal. For example, a client with a previous history of suicide attempts called the CAT team twice but was not responded to by the team although she was at serious risk.

Financial pressures on health services have reduced some services for people at risk of suicide. For example Manly Hospital in NSW used to have a 24 hour phone line which gave useful back up support, however, in recent years this service has reduced its service to the community. The hospital has only a small number of beds and cannot keep suicidal patients for any length of time.

It is noted that the labelling of mental health conditions can be detrimental and stigmatising for consumers and may have consequences in the future, for example when applying for insurance and in disclosing health conditions to employers. While diagnosis plays a role in people being able to access appropriate services, people who are suicidal require a holistic assessment and response that includes areas such as self-esteem, self efficacy and living skills.

Discharge

People at risk of suicide who are hospitalised do not receive adequate counselling and support services while in hospital, and are frequently discharged from hospital without having services put in place for ongoing support. This is frustrating for

relatives who feel the system has let them down, particularly where suicide takes place following discharge. Where practitioners are already involved, 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. 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.

Psychiatric consultations

For counsellors and psychotherapists working in private practice, the lack of psychiatric consultants for clients who are suicidal is severe. If an urgent psychiatric referral is needed, appointments are booked out for months in advance. Clients then need to go to emergency departments for triage and assessment, which is often more traumatising. Having accessible psychiatric appointments is imperative particularly in rural and regional areas.

Police response

One practitioner reported that police were unwilling to become involved with a person at risk of suicide when she contacted them because of his physical size. One research study on suicide has found inadequate responses from police. For example, a mother rang Lifeline for help when she found her son sitting with a rifle in his mouth. Police arrived at the house after being contacted by Lifeline. Her son then shot himself.

He was lying on the floor and by this time, the police were there, and I couldn't get them to come in, because he'd shot himself, no-one was coming in. I walked over and knelt down and felt his pulse, he still had a pulse. I'm screaming out 'get the ambulance, get the ambulance, he's still alive'. Anyway they finally came in and they just left him there until after midnight, because this was where the police went wrong, because they didn't want it to happen on their shift, so they stuffed around until someone else came in. Like on top of everything else you have all this to contend with. So they were all laughing and joking around. They waited until the next shift came on, so they would pass it over, and then they didn't want to do it. Ratnarajah PhD thesis in progress.

First responders to a suicidal death, including police, other emergency services, hospital staff, ministers of religion and funeral staff need to receive training in how to communicate with family members following a suicide. This training should include information on how to contact services specialising in suicide bereavement support. How these initial contacts with the bereaved family are conducted can have a major impact on the bereavement experience and recovery of family members.

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

It is noted that media articles reporting on suicide provide Lifeline phone numbers at the end of articles or television programs. This is very responsible.

There have been varying degrees of success when it comes to public awareness of suicide. While clearly general awareness has increased over time, in the general community there is still fear that speaking about suicide may cause it to happen. Health promotion campaigns which speak out about depression reduce the stigma associated with mental illness, such as depression; however suicide is still often a taboo subject. There is little awareness in the community about how to identify and manage suicide risk. There is a lack of programs for parents to educate them on awareness of suicide risk, warning signs, how to talk openly with their children and how to access acute services and follow up after the crisis.

Health promotion campaigns need to provide clear messages on how to communicate about risk of suicide with friends and family and what services can be contacted for professional assistance. More education and community engagement could assist with public awareness. In evaluating the success of public awareness programs that encourage help seeking, services in the public and private sectors must be available for programs to be successful.

It was noted that the disenfranchised nature of grieving after the suicide of a family member, and theories about suicide that blame the family, do not sit well with some of these health promotion messages.

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

Lifeline is often the first contact for suicidal people, is available after hours and plays a very important role in responding to people at risk of suicide. Not every caller can reach a counsellor. However, young people and those who are socially disadvantaged with mobile phone access only may not have enough credits to call and/or stay on the phone. There currently is no provision for crisis services to take mobile calls without cost. A dedicated line to a national Suicide Prevention service with a free number would be of great benefit.

Community health and community settings provide an important response to people at risk of suicide and in the aftermath of a suicide attempt. The quality of the response to a person at risk of suicide depends on the level of skills the counsellor, therapist or community worker has to provide such support. Many practitioners working in community health settings and front line work feel they are not adequately trained and resourced to support clients who are severely depressed and at risk of suicide.

In most of these settings, suicide prevention training is provided for workers. Most commonly this is the Applied Suicide Intervention Skills Training (ASIST), a suicide intervention program by LivingWorks, Lifeline, ASSERT and Mental Health First Aid. There is now refresher training for practitioners who have completed the ASIST program. TAFE and other institutions offer specialised mental health courses, for example Certificate IV in Mental Health, however workers need access to more short courses. Many mental health professionals have not been trained in counselling skills and this should also be included in suicide prevention training. It is noted that these courses are seen as very worthwhile, however they cost money. It is recommended that all training and degree courses for community workers, counsellors, social

workers, psychologists, psychiatrists and psychotherapists should include suicide prevention training and risk management.

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. Although many long-term unemployed may have depression, these clients are often told “it is just an excuse”. When Centrelink workers refer clients for counselling as a strategy for being job-ready it would be helpful to have leaflets explaining about confidentiality and its limits.

It is reported that clinical supervision and debriefing for workers in frontline and community settings remains minimal. Clinical supervision is an important quality assurance mechanism for professionals working with people at risk of suicide.

As an occupational health and safety measure, it is the service management’s responsibility to ensure staff members are trained to provide support to people at risk of suicide ideation, and that staff are provided with debriefing and support for themselves. Currently there is a proposal to develop national occupational health and safety legislation. In this proposed legislation, it is unclear where the responsibility begins and ends, for example the CEO is responsible for occupational health and safety but not Boards of Management. It is noted that many non government services in the community sector are managed by boards.

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

On average 2,600 suicide deaths occur every year in Australia (Commonwealth of Australia 2001). Adolescents, Indigenous people, the long term unemployed, rural and remote communities, elderly people, lesbian, gay, bisexual and transsexual people, international students and people bereaved by suicide are seen to be particularly vulnerable for risk of suicide. Targeted prevention and intervention programs are therefore important to address the needs of high-risk groups. However such programs often face difficulties in gaining ongoing funding. Often new and successful programs are implemented and then lose their funding. Clients can lose hope as the funding body appears to have stopped believing in them and positive outcomes are lost.

Public health services for adolescents

The number of ‘secure’ or gazetted beds available in ‘acute’ publically funded residential facilities for adolescents is extremely inadequate. In NSW, Westmead Acute Adolescent Unit has 6 beds, Gnakalan, a unit at Campbelltown has 10. The beds at Gnakalan are area specific. These existing beds are often taken up by acute patients who have become chronic inpatients. This leads to the situation where the treating health professional would have to book an acute admission months in advance. Clinicians are at times unable to find a service that will respond to the emergency and admit the adolescent at risk. Other public health facilities for adolescents in Sydney (Rivendell and Prince of Wales Hospital) that take inpatients are extremely reluctant to, or do not take suicidal patients at all, as they are unable to ensure their safety.

Clinicians also report that acutely suicidal adolescents have sometimes been admitted to acute adult psychiatric units. Adult psychiatric mental health staff without an understanding of developmental issues can label adolescents prematurely as 'personality disordered'. There are significant risks to recovery when vulnerable adolescents witness the behaviour and distress of extremely disturbed adult psychiatric patients and can be subject to assault and harassment. One service described a case where an adolescent with a history of eating disorder and suicidality became pregnant to a much older man she met in an adult inpatient unit.

Private health services for adolescents

Private health services are often unwilling to admit adolescents under 18 unless they have a clearly defined eating disorder. Depressed and/or suicidal adolescents are usually rejected for reasons to do with risk to the hospital. This is despite the fact of co-morbidity of depression and eating disorder.

Responsibility placed on families and carers

Adolescents are usually referred to emergency departments and crisis services by parents or carers who are aware of their distress, and who try to obtain help for the troubled adolescent. However, the suicidal crisis is beyond the capacity of most parents or friends to deal with. There are very unhelpful implications for the parents' relationship with their adolescent child if they are left with responsibility for the safety of the adolescent. In many instances these adolescents are prepared to be treated on a voluntary basis, and recognise they do need the containment of a structured environment.

Where health services do not provide inpatient services, then families are placed in the position of having to provide 24 hour monitoring during the acute period. This places parents in a very difficult position. Many parents and families are not able to provide this support. The parents and families of acutely medically unwell children are not expected to take on a similar responsibility of care and responsibility.

Family interventions

The usefulness of using the family as a resource for the suicidal young person is noted. Although there is less evidence-based research to show the efficacy of family therapy, most of the recent research around adolescence and adolescent attachment points to the importance of connection to parents and carers. The most important protective factor that keeps young people safe is a close, connected relationship with their parent/s or carers. When young people present with depression or suicidal thoughts they usually also present with conflictual or distant family relationships. Bringing everyone together at this time to work on parenting and relationship issues is a vital part of helping the young person to feel better.

Indigenous people

Indigenous young people in particular have higher rates of incarceration and mental illness. Maple (2005) notes that Aboriginal suicide has unique social, cultural and political contexts and that the suicide risk for Aboriginal and Torres Strait Islander young people is 40 times greater. An understanding of intergenerational trauma and sociocultural factors are necessary for working with this population. It was noted by practitioners with a role in counselling Indigenous people that positive role models

within their communities are imperative to positive outcomes. Working with families rather than individuals is also very necessary.

Long term unemployed

The long term unemployed are another vulnerable group who are low in social status and not valued in their communities. Programs that are responsive to the needs of the whole person are needed to assist the long-term unemployed and reduce the risk of suicide.

Rural and remote communities

The success of rural and remote mental health programs in reducing suicide risk amongst farm families has been regularly reported at the NSW Farmers Association meetings.

Lesbian, gay, bisexual and transsexual (LGBT) people

These groups are very vulnerable to risk of suicide especially at the point of coming out and revealing their sexual identity to family and friends. Young LGBT people can have rates of suicide attempts at least four times higher than those who are heterosexual (Bagley and Tremblay 2000). One study (Huxdly and Brandin 1981 cited in Remafedi 1994) found that 53% of transsexuals surveyed (n = 72) had made suicide attempts. Other studies have also found significantly higher rates of suicide among transsexuals (Fitzpatrick 2005). The causes of this suicide risk are complex and include bullying, exposure to violence and harassment, stigma, and difficulties in accepting sexual orientation which lead to hopelessness (Rivers 2000; Fitzpatrick et al 2005).

International students

International students are seen as a vulnerable group who are not eligible for Medicare funded services. Some educational settings which cater for international students do not have student counselling and welfare services. On one such setting in Queensland, an international student attempted suicide, was seen by a GP and released to his own care without any support. Although he was medicated, it does take at least 10 to 21 days for this to be effective. The student had no social support as his family lived overseas and he attempted suicide again. The GP could only offer an appointment in 2 weeks time. International students are a group at risk who frequently experience extreme isolation, and who fall between the cracks with no Medicare status.

People bereaved by suicide

There is a great need for specialised postvention support for the families and friends of suicide victims, with an emphasis on the particular needs of bereaved children and young people. In Queensland there is a Survivors of Suicide Bereavement Support Service which is self supported and run by volunteers. A practitioner reports that family members bereaved by suicide find this service has been very useful and say that only those who have lived through such a loss can really understand their experience.

One research study investigated the grief of children after parental suicide and found that postvention suicide support was only available to one participant and that no support was offered to the other bereaved children apart from support from their families who are also grieving. This lack of intervention resulted in ongoing

distressed lives (Ratnarajah and Schofield 2008). The children experienced secondary losses such as loss of home, loss of their school and friends, and foreshortened education. Over half of the participants had attempted suicide in adult life and/or had first degree relatives who made suicide attempts. These suicide attempts resulted in hospitalisation for each of these attempters. There was little or no ongoing support for them unless they sought psychological or counselling support themselves in adulthood. When interviewed (between 5 to 70 years after the suicide of their parent) most could not make meaning of the suicide. Many questions were not answered and there was an unmet need to speak of the loss (Ratnarajah and Schofield 2008, Ratnarajah and Schofield 2007).

g) 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

Practitioners report that current research is inadequate and hard to access. There remains a lack of community education and awareness around the issue of suicide and how to respond.

More attention needs to be paid by researchers to the family circumstances and communication within families of suicidal adolescents in regards to the contribution of these factors to risk for suicidal behaviour. A focus on these family issues could lead to useful hypotheses about preventative factors that could be useful in the response to suicidal adolescents.

References

- Bagley, C. and Tremblay, P. (2000) Elevated rates of suicidal behaviour in gay, lesbian, and bisexual youth. *Crisis*, 21, pp.111–17.
- Commonwealth of Australia. (2001), *Life - Living is for everyone: A framework for prevention of suicide and self harm in Australia*. Commonwealth Department of Health and Ageing.
- Fitzpatrick, K.K., Euton, S.J., Jones, J.N. and Schmidt, N.B. (2005). Gender role, sexual orientation and suicide risk. *Journal of Affective Disorders*, 87, pp.35– 42.
- Maple, M.J. (2005). *Parental portraits of suicide: Narrating the loss of a young adult child*. PhD Thesis, University of New England.
- Ratnarajah, D. and Schofield, M.J. (2008). Survivors' Narratives of the Impact of Parental Suicide. *Suicide & Life - Threatening Behaviour*, 38(5); p.618 (13 pages).
- Ratnarajah, D. and Schofield, M.J. (2007). Parental suicide and its aftermath: A review. *Journal of Family Studies*, 13(1); p.78 (17 pages).
- Remafadi, G. (1994) (ed.). *Death by Denial*. London: Alyson Publications
- Rivers, I. (2000) Long-term consequences of bullying. In C. Neal and D. Davies (eds) *Issues in therapy with lesbian, gay, bisexual and transgender clients*. Buckingham: Open University Press, pp. 146–59.