3.2 Suicide

Mental health remains the biggest risk for suicide even though suicide accounts for less than two per cent of deaths overall (Australian Government 2011b p. 13). It is well accepted that the risk of suicide is higher in some groups of individuals: young men, Indigenous youth, displaced and separated men and those with mental disorders, particularly depression (Coroner's database in Mental Health Division 2009).

Suicide is the most common cause of death in Australians aged 15–44, more common than deaths from motor vehicle accidents or skin cancer, and the 10th most common cause of death overall for Australian males (Commonwealth Department of Health and Aged Care 2000).

Suicide is the main cause of premature death in mental health patients and this group has a 10-fold higher risk than the general population. Rates of suicide peaked in Australia in 1997 and dropped to around 9.8 per 100,000 from 2003 to 2007 (Mental Health Division 2009). WA rates have generally run at higher than the Australian average; it is currently about 11.8 per 100,000.

In WA '35 per cent of men and 60 per cent of women who completed suicide had suffered from a psychiatric disorder in the preceding 12 months' between 1986 and 2006 (Mental Health Division 2009 p. 24). Of those who died from suicide, more than one-third had been admitted to a private or public mental health hospital during their lives, 15 per cent of men and 20 per cent of women completed suicide on the day of discharge, and a third within a month of discharge (Mental Health Division 2009). This data informs us that patients are at high risk of suicide around the time of discharge.

The WA Suicide Prevention Strategy 2009–2013 advises that 'careful discharge planning and continuity of care of patients returning to the community is critical' (Mental Health Division 2009).

People who self-harm carry an increased risk of subsequent suicide. WA data indicates that for people discharged after an initial deliberate self-harm event, the rate of death from all causes, compared to the general population, was significantly higher (five times higher for males and three times higher for females) (Serafino, Somerford & Codde 2000). However, both sexes were more than 20 times more likely to die from suicide.

Patients who present to EDs with self-harm provide an opportunity to intervene. UK data, for example, shows that more than 40 per cent of people who died by suicide had attended an ED in the year before their death (Da Cruz et al. 2012).

A single and identifiable cause of suicide is not known. However, suicide and suicidal behaviour is believed to be an interaction of biological, psychological, social and cultural factors exacerbated by life stressors (Mental Health Division 2009). Life stressors include relationship breakdowns, psychiatric disorders, drug usage, issues with family and friends, financial issues, physical illness and associated issues, death of someone close, job loss and unemployment, loneliness, work issues, childhood abuse, child custody issues, old age and sexual orientation (Mental Health Division 2009).

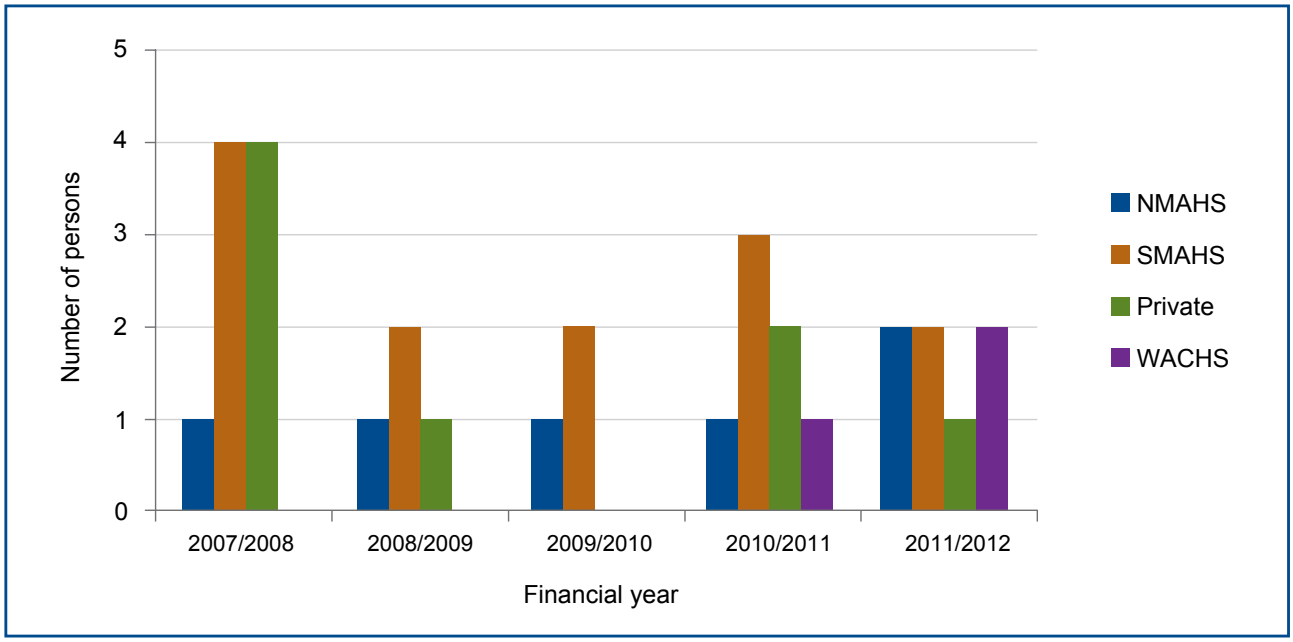
The evidence and processes around suicide risk assessment is a fiercely debated issue in mental health circles. There is a general perception among the public that risk assessment of those who are very likely to suicide is a precise science that only needs to be applied correctly to prevent the regrettable outcome. 'Such expectations have led patients, their relatives, their advocates and the coronial services to the belief that suicide is frequently the result of inadequate risk assessments within mental health services' (Mulder 2011).

Unfortunately, the reality is quite different. Large et al. conducted a meta-analysis of controlled studies of suicide within one year of discharge from psychiatric hospitals (long considered to be a high-risk group) and found:

> *No factor, or combination of factors, was strongly associated with suicide in the year after discharge. About 3 per cent of patients categorized as being at high risk can be expected to commit suicide […] however, about 60 per cent of the patients who commit suicide are likely to be categorized as low risk. Risk categorization is of no value in attempts to decrease the numbers of patients who commit suicide after discharge' (Large et al. 2011b).*

Suicide risk factors are not equivalent to suicide risk assessment. Checklist approaches based on risk factors to predict future suicidal behaviour have long been shown to be statistically significant in populations but of limited utility in individuals (Clark & Fawcett 1992). Suicide risk assessment has to be personalised to the individual and not a population of individuals (Draper 2012).

Figure 5 **Number of persons who suicided while admitted to hospital, WA 2007/12**



Note: NMAHS = North Metropolitan Area Health Service; SMAHS = South Metropolitan Area Health Service; WACHS = Western Australian Country Health Service.

Data source: Performance Activity and Quality Division, DoH (2012).

The majority of medium- to long-term suicides are not likely to come from identified 'high-risk' groups but that does not mean that 'low-risk' individuals do not become 'high-risk' under changed life circumstances. This is why individualised assessment is important and why reassessment needs to occur when the clinical context of a case changes.

Accurate risk assessment and management of the identified risk is crucial and the training of mental health professionals in how to perform risk assessments is a fundamental skill that all mental health professionals need to acquire. There is evidence supporting this call for better training from the findings of two large studies of suicide following contact with psychiatric services (Appleby et al. 2006). These studies conclude that around 20 per cent of studied suicides were considered preventable but for inadequate assessment and management of depression and other psychiatric disorders; poor staff-patient relationships; and inadequate continuity of care, particularly the transition between hospital and the community.

Suicide is rare among patients who are inpatients in adult public mental health services in WA. However, over the past five years, 30 suicides occurred in patients during hospital admission; 22 in public hospitals and eight in private mental health hospitals (see Figure 5).

In 2008 the Deputy State Coroner investigated nine deaths purported to be related to individuals not being able to access the public mental health services. That report identified that patients' difficulties in accessing services were related to extreme pressure on the mental health system and on the practitioners who were struggling to provide services under extremely difficult conditions.

That report also noted the risk of suicide within a short period of discharge from inpatient care. The Deputy State Coroner proposed that some suicides are preventable and extra care must be taken when people are discharged into the community.

The two main areas of difficulties were:

1. Risk assessment/admission to relevant facilities.
2. Discharge planning/communication—communication of the discharge plan to the patient and their carer.

Other issues included:

- not enough specialist mental health beds
- not enough mental health workers
- not enough qualified people to service the beds
- staff exhaustion.

These factors were recognised to have significant impact especially on mental health workers in rural and remote areas.

The Deputy State Coroner reported that many mental health practitioners believed completed suicides are rare and that if a person does not exhibit acute suicidal behaviours they are not always assessed to be at risk of completed suicides (p. 13).

Concerning risk assessment and access to facilities, six of the nine people who unequivocally asked for help did not receive the help they needed in time and there was an absence of assessments by a consultant psychiatrist.

The Deputy State Coroner reflected that previous inquests had also revealed that some patients do not receive a risk assessment and few patients are assessed by psychiatrists. She said:

> *More often, the mental health nurse determines that the patient in crisis has 'situational distress' or a 'substance abuse episode' rather than an episode of mental illness.*
>
> *There are also times when people in crisis are asked to wait in the community until a bed becomes available in a public mental health service*
>
> *(Deputy State Coroner 2008).*

3.2.1 Audit of 255 persons who suicided in WA 2009

Deputy State Coroner Evelyn Vicker offered the data of all WA suicides in 2009 to this Review to assess:

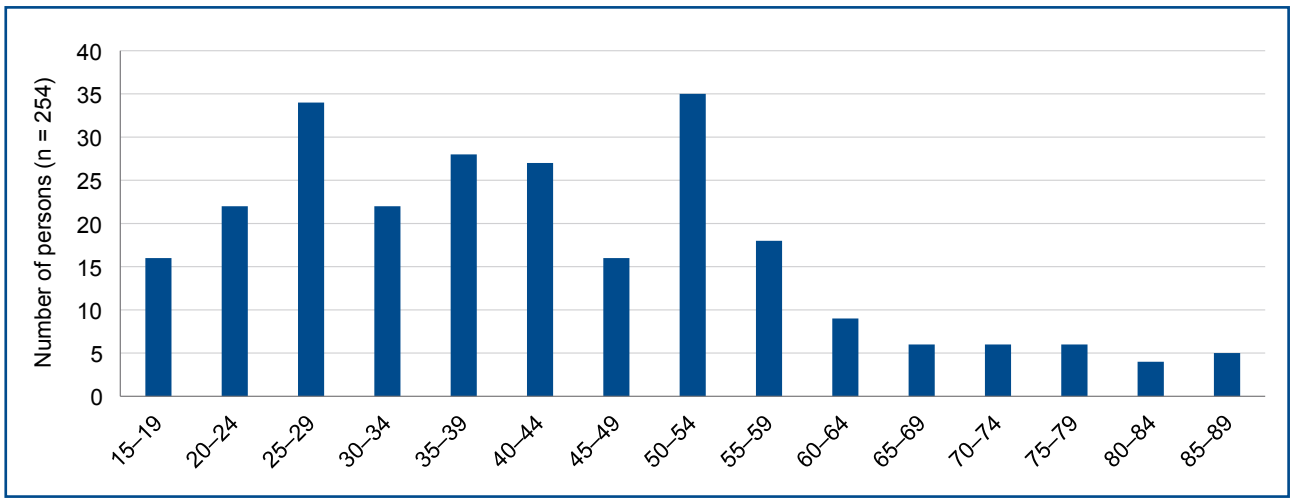
> *What, if any, contact the deceased persons had with the State mental health services in an attempt to determine progress in the provision of improved mental health services to the West Australian Community (Recommendation 16 of the 2008 Coroner's Report).*

For the sample, the Coroner used the Briginshaw 'Standard of Proof' as applied to WA inquests, that is, there is no doubt that suicide is the cause of death. These data therefore exclude deaths from single car accidents or 'natural causes' where chronic illnesses such as heart disease or diabetes are suddenly not managed and lead to death. Applying this criterion, a total of 255 persons died from suicide in WA in 2009.

The data of 255 persons were examined by this Review to determine if there were links between them and the mental health services, and the results of that analysis are presented here.

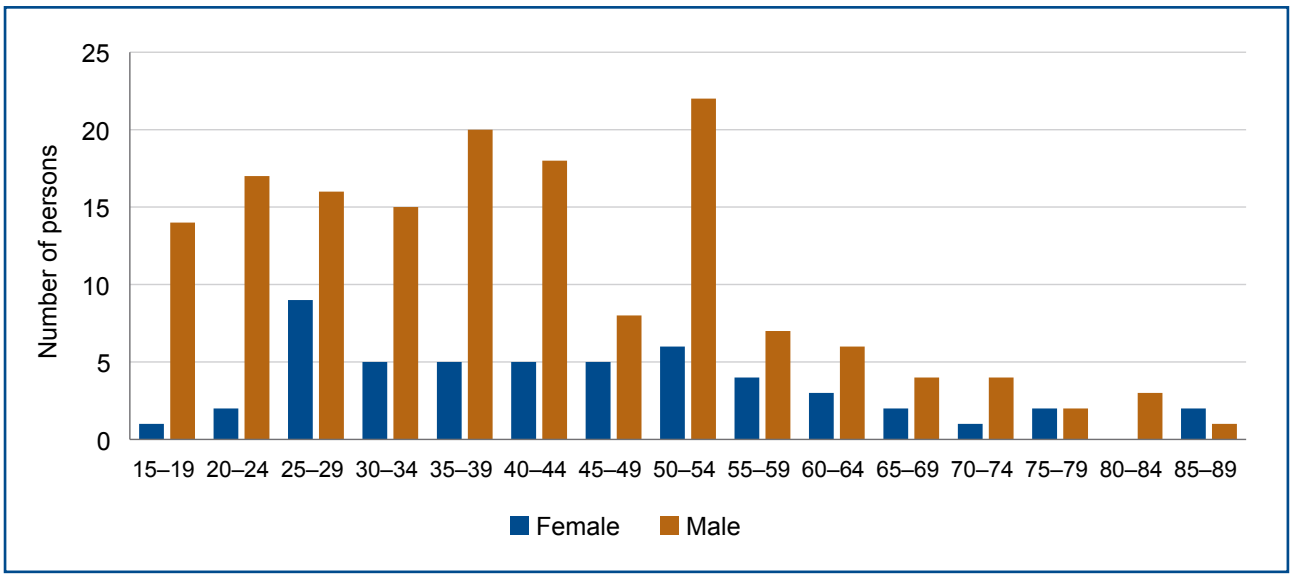
In 2009 suicide occurred within all age groups and a high number of completed suicides occurred among persons aged 50–54 (35 or 13.77% of people). Persons aged 15–39 represent 37 per cent of those who completed suicides (see Figure 6). More men than women completed suicide in each age group under 75 years of age (see Figure 7).

Figure 6 **Age distribution of suicide WA, 2009**



Source: Deputy State Coroner's data (2012).

Figure 7 **Age and gender distribution of suicide WA, 2009**

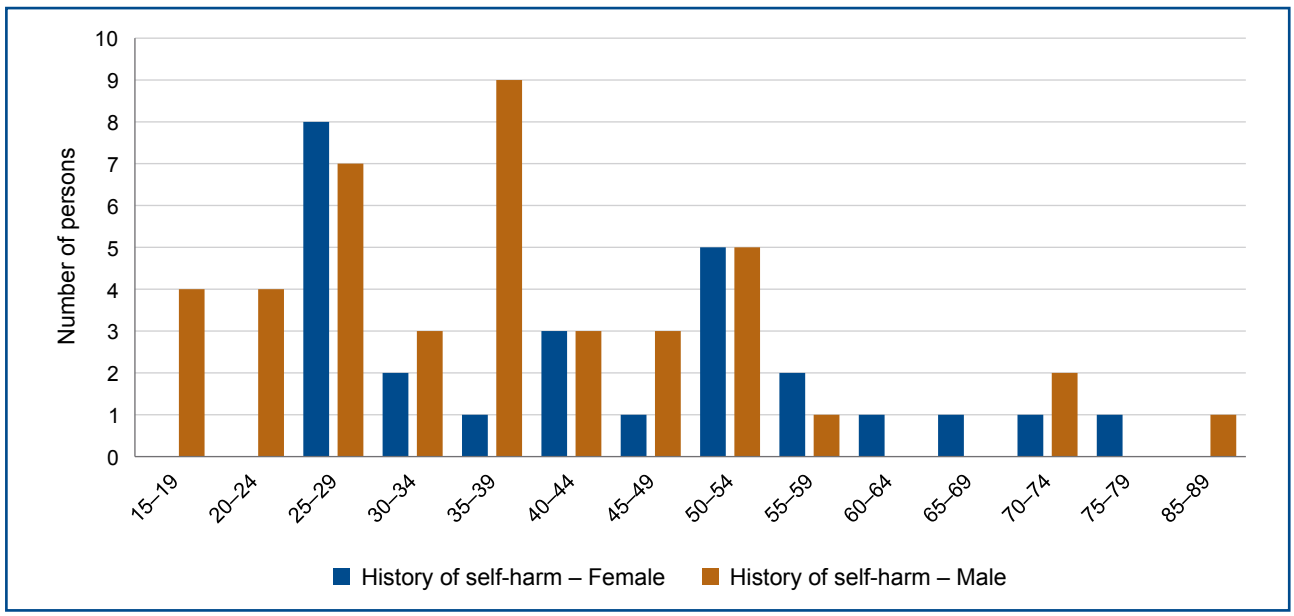


Source: Deputy State Coroner's data (2012).

International research revealed that in western societies half the people who suicide have had contact with mental health services during their lifetimes and 25 per cent have had contact with mental health services within the year of death (Bouch & Marshall 2005; Department of Health, London 2010; Tseng et al. 2010). Those figures align closely with the 2009 cohort where 104 (42.62%) of the persons who suicided had previously contacted mental health services. Of those with previous contact, 43 (41.34%) did not seek help before death; this included 14 women and 29 men. Some of these suicides were impulsive and occurred in association with alcohol consumption.

A history of self-harm was more prevalent among persons aged 25–39. There were 1.6 more men than women with a history of self-harm. Of the 255 people who completed suicide, 68 had a history of self-harm and 37 had known suicidal ideation (see Figure 8). A history of self-harm is strongly associated with suicide (Large et al. 2011a).

Figure 8 **History of self-harm by gender, 2009**



Source: Deputy Coroner's data (2012).

In 2009, 61 (24%) of the people who suicided actively sought help in the period immediately preceding their death. Twenty-one accessed public mental health services; 28 accessed private psychiatry and 12 sought help elsewhere, for example, from family members.

Twelve (4.7%) of those who sought help from public mental health services were unable to obtain services. Of these, nine persons received risk assessment by the mental health services. Five were assessed to be at no risk, four were assessed to be at low risk; and four did not obtain timely assessment (i.e. they were waitlisted). The false negative finding is similar to the findings of Large et al. (2011a) discussed above.

Of those who were accessed and were admitted to mental health services, two completed suicide while on unauthorised leave and a further two completed suicide while on 'official' leave.

Twenty-eight were admitted and then discharged from hospital. More than half were discharged from the mental health services with a discharge plan, including a plan for hospital follow-up. Of the 15 with discharge plans, one did not receive follow-up from community mental health services; five community mental health service referrals were not activated; five patients were discharged without a discharge plan; and three were discharged without discharge plans and did not receive any follow-up.

In addition, three individuals and one family had not complied with treatment plans and one had not disclosed their intent to suicide.

Twenty-seven of those who suicided were treated by private psychiatric services and most of those deaths occurred in association with a change in medication, where the patient's condition destabilised and there was no evidence of referral to community service or involvement of community mental health services to support or monitor the patient between psychiatry visits.

Twenty-one individuals completed suicide after discharge from a mental health facility, three died on the day of discharge and three the following day. The others died within 2, 5, 7, 14, 27 36, 40 and 52 days of discharge. The high risk of suicide following mental health inpatient care, particularly in the first day and week, is well documented (Hunt et al. 2009; Tseng et al. 2010). For example, in Thailand 28 per cent of deaths occurred within a week and in Britain, 43 per cent of suicides occurred within a month of discharge (Hunt et al. 2009; Tseng et al. 2010).

The importance of follow-up care in the days after discharge from inpatient cannot be overemphasised. Hunt et al.'s (2009) controlled study demonstrated that enhanced follow-up decreased the likelihood of suicide and suggests that risk assessments, mental state examinations and follow-up procedures are essential, including for those patients who self discharge. Follow-up may include telephone contact to encourage patients to seek social support and attendance at clinic within the week of discharge (Tseng et al. 2010).

In summary, this examination of the 255 completed suicides in 2009 revealed that almost half the people had contacted mental health services at some time during their lives. Many did not seek help immediately before suicide. Twenty-one accessed public mental health care and 12 were unable to obtain services. For nine persons who sought help from public mental health services, the risk assessment did not identify their need for immediate intervention.

Suicide occurred among those who accessed mental health services, and concern is raised as to whether the deaths that occurred where the patient was on leave could have been prevented. Had a risk assessment had been undertaken and were risk management plans in place prior to leave? Of the 21 persons who suicided after discharge, most had discharge plans. However, not all received the hospital aftercare that was planned.

Improving the processes of response to referrals, risk assessments, discharge planning and follow-up care in the mental health system is essential. Patients' needs for mental health care must be met with a cohesive mental health system, an experienced workforce and effective governance. Despite improving access to risk assessment and management of patients who are suicidal, it must be understood that prediction in this situation is a dynamic and often shifting scenario and, even with best management, not every suicide can be prevented.

See Recommendation 1: Governance (1.1.2, 1.1.3, 1.1.4, 1.1.5); and Recommendation 7: Acute issues and suicide prevention – Deputy State Coroner's Recommendations and Office of the Chief Psychiatrist's Recommendations.

3.2.2 Council for Suicide Prevention

The establishment of a Ministerial Council for Suicide Prevention ('the Council') arose from the WA Suicide Prevention Strategy 2009–2013 developed in response to an election commitment of the current State Government. The State Government committed $14.2 million to implement the strategy over four years. The plan highlighted the importance of a whole-of-government approach to suicide prevention and is a mandated priority for all State Government departments (Mental Health Division 2009).

The Council reports to the Minister for Mental Health. The strategy and budget is administered by Centrecare on behalf of the Council. It includes numerous approved programs to implement what are known as Community Action Plans (CAPs).

To date, 22 Community Action Plans in 163 geographical locations and eight target-group CAPs addressing 180 locations are in action (Centrecare WA Suicide Prevention Strategy, Business Plan 2011–2012 (2010)).

The Chair of the Council, Mr Peter Fitzpatrick, AM, informed this Review that the planned actions include community coordinated programs. For example, the Wheatbelt action plan involves 13 towns, each contributing to the action plan. Programs include suicide awareness training provided to community groups, police and teachers. A reference GP has also been identified for Indigenous persons where access to GPs is difficult.

The suicide prevention strategy operates by engaging communities to improve health through increased recreation facilities, life opportunities and social participation to ameliorate the adverse effects of social disadvantage on health (PHAA 2009), for example, to build community capacity by providing initial support through activities such as football. Coaches are trained to identify illness such as depression (personal communication P Fitzpatrick 2012). Programs also include taking children fishing or camping on the weekend, where trained community members provide informal leadership and young people talk during the course of activities (personal communication P Fitzpatrick 2012).

By attending meetings in a community hall, young people build up trust with leaders. The Chair of the Ministerial Council for Suicide Prevention told the Review that the basis of suicide lies in an individual's self-esteem; it is not all about mental illness. While engaging in social activities, many young people have explained they are reticent to attend professional services where they do not always feel listened to. Often the side effects of medication trouble them and symptoms of mental illness do not subside quickly. In addition, youth reflect that the environment of the ED is inappropriate to discuss self-harm (personal communication P Fitzpatrick 2012).

As yet 24-hour suicide preventions programs have not commenced due to difficulty in engaging willing individuals to provide this service. It has also been difficult to engage some communities, such as Derby, where meetings to date have contained more service providers than independent community members (personal communication P Fitzpatrick 2012).

A number of programs are in development including:

- Mensweb—a 'one-stop shop' to search and access a diverse range of men's services promoting mental health and wellbeing, awareness of mental illness, suicide prevention and self-help behaviours
- Carnarvon Family Support Service Inc—a Suicide Prevention Committee is undertaking service mapping and a gap analysis
- City of Vincent—Developing a Community Action Plan within the City of Vincent
- Abortion Grief Australia—engaging community groups and service providers to promote professional development and community awareness and improve accessibility for those experiencing abortion trauma/grief
- Gay and Lesbian Communities—developing suicide prevention initiatives for the gay, lesbian, bisexual, transgender and intersex community
- Injury Control Council of WA (incorporating 12 regions of the South West)—building capacity with a comprehensive suicide prevention education program
- Relationship Australia—Resilience program; Blokes and Chic's Gender Specific programs; Music program; and programs aimed to teach girls and boys to deal with power, strength and powerlessness (Spini 2012).

Suicide prevention programs identify themselves as the third arm of mental health, filling the gaps between hospital and mental health care (personal communication P Fitzpatrick 2012). However, the Review was informed that the suicide prevention programs do not always feel supported by mainstream mental health services and some have difficulties in obtaining advice from those services.

See Recommendation 1: Governance (1.1.2, 1.1.3, 1.1.4, 1.1.5); Recommendation 7: Acute issues and suicide prevention; and Deputy State Coroner's Recommendations.