Mental Illness and Suicide Prevention

Position Statement
August 2018

Suicide Prevention Australia

Introduction

Suicide is a serious public health concern both in Australia and internationally. It is the fifteenth highest cause of death across all countries (World Health Organisation, 2016), with The Australian Bureau of Statistics (ABS) having reported that 2,866 Australian lives were lost to suicide in 2016 (ABS, 2017). International data suggests that for every adult who dies by suicide, an additional twenty adults attempt to take their life (World Health Organisation, 2016), meaning that approximately 57,320 adults attempt suicide in Australia every year. When we add in data about young people's attempt rates, this figure rises significantly. In the 2015 Australian Child and Adolescent Health and Wellbeing Survey, 7.5% of 12-17 year olds reported having considered suicide in the past year and 2.4% had made an attempt; this equates to approximately 41,000 young people attempting suicide each year (Lawrence et al., 2015), bringing the total number of attempted suicides in Australia to nearly 100,000 per year. This figure is alarming, given that a previous suicide attempt is the single largest risk factor associated with death by suicide.

Although previous attempts are the single largest risk factor, there are multiple, interrelated causes of suicide. While the majority of suicides in the Western world involve a diagnosable mental illness (most commonly depression), less than half of people who die by suicide have been in contact with mental health services in the 12 months prior (Windfuhr, Steeg, Hunt & Kapur, 2016). While there is a generous amount of literature detailing the link between depression and suicide, research on a range of other mental illnesses and their link to suicide remains limited. Based on the largest available study, the population attributable risk of suicide to affective disorders is likely to be less than 35% (Li, Page, Martin & Taylor, 2011). The next highest population attributable risk is substance misuse (approximately 25%) which is at a higher attributable risk than any other psychiatric disorder. Due to the under researched nature drawing out the link between mental illness and rates of suicide, these numbers are only indicative of the potential issue. It is for this reason that this paper focusses squarely on manifestations of mental illness and its relationship to suicide.

People experiencing complex mental illness are 13-45 times more likely to take their own life than those living without mental illness (Chesney, Goodwin, & Fazel, 2014). Not all people who experience mental illness attempt suicide and not all people who experience suicidal thoughts and behaviours have a diagnosed mental illness. Suicide Prevention Australia's (SPA) Consultation Paper on a Strategic Framework for Suicide Prevention states that: suicide and suicidal behaviour arises from complex social, situational, biological and other individual causes, which isolate people and erode their hope (Suicide Prevention Australia, 2017).

Social, environmental and situational factors such as unemployment, homelessness, severe financial stress, legal disputes or a significant relationship break-up also play a role in suicide (SANE Australia, 2015). It is interesting to note, however, that these factors are often the same as those that exacerbate mental illness, and it is therefore very difficult to understand and address mental illness and suicide independent from one another (Robert D. Goldney, 2015). It is crucial that suicide and mental illness be treated as more than simply psychiatric problems, and that we apply a psychosocial lens so that all the factors that may be impacting an individual and their mental health and wellbeing are addressed (Jorm, 2016). While this position paper primarily focuses on the link between mental illness and suicide, SPA continues to review and update position statements across a broad range of factors and social determinants. These can be viewed on the **suicidepreventionaust.org** website.

It is imperative that strategies to prevent suicide include accessible, affordable and timely mental health care and appropriate follow-up for people being discharged from hospital or when treatment is changed or support reduced (Australian Government Department of Health, 2017). Addressing the stigma surrounding both suicide and mental illness is also essential in supporting people to access care and support, as we know that many of the consequences of stigma such as social isolation, unemployment, hopelessness or stress are also risk factors for suicidality (Rüsch, Zlati, Black, & Thornicroft, 2014). Further, we must partner with those living with mental illness and suicidal ideation, their loved ones and those bereaved by suicide to be able to understand how best to support them (National Mental Health Commission, 2014).

What is the purpose of this position statement?

This position statement represents the public position of Suicide Prevention Australia and is used to inform the ways in which Suicide Prevention Australia engages with stakeholders. The statement provides recommendations to guide future investments in addressing issues relating to mental health, mental illness and suicide prevention, as well as a background resource describing the key issues involved in mental illness and suicide.

The position statement and background are specific to the issue of mental illness and suicide. It does not discuss the general issues of suicide and suicide prevention, nor address risk factors experienced by other cohorts deemed to be at an increased risk of suicide such as LGBTI or Aboriginal and Torres Strait Islander communities, except where the risk factors experienced by these communities also intersect with risk factors for those experiencing mental illness. Suicide Prevention Australia has prepared a series of position statements on other aspects of suicide prevention, and these can be accessed through the Suicide Prevention Australia website at **www.suicidepreventionaust.org**

Support for the directions of the Australian Government

Suicide Prevention Australia largely supports the recommendations from the 2014 Review of Services and Programmes by the National Mental Health Commission, as well as those from the Fifth National Mental Health and Suicide Prevention Plan, and looks forward to detailed Government monitoring and reporting on these commitments. These, together with additional insights from our understanding of the evidence, inform the following recommendations.

It is expected that if these recommendations were enacted in full, we would see a substantial reduction in the number of individuals dying by suicide in Australia and an overall improvement in the mental health and wellbeing of the community.

SPA Position Statement on Mental Illness and Suicide

General

1. All suicide prevention and mental health activities should be comprehensively informed by those with a lived experience of suicide and those living with mental illness as well as their loved ones. It should be oriented to support recovery.

2. Investment in public awareness and behavioural change programs to address stigma and improve mental health literacy across the range of conditions. Strategies must be tailored towards both target and diverse populations, and include a focus on the links between discrimination and the prevalence of mental illness and suicide.

3. Increased investment and access to effective mental health services, based on population and local community need, especially in rural and regional areas of Australia due to lower levels of access to services.

4. The development of peer support mechanisms to promote social inclusion and meaningful participation for people living with mental illness, including physical and online community spaces, and peer-led psychosocial services.

Bereavement and postvention support

5. Greater recognition of the needs of bereaved families and carers, including those aggrieved by experiences of sub-optimal (mental) health care, through resources and support services to reduce the ongoing impact of trauma associated with their loved one's death.

6. Improved supervision and support programs for the medical and mental health workforce (clinical and non-clinical) following the death of a patient by suicide.

System-level improvements

7. Improved integration of mental health and suicide prevention planning and implementation at a regional level, inclusive of Primary Health Networks and Local Health Districts.
Such planning and implementation should also

factor in the specific needs of diverse populations including Aboriginal and Torres Strait Islander communities, those with diverse cultural and linguistic backgrounds, those from the LGBTI community as well as other groups.

8. Transformation of the existing mental health care system away from delivery focussed on episodic care in response to acute illness, to a more comprehensive system of care focussed on prevention and early intervention, mainstream service linkages and trauma-informed service models that address the holistic and long-term recovery needs of consumers, including the needs of people with co-occurring conditions, such as drug and alcohol dependency, disability or homelessness.

9. Investment in collaborative stepped care mental health services across Australia (such as drop-in centres and step-up/step-down services) to minimise the likelihood of hospitalisation for those with mental illness and to ensure that everyone who is discharged from acute care has appropriate aftercare and effective support.

10. Improved interagency communication and information-sharing among all systems of care for those living with mental illness or at heightened risk of suicide, especially for those being discharged from care.

11. Support and collaboration between the mental health system and online and telephone support services, particularly those which provide crisis support, to ensure individuals at risk of suicide, including those who have made a suicide attempt, are always followed up appropriately and can readily access quality crisis support services.

Capacity building

12. Improved education, training and resourcing, including training by people with lived experience, for primary care physicians, general practitioners and general practice teams to enhance multidisciplinary mental health care and early interventions to mental illness and suicidal ideation.

13. Improved education, training and resourcing, including training by people with lived experience, of psychiatrists and allied health workers (psychologists, nurses, peer workers, case-workers, social workers, occupational therapists, etc) to better understand the needs of those living with mental illness and be confident, capable

and person-centred when responding to suicidal ideation. This should include a review of the training that is provided to these professionals as part of the attainment of their qualification.

14. Improved education and training, including training by people with lived experience, to support practitioners working in employment, homelessness, financial counselling, legal services, corrective services and relationship counselling services to create pathways to early intervention for those living with mental illness and to respond to those experiencing suicidal ideation.

15. Greater education and information regarding care and support for the loved ones of those living with mental illness and at risk of suicide, especially prior to discharge from hospital.

16. Better targeting of information, awareness and prevention strategies with employers and employees in high risk occupations.

17. Greater efforts across the Australian community in response to childhood trauma, abuse, neglect and loss to reduce the likelihood of the development of psychological problems, including mental illness and suicide. This relates to government policy in early childhood development, child protection and family support.

18. Integration into suicide prevention policy of recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse.

Strategic research and evaluation

19. Significantly increased investment in suicide and suicide prevention research and evaluation. This should include:

- a national suicide and suicide prevention research strategy

- establishment of high quality, rigorous, longitudinal research projects with sufficient power to assess the effectiveness of interventions

- quantification of the impact and cost of suicide and self-harm to the Australian community

- understanding and identifying those intervention components that result in enhanced outcomes. Consideration should also be given to the outcome measures indicative of risk and protective factors for suicidal behaviour included in clinical studies

- examination of the impact of psychosocial risk factors as they relate to mental illness and suicide

- ongoing review of suicide deaths and suicide attempts by persons refused admission, whilst in psychiatric care and following hospital discharge, to identify potentially modifiable risk factors and assess the effectiveness of current and proposed interventions

- more comprehensive and integrated data to ascertain client outcomes and consumer satisfaction in a range of health care settings

- the publication and dissemination of research and evaluation findings

- the impact of stigma on mental health and suicide

- infrastructure to support regional benchmarking and quality improvement in relation to suicide prevention mechanisms to ensure a reduction in duplication of research

- systems and resources to ensure research outcomes are made publicly available and translated into practice

- continued work to standardise and improve data collection

- funding for evaluation of programs, before publication.

Background Paper

Contents

The prevalence of mental illness in Australia

The terms 'mental illness' and 'mental disorder' are both used to describe a wide spectrum of mental and behavioural disorders which can vary in both severity and duration. The most recent National Survey of Mental Health and Wellbeing of Australian adults aged 16–85, conducted in 2007, estimated that almost half (45%) of those in this age range will experience a mental disorder at some time in their life. It was also estimated that one in five (20%) of the population had experienced a common mental disorder in the previous twelve months. Of these, anxiety disorders (such as social phobia) were the most prevalent, experienced by one in seven (14%) of the population, followed by mood disorders (6%) and substance use disorders (5%) (Australian Bureau of Statistics, 2008).

A similar national household survey of the mental health and wellbeing of children and adolescents was conducted in 2013–14 (*Young Minds Matter*). In this survey, almost one in seven (14%) of children and adolescents aged 4–17 were assessed as having mental disorders in the previous twelve months. Attention deficit hyperactivity disorder (ADHD) was the most common disorder reported (over 7%), followed by anxiety disorders (nearly 7%), major depressive disorder (3%) and conduct disorder (2%) (Lawrence et al., 2015).

Mental illnesses also include conditions that are poorly understood. These illnesses often occur with lower prevalence and more severe or complex presentations. This group includes bipolar disorder, psychotic illnesses, eating disorders, severe mood and anxiety disorders and personality disorders.

Bipolar disorder is a serious mental illness in which common emotions become intensely and often unpredictably magnified. Individuals with bipolar disorder can swing from extremes of happiness, energy and clarity to sadness, fatigue and confusion. There are 568,000 Australians with severe and sub-threshold forms of bipolar spectrum disorders (2.9%, based on ABS, 2008 & 2016). This is similar to the reported rate of 2.63% internationally (Clemente et al., 2015).

Psychotic disorders include schizophrenia, schizoaffective disorder and delusional disorder and are characterised by fundamental distortions of thinking, perception and emotional response.

Estimates from the 2010 Survey of People Living with Psychotic Illness indicate that 64,000 people in Australia aged 18–64 had a psychotic illness and were in contact with public specialised mental health services each year. The survey found the most frequently recorded of these disorders was schizophrenia which accounted for almost half of all diagnoses (47%) (Morgan et al., 2012).

Eating disorders are another form of serious mental illness resulting in significant physical complications and impairment together with an increased risk of mortality. Deloitte Access Economics estimates that there were 913,986 people in Australia with eating disorders in 2012, or around 4% of the population. Women comprise around 64% of the total (The Butterfly Foundation, 2012) although it is acknowledged that eating disorders amongst men are under-reported.

Personality disorders encompass a range of serious mental illnesses including schizotypal, antisocial, histrionic, and borderline. Personality disorders can impact upon various psychosocial difficulties such as maintaining fulfilling relationships, finding and maintaining employment, and functioning well with education (Zanarini et al, 2010). Borderline Personality Disorder (BPD) is a term used to describe a certain set of difficult experiences often resulting in strong emotional pain and overwhelming emotions that are easily triggered. BPD is often precipitated by complex traumatic events including child abuse, and it is estimated that at any point in time, around 1% of the general population experience BPD (National Health and Medical Research Council, 2012).

It is important to note that the prevalence of mental illness in the community is likely to be significantly underestimated given that research has demonstrated most people experiencing symptoms do not seek help. A 2014 study (Whiteford et al., 2014) estimated that only 46% of Australians with a mental disorder receive treatment in any given year. This is, however, an increase from the 2007 National Survey of Mental Health and Wellbeing that revealed only 35% of people with a need for mental health care received any care. Although the rates of help-seeking are increasing, the survey also clearly showed that, while 75% of all mental illness manifests before the age of 25 years, it is precisely this younger age group that is least likely to access care (Australian Bureau of Statistics, 2008).

Mental illness and mortality

Tragically, people living with mental illness are at a much increased risk of premature death compared with the general population (Chesney et al., 2014). In a number of mental illnesses, the risk of premature death is comparable with risks due to smoking. Data from the 2017 Global Burden of Disease study suggested that mental and behavioural disorders account for 8.6 million, or 0.5%, of all years of life lost to premature mortality (Whiteford et al., 2017) and it is believed that the risk of mortality may in fact be worsening over time (Chesney et al., 2014). People living with Anorexia Nervosa or substance use disorders have the highest levels of mortality from any cause. This translates to a 10 to 20 year reduction in life expectancy, compared to the general population (Chesney et al., 2014). In addition, four out of every five people living with mental illness have a co-occurring physical illness (National Mental Health Commission, 2016). It should also be acknowledged that although heart disease and lung cancer are the most common cause of mortality for those living with mental illness, suicide still remains one of the main causes of early death among people with a mental illness (Australian Bureau of Statistics, 2017b).

A significant meta-review was conducted in 2014 to explore the risks of all-cause and suicide mortality amongst individuals experiencing major mental disorders (Chesney et al., 2014). This review looked at 407 separate and relevant systematic reviews. Amongst these, 20 reported mortality risks across 20 different mental disorders. These studies considered over 1.7 million patients and more than 250,000 deaths. It was concluded that suicide risk was highest amongst individuals with borderline personality disorder, anorexia nervosa, major depressive disorder, bipolar disorder and schizophrenia.

The risk of suicide amongst people with:

- borderline personality disorder is 45 times that of the general population
- anorexia nervosa is 31 times that of the general population
- major depressive disorder is 20 times that of the general population
- bipolar disorder is 17 times that of the general population
- schizophrenia is 13 times that of the general population.

A 2004 meta-analysis of 27 studies considering 3,275 deaths, found that the mean percentage of individuals with a diagnosis of a mental illness amongst those who died by suicide was 87.3% (Arsenault-Lapierre, Kim, & Turecki, 2004). This figure ranged from 63% to 98% depending on the study. Furthermore, studies have shown that around 90% of young people aged 6-25 who die by suicide have experienced mental ill health (De Silva et al., 2013). These findings are consistent with research that shows that mental illness, whether diagnosed or undiagnosed, is associated with the vast majority of suicide attempts (Ridani et al., 2016).

At present, while substance use disorders are included in the formal definition of 'mental illness', as described by the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases, they are typically excluded from Australian health care planning. This can create gaps when people seek services for co-existing mental health and substance use issues (National Mental Health Commission, 2014).

The 2017 ABS causes of death report showed that drug-related deaths are at a 20 year high (Australian Bureau of Statistics, 2017b). Many people with mental illness use drugs and alcohol as a way to reduce the impact of their symptoms, however drug and alcohol use tends to exacerbate and sometimes precipitate mental illness in the long term. It is essential that people are able to access services that can address co-morbid mental illness and substance use issues to be most effective in alleviating the underlying causes of mental distress (Australian Government Department of Health, 2009). Although there has been progress in Australia to combine mental health and drug services, people with dual diagnosis are often "shuffled between services [that are] unable and sometimes unwilling to treat both conditions" (Senate Select Committee on Mental Health, 2006).

Why are people with mental illness at increased risk of suicide?

While there is significant evidence that people living with mental illness are at increased risk of suicide, as the National Mental Health Commission's review of Programmes and Services noted, "a complex interaction of variables which may or may not include mental illness can lay behind a person's suicide or suicide attempt" (National Mental Health Commission, 2014). Haw and Hawton summarise that, "psychiatric disorders alone do not explain why people chose to end their lives but it is an established fact that in the majority of cases there is an underlying mental disorder and there is evidence this vulnerability interacts with multiple psychological and social factors which leads some individuals to end their lives or try to do so" (Haw & Hawton, 2015).

SANE Australia's Lessons for Life research with individuals who have attempted suicide supports this view. This research found that the most commonly reported issue at the time of their attempt was

mental illness, but that there were many other challenges including stigma, a lack of appropriate professional support, being bereaved by suicide, work pressures, drug and alcohol use, interpersonal relationship problems, experiencing abuse or sexual assault, transitions from school to university, caring for an unwell family member and physical health problems that interplayed with the experience of mental illness (SANE Australia, 2015).

> "I think that, suffering from PTSD as well also worsened the depression. One of the things that I would like to say is that when I became suicidal there weren't thoughts of me deciding that I didn't want to actually be here. It was the depression controlling me, if that makes any sense".
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> **Lessons for Life participant, Margaret, 42 years old (SANE Australia, 2015).**

Complex trauma, particularly in childhood, is a shared risk factor for both mental illness and suicide. It is therefore imperative that approaches to addressing mental illness are implemented in a way that adopts a trauma-informed approach. Trauma-informed care is an organisational structure and treatment framework that involves understanding, recognising and responding to the effects of all types of trauma (Department of Health and Human Services, 2015). Trauma-informed care is based on the premise that many behaviours or responses expressed by people with mental illness are directly related to an experience, or experiences, of trauma. For the best recovery outcomes, the causes of a person's symptoms or responses must be understood.

Stigma of mental illness and suicide

Although suicidality is often related to mental disorders and their symptoms, people with mental illness face a two-fold problem. In addition to their symptoms, they belong to a stigmatised group and experience frequent discrimination in their daily lives. Many consequences of stigma, such as social isolation, unemployment, hopelessness or stress, are risk factors for suicidality (Rüsch et al., 2014). Stigma also plays a role in reducing the likelihood

of people being open to discussing their experience of mental illness or suicidal thoughts with others and seeking appropriate support. For example, social stigma remains a major inhibiting factor in peoples reluctance towards help-seeking as exhibited by many people in Australia's rural and remote communities. It also may potentially preclude successful suicide prevention and crisis intervention strategies (Kennedy, Versace, & Brumby, 2016).

> "I've watched my family judge other members of my family who were very mentally ill, and friends judge members of my family because they are very mentally ill. So I just went, well I'm not even gonna go there because I know what people have said about my mother or my sister or my brother. And I don't need that label as well. I know how nasty people can be."
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> **Lessons for Life Participant, Emma, 26 years old (SANE Australia, 2015).**

A reduction in stigma as a result of increased mental health literacy has been demonstrated to lower the prevalence of disorders such as depression and anxiety. This has not necessarily resulted in changes in treatment-seeking behaviours among those most in need of intervention—that is, those individuals experiencing complex mental illness and suicidal ideation (R. D. Goldney & Fisher, 2008). Rüsch et al 2014 conclude that unlike other variables, stigma and discrimination – whether at the societal or individual level – are in principle modifiable risk factors. Therefore, research on interventions in this domain is needed with the ultimate goal of reducing suicide rates (Rüsch et al., 2014).

Access to effective services and treatments

It is essential that people experiencing mental illness have access to appropriate and effective services and treatments. However, as every person's experience of mental illness is somewhat different, what constitutes effective treatment and support will vary accordingly. It is therefore important that services take a person-led approach to understanding an individual's needs. Nonetheless, the contribution of pharmacological treatments, psychological therapies and support for physical health all form important components of people's mental health care (SANE Australia, 2015). There is also growing evidence for the effectiveness of some complementary approaches such as mindfulness and yoga in improving health outcomes (Coronado-Montoya et al., 2016; Grossman, Niemann, Schmidt, & Walach, 2004).

The use of emergency hospital services, access to general practitioners, crisis support lines, and community mental health services are all crucial in the identification, assessment, and treatment of mental illness and suicide risk. Unfortunately, even when people experiencing mental illness are willing and able to seek appropriate services, those services are not always available in a timely and effective manner. This is especially relevant for people in rural and remote areas of Australia who have less access to services than their urban counterparts. The rates of mental illness are similar for those living in regional and remote areas when compared with those living in metropolitan areas. However, as Figure 1 below suggests, in addition to the reduced access to mental health professionals, there is also lower expenditure per capita that occurs compared with non-metropolitan areas (National Rural Health Alliance, 2014). This is particularly concerning for people living with complex mental illness for whom lack of treatment can severely impact recovery. It may also help explain the fact that the rates of suicide for people in rural and remote areas is around double that of people living in metropolitan areas (Kõlves, Milner, McKay, & de Leo, 2012).

Isolation & Mental Health

Access to Mental Health Professionals
Psychiatrists / Psychologists /MH Nurses
FTE per 100,000

Per capita MBS expenditure Mental Health services

3 / 30 / 51	Remote/ Very Remote — $10 / $5
4 / 41 / 51	Outter Regional — $21
6 / 56 / 82	Inner Regional — $35
17 / 92 / 87	Major Cities — $45

Suicide Rate per 100,000
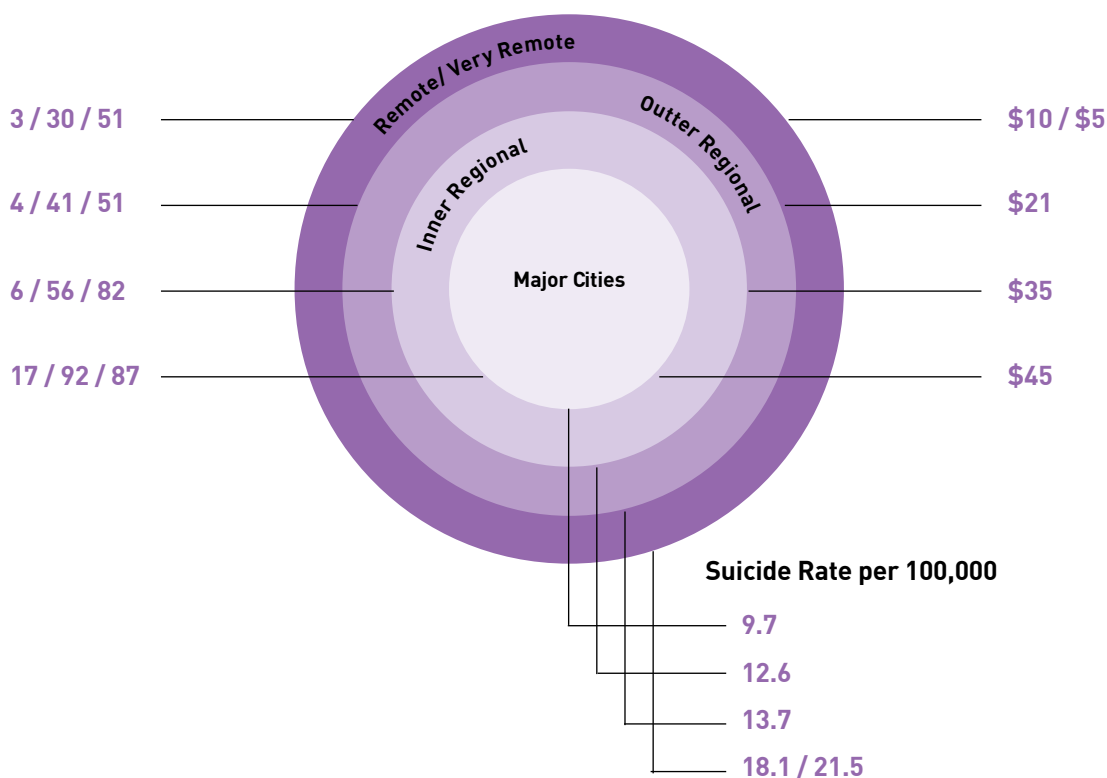
9.7

12.6

13.7

18.1 / 21.5

Figure One. Access to health services for people in regional and remote Australia. Adapted from NRHA (National Rural Health Alliance, 2014).

Internationally, up to 87% of individuals who die by suicide had contact with a primary care physician within a year of their death and up to 39% within a month (Leavey et al., 2016). This is despite the fact that depression and other psychiatric illnesses are often under-recognised and under-treated in primary care settings (Mann, Apter, Bertolote, Beautrais, Currier, Haas, et al., 2005). A common theme across studies maintains that mood disorders have often not been diagnosed in many of the individuals who have died by suicide. In instances where they had been, those people had often not received "adequate treatment for their depressive conditions" (R. D. Goldney, 2008). Thus, a key prevention strategy could well be the "improved screening of depressed patients by primary care physicians and better treatment of major depression" (Mann, Apter, Bertolote, Beautrais, Currier, & Haas, 2005).

However, not all treatments have a clinical focus, with much work in the psychosocial rehabilitation sector focusing on addressing risk factors that can increase vulnerability. For example, community based services work hard to reduce the impact of social isolation, help with financial and legal issues, encourage treatment, and provide safe housing, which are all valuable suicide prevention activities when suicide prevention is viewed through an holistic lens (SANE Australia, 2014).

Examples of psychosocial support include initiatives such as Prevention and Recovery Care Service (PARCS) in Victoria, which aims to keep consumers out of acute care settings by providing step-up care when their symptoms are escalating, or conversely, provide step-down care when symptoms are improving. PARCS is an example of a program working to reduce the risk of suicide, especially in

times of transition (Galloway, Scollo, & Thomson, 2016). However, it should be noted that the recent introduction of the National Disability Insurance Scheme (NDIS) has led to some fundamental changes in the way that mental health psychosocial rehabilitation programs such as PARCS are funded and delivered. With the change to a user-pays approach, there is concern within the mental health sector about potential fragmentation of delivery and the ability to design services that meet recovery-oriented objectives that may not be prioritised under the NDIS (Crowther & Collister, 2014).

In addition to mental health services, people experiencing mental ill health may use a range of services in areas such as employment, homelessness and housing, legal services, and financial counselling. At these times, workers in those programs are at the 'front line' of suicide support, and play an important role as gate-keepers to refer to more formal supports. It is therefore important that workers operating in these domains are educated and resourced to respond effectively to the risks and instances of suicide.

Although there are many avenues, via both formal and informal support, through which suicide risk might be detected, the most common outcome for many people who are experiencing a suicidal crisis is admission to an inpatient unit or hospital. This process can sometimes be involuntary and often involves crisis assessment, emergency departments and/or police. Such a process can be traumatising and demoralising, and can undermine a person's recovery (SANE Australia, 2015).

In fact, the rates of suicide for people discharged from hospital after admission for mental illness or suicidality are alarmingly high. A 2017 meta-analysis by Chung et al showed the post discharge suicide rate was approximately 100 times the global suicide rate during the first three months after discharge. Patients admitted with suicidal thoughts or behaviours had rates near 200 times the global rate. Even many years after discharge, previous psychiatric inpatients have suicide rates that are approximately 30 times higher than typical global rates (Chung et al., 2017). This is supported by other research which suggests that the first week and the first day after discharge represent particularly high-risk periods (Hunt et al., 2009).

Active outreach at this time and continuity of care between services have been found to be an effective way of reducing re-admissions and suicidal behaviour (De Leo, Cerin, Spathonis, & Burgis, 2017; Luxton,

June, & Comtois, 2013). However, such high rates of suicide after hospitalisation raises questions about the effectiveness of interventions that are being delivered and the potential systemic problems, such as admission and discharge procedures, that may mean people's mental health needs are not being adequately met.

Also of concern is that family and friends report that people are at times discharged home either alone or without loved ones being informed (Leggatt, M. & Cavill, 2010). An important part of discharge planning is that significant others are informed about when and where the person is being discharged and what their role will be in the continued support of their loved one. Discharge from or transition between services can be complicated and may involve a range of professionals and organisations. This is a time when it is easy for people to slip through the cracks, and there is a risk suicide may occur.

Reports such as Tracking Tragedy have previously shown that constraints on the availability and capacity of Australia's mental health care services may contribute to deaths by suicide. In fact, systemic reviews of suicide estimate that "around a third of suicides may realistically have been preventable with more optimal care" (NSW Mental Health Sentinel Events Review Committee, 2003).

There are few alternatives to hospital care when people are in crisis in Australia, but there are alternative models overseas that may prove helpful (Beaton, 2012). Research has demonstrated the effectiveness of community-based 'safe houses' where people can find refuge and are supported by health professionals and in some cases, volunteers with lived experience. Although such alternatives to suicide care are currently not available in Australia, it is important that we consider ways to encourage access to appropriate services that are driven by the needs of people with lived experience of suicide and consider what models may provide more effective care.

Assessing suicide risk

Risk assessment continues to be heavily relied upon in many mental health care settings to manage suicide risk (Perlman, Neufeld, Martin, Goy, & Hirdes, 2011). However, there is concern by many within the suicide prevention field about the reliability to accurately predict suicide using risk assessment categorisation of people at low versus high risk (Large et al., 2016). The reliability of risk assessments to determine suicide has been examined in a meta-analysis (Large et al., 2016). This study shows that approximately half of inpatients that died by suicide in the first year after discharge were assessed as being at low risk. It suggests that risk assessments are time-specific, as they only give a snapshot at a certain moment in time and cannot predict future risk.

A potential problem with risk assessment tools is if they are used as a substitute for engaging in a deeper conversation about the person's state of mind, or if factors, such as a history of previous attempts and connectedness to social supports are not asked about. It has been argued that it is a dangerous practice for mental health workers to rely solely on risk assessments:

"Risk assessments should be used where appropriate and be a consensual process with the patient and clinician striving towards a realistic conceptualisation of the risk and then deciding how to manage it." (Mulder, 2011).

Also of particular concern is when risk assessments are used as a tool to decide on the suitability of provision of treatment. It is argued that rather than selecting who gets information and/or suicide prevention services based on their level of identified risk, universal strategies that direct suicide prevention activities towards everyone who comes into contact with mental health services may be needed (Pirkis, 2006).

Suicide bereavement

Where suicide does occur, there is a need to address the responses and needs of bereaved friends and families, including those aggrieved by a perceived failure of (mental) health care and treatment. Research tells us that people bereaved by suicide may be at higher risk of taking their own lives (Stroebe, Stroebe, & Abakoumkin, 2005), and are also at risk of ongoing mental health concerns, so intervention at this stage is an important, and often overlooked, suicide prevention strategy. Similarly, it should not be forgotten that the impact of patient suicide can also be significant for mental health services staff (particularly clinicians) and general practitioners (Gulfi, Dransart, Heeb, & Gutjahr, 2010).

Information and support are essential in helping family and friends cope after someone takes their own life. In many cases the friends of the person who died may be other clients of a mental health service, and services have a role in offering extra bereavement support to this vulnerable group. Bereaved family and friends can feel confused, guilty and angry, but having their grief acknowledged, and where possible questions answered, can aid the process of understanding and living with the death of someone close (SANE Australia, 2012).

What works to prevent suicide for people with mental illness?

The National Mental Health Commission's 2013 report on mental illness and suicide highlights the overall lack of evidence in terms of what works to prevent suicide. We know that the most effective programs are those which are comprehensive and systemic, and which incorporate multiple and co-ordinated approaches and interventions. However, there is little knowledge about how different elements of these systemic approaches interact with each other, how they might be best integrated, nor about how different combinations of approaches work in different settings (National Mental Health Commission, 2013). Attempts are underway to understand these challenges further in an Australian context. The Black Dog Institute's Lifespan initiative involves the implementation of nine evidence-based strategies simultaneously delivered within a localised area. For each strategy, LifeSpan selects and implements the interventions or programs that have the strongest evidence base.

For successful delivery, all strategies require a thorough consultation and review process to ensure their relevance and tailoring to the local context and community.

The nine strategies are:

1. Improving emergency and follow-up care for suicidal crisis

2. Using evidence-based treatment for suicidality

3. Equipping primary care to identify and support people in distress

4. Improving the competency and confidence of front line workers to deal with suicidal crisis

5. Promoting help-seeking, mental health and resilience in schools

6. Training the community to recognise and respond to suicidality

7. Engaging the community and providing opportunities to be part of the change

8. Encouraging safe and purposeful media reporting

9. Improving safety and reducing access to means of suicide (Ridani et al., 2016).

These nine strategies are supported by some of the following evidence. A 2016 meta-analysis by Zalsman et al looked at the effectiveness of different suicide prevention strategies from 2005-2014. This study found that the most effective strategies included the restriction of access to means of suicide; school-based awareness programs; the self-harm reducing effects of some psychoactive medications; and effective pharmacological and psychological treatments for depression (Zalsman et al., 2016). Likewise, there has been some authentication given to the effectiveness of the promotion of more responsible reporting of suicide and mental illness and self-management strategies including use of the internet, telephone counselling, and self-help groups, although the lack of randomised controlled trials is a major limitation in the evaluation of these preventive interventions (Zalsman et al., 2016).

The education of general practitioners to recognise and treat depression can greatly contribute to reduced suicide rates (Mann, Haas, Mehlum, & Phillips, 2005). Government reforms towards a more multidisciplinary approach to the diagnosis and treatment of mental illness suggest that greater value is being invested in the central importance of primary care. However, this recognition requires increased support of primary care physicians and general practitioners in the form of additional education, training and resourcing to better support patients who may be experiencing mental health and suicide related issues. This is a sentiment voiced by many general practitioners themselves (Michail & Tait, 2016).

Studies have also shown that psychological therapies such as group therapy—drawing on techniques from cognitive behavioural therapy (CBT) and dialectical

behaviour therapy (DBT)—as well as family therapy and problem-solving therapy are often directly effective in reducing rates of suicidal ideation and suicidal behaviours. However, further rigorous research is needed to more firmly ground the benefits of these therapies in suicide prevention (Brown & Jager-Hyman, 2014). Furthermore, post-discharge outreach programs such as long-term letter or postcard interventions are similarly clinically and statistically significant in reducing repeat episodes of self-harm and death by suicide among psychiatric inpatients following discharge from hospital (Brown & Green, 2014; Luxton et al., 2013).

It is equally important to emphasise that pathways to care for those living with mental illness and experiencing suicidal ideation are not (and should not be) restricted to those of a clinical context alone. For instance, there may be a greater chance of intervening in the progression of suicidal ideation if family, friends, colleagues and other 'gate-keepers' in the community are able to recognise instances of social, situational, emotional or interpersonal precipitating risk factors, and then act to refer to more formal supports. Campaigns such at *R U OK? Day* work on this principle to encourage the community to check in and connect with each other and act if they notice someone not doing so well.

Another potential way of reducing the likelihood of a suicidal crisis is by helping people develop their own self-management skills such as the ability to recognise triggers and respond to symptoms of mental illness. Such skills lead to an increased sense of empowerment, control and resilience to cope with setbacks. One of the most commonly used and positively evaluated strategies is the Wellness Recovery Action Plan (WRAP®) (Cook et al., 2012; Higgins et al., 2012). Participants of WRAP® learn to identify the early warning signs or triggers of distress. People are empowered to take control of their own wellness with a focus on personal responsibility, education, hope, self-advocacy, peer support and future planning. WRAP® includes a specific section on the development of advance directives and it imparts important skills that can assist consumers to help avoid crises (Harvey & Brophy, 2011).

It is essential in recovery focussed suicide prevention that services focus on building a person's strengths and reducing social isolation. Social isolation is thought to be a risk factor that is strongly associated with suicide (Lakeman & Fitzgerald, 2008). Unfortunately, people experiencing complex mental illness are often socially isolated with few community supports. Encouraging people to develop supportive relationships with peers, informing them of what community support services are available, and involving family are all important ways of helping to reduce social isolation and the risk of suicide.

Social networks and caregiving

Social isolation in people with complex mental illness is common and has a significant impact on wellbeing, recovery and community participation. Often, it occurs as a result of the symptoms of mental illness, as well as being a consequence of the associated stigma, disadvantage and social exclusion that people with complex mental illness can face.

The building of strong partnerships and social support networks (both online and offline), as well as capacity building among Australian communities, more generally, may function as protective factors to those living with mental illness at risk of self-harm or suicide. Peer support is one way to increase access to social networks for people with complex mental illness (Naslund, Aschbrenner, Marsch, & Bartels, 2016). It is not explicitly based on psychiatric models and diagnostic criteria, but on understanding another's situation empathically through shared experience. When people find affiliation with others they feel are similar to themselves, they experience a connection. This connection is based on an understanding of mutual experience, where people are able to be with each other without the strictures of a formal therapeutic relationship (Repper & Carter, 2011).

Working with significant family members and friends, or carers, is also a crucial part of mental health care that was promoted within Australia's Fifth National Mental Health and Suicide Prevention Plan. It is recognised that carers play a vital role in the support of people with mental illness, and carers need support and education to help them manage their own and their relatives' needs, especially when suicide is a risk. Significant family and friends are often traumatised by the experience of their loved one's attempted suicide and terrified of the likelihood of it happening again.

Qualitative research describes the concerns that carers express about their dealings with mental health services when their loved one was suicidal (Leggatt, M. & Cavill, 2010; National Mental Health Commission, 2013). Of concern to families was that their own assessment of the person's risk of suicide was not heeded. It was also reported that interventions were felt to be too brief to be of benefit and that the focus appeared to be on discharge to free up beds. Carers reported feeling excluded from all aspects of care while the person was in a psychiatric unit, and their own psychological needs were not assessed or supported.

It is vital that services listen to carers as an important source of information regarding the consumer's suicidal intent, current life stressors, behavioural

changes and available social supports. Although the person with mental illness needs to agree to involve carers, it should be a priority for services to encourage carer involvement in order to gain a deeper understanding of the person's health and social context.

In summary, there is great benefit in fostering social, clinical, workplace and family environments that encourage and support not only social inclusion more generally, but more specifically, help-seeking by people experiencing signs of mental ill health in order to reduce suicide. This requires a multidisciplinary approach that encompasses long-term planning for Australia's health system and the capacity to engage those in need; ranging from better screening and holistic risk assessment through to evidence-based treatment options, consistent and effective crisis support and follow-up care and support. The following section will discuss how the current policy context and funding of mental health services at the federal, state and local levels impact on the design and delivery of effective suicide prevention services in Australia.

Federal, State and Territory Government policy implications

Several decades have now passed since the deinstitutionalisation of people experiencing mental illness, "shifting the care and support for these patients from psychiatric custodial institutions to community-based settings."

The 2014 National Mental Health Commission's Review of Programs and Services represented a significant undertaking to examine the state of mental health care in Australia with a focus on those services which fall under the purview of the Commonwealth. The review reached a number of conclusions and changes to improve the longer-term sustainability of the mental health system based on three key components in order to achieve the required system reform:

1. person-led design principles

2. a new system architecture

3. shifting funding to more efficient and effective 'upstream' services and supports.

To support this, the Commission recommended shifting funding priorities from hospitals and income support to community and primary health services. A key element of this involves extending the scope of Primary Health Networks as the key regional architecture for equitable planning and purchasing of mental health programs, services and integrated care pathways. At the centre of this architecture is a new model of stepped care which the government advocates will promote easy access to self-help options to help people, their families and communities to support themselves and each other, and improve ease of navigation for stepping through the mental health system. This also strengthens the central role of general practitioners in mental health care through incentives for use of evidence-based practice guidelines, changes to the Medicare Benefits Schedule and staged implementation of Medical Homes for Mental Health. It was also recommended that there be enhanced access to the Better Access program for those who need it most through changed eligibility and payment arrangements and a more equitable geographical distribution of psychological services.

It was also recommended that a commitment be made to reducing suicide by 50% over the next decade. While this recommendation has not been formally adopted by the Australian government, the government has resourced twelve regional suicide prevention trials as part of a first wave to support the introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.

Primary Health Networks have an important role to play in suicide prevention. The regional trials of systems approaches to suicide prevention are in identified Primary Health Networks. Those trials using the Lifespan initiative model are supported by capacity building training provided by the Black Dog Institute. In some states and territories (for example, Victoria), these intersect with specific trials being resourced by the state government, as well as those being funded by the Paul Ramsay Foundation in New South Wales.

As many of these trials are still in the very early stages, it is difficult to know how effective they have been. However, it is critical that these trials are implemented with robust evaluation frameworks in place, as well as real-time monitoring to determine their effectiveness.

The Fifth National Mental Health and Suicide Prevention Plan (The Fifth Plan) and the corresponding Implementation Plan was signed off by the Council of Australian Governments (COAG) Health Ministers in August 2017 and was released publicly in October 2017. The renaming of the Fifth Plan to include suicide prevention is significant as it highlights the significant intersection between suicide and mental illness and the critical need to address poor mental health in order to prevent suicide. This is a welcome step. The Fifth Plan includes several significant actions which will promote further integration between suicide prevention and mental health services. This includes the establishment of a Suicide Prevention Subcommittee that will report to the Mental Health Expert Reference Group.

A key theme of the proposed actions in the Fifth Plan is the promotion of better integration of planning and service delivery at the regional level. To support this, the Federal Government requires the development and public release of joint regional mental health and suicide prevention plans. Guidance will be provided to support the development of these plans to promote consistency and, where possible, existing arrangements between the Commonwealth and

individual State and Territory Governments will be used to support planning and governments. This is particularly important in supporting integration between Primary Health Networks and their state health counterparts.

Another area for exploration is the role of the National Disability Insurance Scheme (NDIS) in relation to suicide prevention. While there is no specific documented role for the NDIS in suicide prevention, by the very nature of the NDIS providing support for those Australians living with the most complex, severe and persistent mental illnesses, these activities are contributing to suicide prevention. The original Productivity Commission estimated that there would be 57,000 people with enduring and significant psychiatric disabilities who would meet the NDIS eligibility criteria.

The National Disability Insurance Agency estimates that in 2019–20 the total number of expected participants in the NDIS with a primary psychosocial disability will be approximately 64,000. This is far fewer than the 690,000 Australians who are estimated to be living with a complex or severe and persistent mental illness. It is critical that with increasing investments in the National Disability Insurance Scheme, resources continue to be allocated to provide evidence-based psychosocial support for those people living with mental illness who do not meet the criteria for the NDIS so as to not increase the risk of suicide for these individuals by further isolating them from the community.

"A lot of people think that having a mental illness or feeling like [dying by] suicide or even attempting suicide, that it's a weakness. And my long-term experience is that it is quite the reverse – that to continue to survive, to continue to live with that much pain, especially if you don't have help and adequate support, it takes an enormous amount of strength".

Lessons for Life participant, Glenda, 50 years old (SANE Australia, 2015).

Appendix: References

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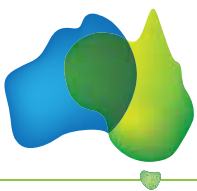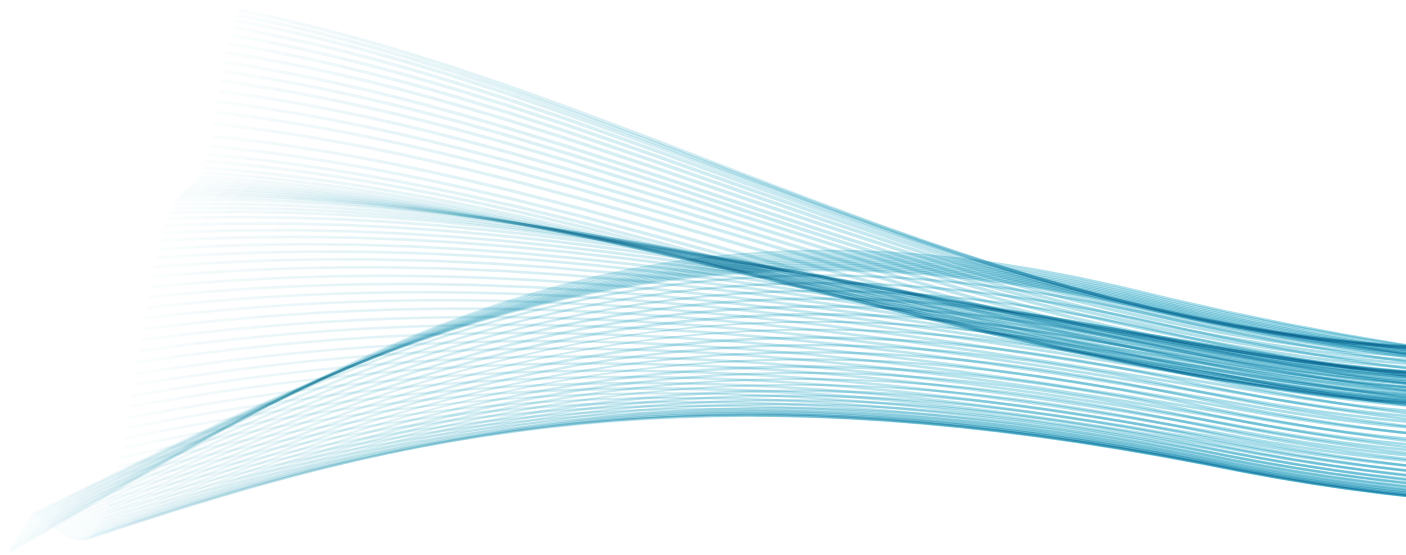
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Listed below is a summary of key crisis support services available across Australia.

Service	Who?	Telephone counselling	Online crisis counselling	Other details
Lifeline Phone: 13 11 14 www.lifeline.org.au	Anyone experiencing a personal crisis or thinking about suicide	Available 24/7	Available at set times - see website for details	–
Suicide Call Back Service Phone: 1300 659 467www.suicidecallbackservice.org.au	Anyone aged 15+ yrs who is suicidal, caring for someone who is suicidal, bereaved by suicide, or a health professional supporting a suicidal individual	Available 24/7	Available at set times - see website for details	Access up to 6 x 1 hr telephone counselling sessions
Kids Helpline Phone: 1800 55 1800 www.kidshelp.com.au	Young people aged 5-25 yrs	Available 24/7	Web & email counselling	–
MensLine Australia Phone: 1300 78 99 78 www.menslineaus.org.au	Men, all ages	Available 24/7	Online & video counselling at set times - see website for details	Access up to 6 x 1 hr telephone counselling sessions. Services also available in Arabic.