

PLWSA LIVED EXPERIENCE

2019 SURVEY REPORT



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Parents Living with Suicide Australia Survey Report

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Parents Living with Suicide Australia Survey Report

+ 1. INTRODUCTION: PARENTS LIVING WITH SUICIDE AUSTRALIA

Parents Living with Suicide Australia (PLWSA) is an online postvention support group consisting of parents and grandparents who have lost loved ones to suicide. This document reports the findings of a lived experience survey undertaken by 42 PLWSA respondents located in metropolitan, regional, and rural areas across every state in Australia. The survey included questions pertaining to access to, satisfaction with, and recommendations around Australia's mental health system when seeking help for loved ones at imminent risk of suicide.¹ Accordingly, this report offers respondents' experiences, insights, key concerns, and practical recommendations.

The responses of this survey represent a broad range of experiences, insights, ideas, and concerns important to us as parents and support people of individuals experiencing acute and/or chronic mental health issues. The issues raised point to a range of critical failures in the mental health system, and we argue that it is in desperate need of change. Suicide is the leading cause of death for Australians aged between 15-44; and for every death by suicide it is estimated that as many as 30 people have attempted to end their lives.² After a suicide attempt it is family and friends that have the most contact with the individual who has made a suicide attempt.³ Therefore, if they are properly supported, resourced, and informed, family and friends can play a major role in suicide prevention.⁴

We strongly assert that the experiences and insights gained by those of us who have lost loved ones to suicide provides invaluable information about Australia's mental health care system, particularly its limits and failures. It is imperative that this perspective contributes to the discussions about, and the evaluation of, how the mental health care system works *in practice* for individuals and their families requiring their services.

¹ See Appendix A for survey pro forma and for further information related to research methods, please contact authors.

² Lifeline, 2015 <https://www.lifeline.org.au/about-lifeline/lifeline-information/statistics-on-suicide-in-australia>

³ This term refers to a suicide attempt that does not result in death.

⁴ Victorian Government, Royal Commission into Victoria's Mental Health System, *Tandem Submission into the Royal Commission into Victoria's Mental Health System*, 2019, <https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rvcvmhs.files/5815/6513/7243/Tandem.pdf>

+ 2. SEEKING SUPPORT FROM MENTAL HEALTH SERVICES

Lack of compassion and not being heard

A significant proportion of respondents reported that they and/or their children were not taken seriously or treated with compassion when presenting to mental health services seeking support.

Everywhere we attempted to seek support we were ignored or told that there was not an issue even after self-harm attempts.⁵

This was identified as a key factor contributing to negative outcomes. This experience was described across all services including, but not limited to: GPs, public and private mental health services, schools, and hospitals. Respondents reported that rather than health professional taking the lead to ask the right questions to acquire the correct information in order to make properly informed decisions about treatment/services, the onus of responsibility to understand and articulate concerns and risk factors seemed to sit with the help-seeker.

This lived experience of the mental health system echoes the findings of the 2005 *Not for Service: experiences of justice and despair in mental health care in Australia report*:

The contrast between experiences of care when presenting with a physical illness as compared to presenting with a mental illness was profound. A lack of respect for persons with mental illness or their families was commonly reported. The combination of a lack of respect, poor resources and inadequate facilities appeared to underpin the numerous reports of reduced safety within mental health care services.⁶

These problems, clearly identified 15 years ago, remain unchanged. Immediate action is required to help reduce the current suicide rate.

Getting support has been extremely difficult...there is no proper support for families.

[The] hospital should not [have] released my daughter only a few hours after she was admitted.

⁵ Survey participants' responses are included in italics; no identifying material is provided due to confidentiality.

⁶ Australian Human Rights Commission, *Disability Rights: Not for Service Report: Part 2, Not for Service: Experiences of Justice and Despair in Mental Health Care in Australia*, 2005, <https://www.humanrights.gov.au/our-work/disability-rights-not-service-report-part-2>

Lack of involvement of caregivers

*The Mental Health Statement of Rights and Responsibilities Part V: Rights and responsibilities of carers and support persons*⁷ ‘acknowledges the contributions and expertise of informal, professional, non-professional and statutory carers and support persons’, and states that the Australian government and community ‘should endeavour to assist carers and support persons in their respective roles’. Despite this, a commonly reported problem was the lack of involvement of families, caregivers, and support people when seeking help from mental health services for loved ones experiencing suicidality.

My son, being an adult, we were not included. Minimal contact with his psychiatrist. No education, no support, nothing. Not told that he was suicidal at times.

When our child is an adult, family is kept mostly in the dark. We had no rights or support.

We were actively excluded many times.

We concur with this Statement of Rights that carers need to be able to ‘participate in treatment decisions and decisions about ongoing care’; that they should ‘receive additional information [with consent] about the mental health consumer’s support, care, treatment, rehabilitation and recovery’; and be provided ‘comprehensive information, education, training and support to facilitate their care and support roles’.⁸

Families are heavily invested in the wellbeing of a person at risk of suicide. Families therefore often have the most contact, access and capacity to effect change and mobilise support for these vulnerable people. Many respondent families strongly feel that professionals should be legally obliged to disclose to family when a person is at risk of suicide, irrespective of the age of the person at risk.

I don’t know the full extent of his mental health as his medical team has refused to speak to us. I found out after his death, that he had made a previous attempt. We were never notified.

⁷ Australian Government, The Department of Health *The Mental Health Statement of Rights and Responsibilities Part V: Rights and responsibilities of carers and support persons*, 2012, <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/pub-sqps-rights-toc~pub-sqps-rights-5>

⁸ Australian Government, The Department of Health *The Mental Health Statement of Rights and Responsibilities Part V: Rights and responsibilities of carers and support persons*, 2012, <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/pub-sqps-rights-toc~pub-sqps-rights-5>

We suggest that the person at risk would be better supported if it became standard practice for families to ‘participate in treatment decisions and decisions about ongoing care’⁹, including post-discharge care plans. While it could be argued that this proposal does not conform to current privacy legislation, respondents stressed that access to relevant information could have made the difference between life and death for their loved ones, and this raises an issue that needs to be addressed. Confidentiality and privacy must not be allowed to contribute to loss of life.

We argue that privacy legislation needs to be balanced with the need to act and provide optimal care for people at imminent risk of suicide. However, a majority of respondents reported that the main problem experienced regarding information sharing was not actually privacy laws (i.e., because the person at risk chose to exercise the right to privacy), it was the unwillingness of service providers to include family in treatment decisions and decisions about ongoing care, often despite the person at risk agreeing to their family’s involvement. We note that the Australian Psychological Society states in *White Paper: The Future of Psychology in Australia*¹⁰ that there is ‘strong evidence for enhanced clinical outcomes for people with a mental health disorder when the client’s support people can be involved in their care and treatment’.

Recommendations

- 1. Implement strategies designed to create a person-centred culture; a culture with compassion and respect at its core.**
- 2. Implement policies and procedures that recognise and incorporate the critical role family plays in supporting people at risk of suicide through crisis care and the recovery process.**
- 3. Implement a practical approach to include families and caregivers which aligns with the Australian Department of Health’s *Mental Health Statement of Rights and Responsibilities*.**
- 4. Revise the Mental Health Act to include an exemption for families related to communication about persons at risk thereby allowing families access to basic information about the patient and to “participate in treatment decisions and decisions about ongoing care”, including when the person at risk is an adult.**

⁹ Australian Government, The Department of Health *The Mental Health Statement of Rights and Responsibilities Part V: Rights and responsibilities of carers and support persons*, 2012,

<https://www1.health.gov.au/internet/publications/publishing.nsf/Content/pub-sqps-rights-toc~pub-sqps-rights-5>

¹⁰ Australian Psychological Society, *APS White Paper: The Future of Psychology in Australia*, 2019

<https://www.psychology.org.au/for-members/advocating-for-psychology/Medicare-Benefits-Schedule>

+ 3. ACCESSING SERVICES

Among those respondents who sought help, the majority expressed strong dissatisfaction with the care and support received from mental health services. A common experience was lack of access to appropriate support services. Key reasons are outlined in the following sections.

Costs associated with accessing services

While *Medicare's* Better Access System provides ten subsidised psychology sessions per year, for those at risk of suicide, ten psychology sessions per year are utterly inadequate. As a result, many respondents reported having to manage the cost of psychology sessions by spreading them out, resulting in sub-therapeutic treatment. Others reported putting psychological treatment on hold or ceasing treatment altogether despite a desperate need for psychological support due to the prohibitive cost of full fee psychology sessions (which, for clinical psychologists, generally ranges from \$200-251 per hour).

■ *...the cost of see[ing] a psychologist is out of my range.*

■ *10 visits only, partly funded by the government means we ended up [having treatment] with lower end Psychologists, so we can manage the gap. Unfortunately, they haven't the skills required.*

■ *[The] cost of private services and private health insurance is prohibitive.*

We argue that greater funding needs to be allocated to the Medicare Benefits Scheme (MBS) to ensure a greater number and wider range of mental health services be available to those individuals experiencing serious mental health issues and/or at risk of suicide. Further, funding needs to be made available for a broader family-focused approach, in which people experiencing more complex mental health issues and their family members and/or carers can access appropriate mental health support services. We note that recommendations made in the Australian Psychological Society's White Paper works towards addressing some of these gaps in the mental health system and we concur with those recommendations. Notably, these gaps were experienced by respondents as a lack of a family-focused approach to service provision and the capping of the MBS funded psychology sessions resulting in sub-therapeutic care.

Recommendation

- 5. Ensure that the 17 recommendations made in the Australian Psychological Society's *White Paper: The Future of Psychology*¹¹ in Australia are adopted.**

Overburdened services and lack of follow-up

The problem of overburdened services manifested in a broad range of ways, such as people at high to imminent risk of suicide being turned away from hospital due to unavailability of beds, being discharged prematurely, or minors not being assessed properly due to hospitals lacking child and adolescent psychiatric services/units. The latter problem was more common in rural and regional areas, which often lack child and adolescent psychiatric services, requiring children and their families to travel to hospitals far from their home and community to access appropriate psychiatric services or secure hospital admission. Further, severely under resourced services result in inappropriately long wait times to access mental health and/or psychiatric services, even for crisis care. We argue that this contributes to our suicide rate, and respondents' experiences reflect this.

We had to travel to be able to speak with counsellors who were qualified to help families who had suffered from losing a loved one to suicide. Nearly 16 months in and my children are only now about to access help locally.

My son recently had an attempt. After waiting 9 hours in emergency to see a mental health worker we were told there wasn't enough beds in the adolescent ward.

[My son] got in eventually, but it was too late.

The Royal Australian and New Zealand College of Psychiatrists issued a statement in April 2019 that elucidates our experiences and perspective:

A number of shortfalls in the mental health system has resulted in mental health services only being able to treat those who are most unwell, meaning many get turned away and opportunities to intervene early are lost. Recovery from a mental illness is possible, but without access to services we risk losing that hope ... we need urgent investment now and we need a dedicated plan for how we are going to do it.¹²

¹¹ Australian Psychological Society, *APS White Paper: The Future of Psychology in Australia, 2019*, <https://www.psychology.org.au/for-members/advocating-for-psychology/Medicare-Benefits-Schedule>

¹² The Royal Australian and New Zealand College of Psychiatrists, *Report shows stark reality of Victoria's mental health system, 2019*, <https://www.ranzcp.org/news-policy/news/report-shows-stark-reality-of-victoria's-mental-he>

Respondents also reported that there was often no follow-up plan after a diagnosis, no follow-up plan post-discharge from hospital, no safety plan post-discharge after a suicide attempt, and no post-discharge psychoeducation for patients and caregivers to better manage mental health.

■ *No safety plan was given to me, no meeting upon release [from hospital].*

We argue that these follow-up deficits also contribute to our suicide rate.

Although there has been promotional activity by organisations such as Beyond Blue and Mental Health Australia around de-stigmatising mental health issues and promoting active help-seeking, it is important to recognise that in the current overburdened mental health sector, appropriate help is often unavailable when it is sought out. As a result, those seeking this help often end up disenfranchised and disengaging from mental health services which, in turn, increases suicide risk.

■ *It's all good having all this suicide awareness, but if the services aren't there, what's the point.*

We contend that critical work needs to be done around funding and service provision to ensure that appropriate and timely services are available for those seeking help in metropolitan, regional, and rural areas in order to improve mental health outcomes. Further, post-diagnosis and post-discharge treatment plans need to be routinely formulated to ensure that at-risk individuals and their family leave mental health services feeling supported, understood, and educated about the next steps forward.

Recommendations

- 6. Improve assessment, referral, and support for people at risk of imminent suicide and/or post-suicide attempt when being discharged from hospital.**
- 7. Improve health care professionals' suicide risk assessment skills, understanding of how to work within the mental health system, and ability to provide and support care plans.**
- 8. Increase funding for assertive mental health outreach programs following a suicide attempt.**
- 9. Ensure that the mental health system provides for the mental health needs of people located in regional and rural areas.**

Lack of service coordination

Respondents commonly identified lack of integration across services as a problem resulting in help-seekers having to tell their story multiple times to multiple clinicians across multiple services. Mental health services are not streamlined, and service providers often don't coordinate with other services. This seems to be further complicated by multiple types of funding and fee-for-service models, which is both inefficient and confusing for help-seekers.

It is detrimental to the treatment and recovery of a mentally unwell person when they are obliged to repeat their story numerous times to numerous people. Respondents noted that not only do mental health care services appear not to work together, but there also seems to be a lack of knowledge within the industry about what other mental health care options may be available in the community. Access to alternate mental health services are critical when Mental Health Care Plans and/or private health funds for psychological sessions have been exhausted. Respondents consistently reported that navigating the mental health system is confusing, and this is highly problematic given that individuals struggling with depression and other mental health problems are often unable to proactively research and understand the complicated, disjointed mental health system.

We argue that mental health services need to work cooperatively and collaboratively to assist help-seekers find and secure the support and treatment they require. Our mental health care system needs to be truly person-centred, rather than service-centred.

Recommendations

- 10. Improve coordination between state and federally funded mental health services, and/or**
- 11. Consider abolishing PHNs¹³ and implementing a more centralised, federally funded system that is overseen on a state and/or local level (rather than the current model in which there is competition for funding cross services creating unnecessary disjointedness).**
- 12. Ensure that there is a 'no wrong door' approach to accessing support.**

¹³ Primary Health Networks

Gaps in service provision

Respondents noted that there is a significant gap in the system between services available for primary care (low-risk mental health services) and crisis intervention (imminent-risk mental health services), often referred to as the 'missing middle'. A 2016 Case Study Report by the National Mental Health Commission states that people in the 'missing middle':

...may have more complex needs than generally provided by unidimensional psychological support, yet are not considered 'severe enough' for constrained state mental health services [and]...are at risk of falling through the silos and divides of our health system'.¹⁴

This statement encapsulates the lived experiences of the PLWSA cohort when attempts to access tertiary level care were made for their at-risk loved ones. These gaps and inadequacy between service tiers can cause an escalation of the severity of people's risk of suicide.

Help needs to be available in a timely manner. Waiting 3 months for an 'emergency' appointment is not good enough. Follow up needs to occur both between treatment and when a young person has left a facility rather than leaving them to their own devices to try to get further help.

He fell through the cracks.

We concur with the recommendations the Australian Psychological Society's *White Paper: The Future of Psychology in Australia*¹⁵ make for additional services to be funded under the MBS to fill the gaps in subsidised service provision.

Recommendation

13 Introduce appropriate tiered intervention services that are accessible to people needing care that sits between the two ends of the spectrum of mental health care.

Disengagement

Respondents noted that there is an absence of mental health outreach services available for people requiring help (short of a crisis intervention when the person is deemed to be at imminent

¹⁴ Australian Government, National Mental Health Commission, *Leading, Collaborating, Advising, Reporting: 2016 Report Card*, 2016, <http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2016-report-card/case-studies.aspx>

¹⁵ Australian Psychological Society, *APS White Paper: The Future of Psychology in Australia*, 2019 <https://www.psychology.org.au/for-members/advocating-for-psychology/Medicare-Benefits-Schedule>

risk). As a result, family and/or carers were often forced to take people who required help but are unwilling to engage to Emergency Departments.

Emergency departments are not the best place for dealing with suicidal crises, but if they are the only option, they must be equipped to deal with the patient adequately.

This resulted in negative experiences and a further loss of trust in the mental health care system, from which they were already disengaged. Emergency Departments do not provide a therapeutic environment for someone who is acutely mentally unwell. Long wait times, over-stimulation, limited access to trained mental health clinicians and, at times, the use of security personnel, are some of the negative issues experienced when seeking mental health care in Emergency Departments.

Recommendation

- 14 Introduce a stepped care system with the capacity to manage people who need mental health care but who are reluctant or unwilling to engage, including crisis assessment and treatment teams (CATT) and other outreach services.**

Staff turnover and training

Many respondents stated that continuity of care was greatly affected by staff turnover and/or an inadequate first response. These experiences are reflected in SANE's submission to the Royal Commission, which highlighted the impact of both a resource-constrained environment and the pressure involved in being the 'public face of system failures'.¹⁶ This combination of pressures, as identified in a 2019 VCOSS report, is described as resulting in an inordinate level of stress on the individuals working in the sector, in turn affecting their mental health and resulting in burnout and high staff turnover.¹⁷ The impact of this compromised mental health system was evident in the lived experience of the PLWSA cohort.

It would appear that significant issues are emerging in relation to recruitment, retention and/or development of the mental health workforce. Specifically, as the Australian Psychological Society's submission details, both recruitment and retention of sufficient skilled practitioners within the mental

¹⁶ Victorian Government, Royal Commission into Victoria's Mental Health System, *SANE Australia: Submission into Victoria's Mental Health System*, 2019,

https://s3.ap-southeast2.amazonaws.com/hdp.au.prod.app.vicrcvmhs.files/7115/6513/7242/SANE_Australia.pdf

¹⁷ Victorian Council of Social Service, *VCOSS Submission to Issues Paper into the Social and Economic Benefits of Improving Mental Health*, 2019, <https://vcoss.org.au/policy/rethinking-mental-health/#>

health system results from 'unsustainable workloads, lack of incentives for rural and remote practice, lack of employment flexibility and career progression, and lack of support and recognition'.¹⁸

When we dealt with the local hospital psych[iatric] ward there was no psychiatrist in the hospital, only visiting once [who came] once or twice a week and then it was a different one each time.

Our kids need to build up trust and have confidence that they are being looked after.

There is never enough staff.

[My son] needed continuity of care. He felt like the service/carer had abandoned him and that worsened his suicidality (worsened his sense of worthlessness) and severely impacted his faith in the service helping him (also worsening the sense of helplessness and hopelessness linked to suicidality).

Recommendations

15 Implement incentives to attract and retain mental health staff in regional and rural areas.

16 Increase training and support for mental health workers and first responders.

17 Create opportunities for people with lived experience to pursue opportunities in the system beyond informal carer roles.

Complex needs

The needs of people with complex and/or comorbid mental health issues require a broad suite of system responses including recognising, assessing and responding to those with a lived experience trauma. Further, people affected by mental health issues experience problematic substance use at a far higher rate than that of the general community. Depression and anxiety are the most prevalent disorders co-occurring with drug and alcohol misuse.

[My son] should have been seen as a person in crisis and given the help he desperately needed[,] not treated as someone with a drinking and drug problem.

¹⁸ Victorian Government, Royal Commission into Victoria's Mental Health System, *Australian Psychological Society: Submission*, 2019, https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/4115/6573/8945/Australian_Psychological_Society.pdf

A number of respondents reported the distressing experience of having their mentally unwell child being first assessed by police for criminality without or before considering and/or managing mental health issues.¹⁹

■ *Police Officers and Doctors need better training dealing with mental health.*

Echoing the experiences of survey respondents, Victoria Police's submission to the Royal Commission into Victoria's Mental Health System purports that due to systemic limitations and an absence of coordinated and appropriate support services, police can become responsible for managing acutely unwell individuals who, had they not been in police custody, may otherwise have been able to access the support they needed.²⁰

Furthermore, the experience of survey respondents aligns with observations made in the Victorian Government's submission to the Royal Commission into Victoria's Mental Health System whereby those experiencing mental health issues may have their first support seeking contact with services unrelated to mental health. These services can play a key role in identifying or support to people with mental illness however their capacity to identify and respond to people at risk of or experiencing mental illness appears to be limited.²¹

Recommendation

18 Explore how complex mental health treatment pathways can be improved and increase training for first responders to ensure they can recognise mental health symptoms and respond appropriately.

+ 4. EDUCATION

The World Health Organisation describes the social determinants of health as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.²² The way health systems are designed, operate, and financed act as a powerful determinant of health, including mental health. Preventing and addressing mental ill health

¹⁹ Victorian Government, health.vic, *Dual Diagnosis*, 2016, <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/specialist-responses/dual-diagnosis>

²⁰ Victorian Government, Royal Commission into Victoria's Mental Health System, *Victoria Police submission*, 2019, https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/9615/6522/1975/Victoria_Police.pdf

²¹ Victorian Government, Royal Commission into Victoria's Mental Health System, *Victorian Government submission*, 2019, https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/5215/6514/1027/Victorian_Government.pdf

²² World Health Organisation. *Social Determinants of Health*, https://www.who.int/social_determinants/en/

is therefore the responsibility of our government and this requires the allocation of funding for prevention and early intervention initiatives in our schools, workplaces, and communities.

Many respondents asserted that early intervention initiatives targeting mental health issues and suicide risk in schools would be valuable. While ideas about delivery formats varied, suggestions included visits by those with lived experience of mental illness to speak at schools, and education around suicide, including how to identify someone at risk and what to do when oneself or someone else is at risk. There is a need, for the future mental health of our communities, to embed mental health education, wellbeing strategies, and resilience building into school curricula at all year levels.

Recommendations

- 19 Fund mental health promotion and early intervention initiatives in schools, universities, TAFEs, and workplaces.**
- 20 Further invest in funding for mental health research and preventative care.**
- 21 Increase public and workplace based mental health promotion campaigns including educating the public about how to identify and respond to individuals in crisis and/or at imminent risk of suicide.**
- 22 Provide funding for innovative suicide prevention initiatives that draw upon the knowledge, experience, and insights of people with lived experience of mental illness and/or suicide of a loved one. These lived experience perspectives could be incorporated into mental health training, therapeutic programs, grief support programs, and school and public education.**

+ 5. BULLYING

A critically important issue that emerged from the survey results is that many respondents identified that prior to their deaths by suicide, their child had been bullied. Whilst most respondents reported that this had occurred at school, bullying was also evident in workplaces, universities, and the Australian Defence Force. Respondents unequivocally reported that the bullying their child had experienced had not been taken seriously by the relevant organisation, nor had it been adequately dealt with. Of great concern is the culture of stigmatisation of the individual being bullied, as is a tendency for bullying, when raised, not being taken seriously.

Control bullying in schools, sports, and the workplace, making bullies accountable for their actions. Not only do people take their lives, but they leave a trail of devastation and heartbreak for family and friends.

Legislative changes effected in recent years allow police to charge offenders of serious forms of bullying, including cyberbullying, with criminal offences. The 2014 changes to the Fair Work Act²³ (which works on a federal level), the 2017 Statutes Amendments (Bullying) Bill introduced by the South Australian Legislative Council (known as 'Libby's Law'),²⁴ and the extension of the Crimes Act 1958 in Victoria²⁵ (known as 'Brodie's Law') have provided some anti-bullying jurisdiction in South Australia and Victoria. There is clearly scope, however, for legislation of this nature to be more widely adopted throughout other states and territories in Australia.

Recommendations

- 23 Consider amending legislation to ensure that workplaces, educational institutions, and the Australian Defence Force are held accountable if found not to address cases and cultures of bullying within their organisations.**
- 24 Consider introducing legislation at a federal level that also covers individuals outside workplace settings.**
- 25 Amend, and where there is none introduce, legislation at a state level to criminalise serious forms of bullying.**

+ 6. POSTVENTION CARE

An overwhelming number of respondents reported a lack of postvention care for themselves and other family members. Respondents unequivocally argue that postvention is critically important in the aftermath of suicide. Many reported that they and/or other members of the family have had great difficulty coping emotionally and psychologically after the suicide of their loved one. Postvention is particularly important because the family and friends of someone who has suicided often become at

²³ Fair Work Commission, *Antibullying*, <https://www.fwc.gov.au/disputes-at-work/anti-bullying>

²⁴ South Australia State Government, *Report Bullying and Harassment*, <https://www.sa.gov.au/topics/education-and-learning/health-wellbeing-and-special-needs/bullying-and-harassment/reporting-bullying-and-harassment>

²⁵ Victoria Government, *Bullying - Brodie's Law*, <https://www.justice.vic.gov.au/safercommunities/crime-prevention/bullying-brodies-law>

increased risk of suicide themselves and, thus, postvention care is also a critical component of suicide prevention.²⁶

■ *No proper support for families who suffered from losing a loved one to suicide.*

Currently, there are a number of organisations providing postvention support across Australia such as Postvention Australia, Standby and Support After Suicide (HOPE), and Wellways. StandBy is Australia's largest suicide postvention program and is funded through the Australian Government's Department of Health 'National Suicide Prevention Leadership and Support Program' (NSPLSP)²⁷ for which funding has been extended through to 2021.²⁸ StandBy works in eleven Primary Health Networks (PHN's) in ten sites across the country, and partners with local service organisations to run the program.²⁹ In geographical areas outside of those in which Standby operates, complex funding models and a lack of certainty regarding ongoing funding provided by the Commonwealth for these support services put those bereaved by suicide at risk of missing out on accessible and timely support. This is a gap in mental health services provision that needs to be addressed with ongoing Commonwealth funding for this crucial support to be made available to families Australia wide.

Volume 2 of the 2019 Draft Report by the Australian Government Productivity Commission³⁰ recommends that further research is required by the National Mental Health Commission to determine the effectiveness, and the cost effectiveness of postvention programs. Our lived experience as families bereaved by suicide affords us an expert understanding of the impact that access or lack of access to postvention support services can have and we therefore support the view expressed in the Royal Commission into Victoria's Mental Health System Interim Report that there is a need for more post-suicide support services and agree with the statement that this is an important part of a comprehensive approach to suicide prevention.³¹ We therefore strongly advise that funding support for the provision of these programs is a crucial part of suicide prevention, is essential to improving the lives of families bereaved by suicide, and that Commonwealth funded

²⁶ Victorian Government, Royal Commission into Victoria's Mental Health System, *Jesuit Social Services: Submission into the Royal Commission into Victoria's Mental Health System*, 2019, https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/7015/6625/3724/Jesuit_Social_Services.pdf

²⁷ Australian Government, National Suicide Prevention Leadership and Support Program, [https://www1.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/\\$File/National%20Suicide%20Prevention%20Leadership%20and%20Support%20Program%20-%20PHN%20Resource.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/National%20Suicide%20Prevention%20Leadership%20and%20Support%20Program%20-%20PHN%20Resource.pdf)

²⁸ Australian Government, Grant Connect, 2019, <https://www.grants.gov.au/?event=public.GO.show&GOUUID=67F887D9-DCDB-B99A-8FDE7FD4B1D367D9>

²⁹ StandBy Support After Suicide, <http://standbysupport.com.au/>

³⁰ Australian Government, Productivity Commission, *Volume 2 – Draft Report – Productivity Commission*, 2019, <https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-volume2.docx>

³¹ Victorian Government, Royal Commission into Victoria's Mental Health System, *Royal Commission into Victoria's Mental Health System Interim Report*, 2019, https://rcvmhs.vic.gov.au/download_file/view_inline/2175

support for these programs cannot wait for the time it takes to undertake the recommended research. We propose that interim funding is allocated for the duration of the period during which studies are undertaken and until a report is available on the findings this research.

■ *Put more resources into suicide bereavement.*

Recommendation

26 Commit to ongoing Commonwealth funding to coordinate and provide postvention support services across Australia.

+ 7. CHANGE TO DEATH CERTIFICATE WORDING

Respondents noted that the wording on the death certificate is traumatising because the certificates report the methods of suicide in graphic detail.

■ *[We would like] Death Certificates to state [‘]passed away from suicide illness[’] and not state the exact way it occurred. I feel this [stating the details] is disgusting for families left behind to sort everything out and have to show this to multiple people and go through trauma each time.*

Recommendation

27 A request that in cases of suicide, death certificates report the cause of death as “suicide” (and this correlates with the established practise of not detailing methods of suicide in news reporting).

+ 8. CONCLUSION

The survey responses this report is based upon represents a broad view of the issues, concerns and ideas that we have experienced, as parents and grandparents who have lost loved ones to suicide. Our experiences and resultant views and recommendations concur with a wide body of evidence, some of which is referred to in this report. We strongly believe that the lived experience perspective provides invaluable information and insights into what is, and is not, working with Australia’s mental health care system. We believe, and hope, that the perspectives offered and recommendations made in this report can to contribute to plans to improve the Australia’s mental health system; a system that requires substantial cultural, structural and funding changes.

We would like an opportunity to discuss further our recommendations and invite you to contact us via the details provided below.

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APPENDIX A: SURVEY PRO FORMA QUESTIONS

1. Would you like to say who you are or remain anonymous? If you prefer to stay anonymous, leave this field blank, otherwise provide your full name from the electoral roll and your contact email (*optional*).
2. Please provide the following information if you are comfortable with sharing:
 - Your child's name and age at passing.
 - The State or Territory that you and/or your child live(d) in.
 - If you live in a regional or rural area.
3. How would you describe your experience with seeking support from any or all of the following: GP, public mental health services, private mental health clinician, helplines, school, other?
4. Do you think your experience with any or all of the above could have been improved upon? If so, how? (*Please name which service you are referring to.*)
5. How satisfied were you with the care your child received from public services prior to suicide? (*This includes public mental health, hospitals, emergency services, schools.*)

[Multiple choice: 1- very satisfied, 2- somewhat satisfied, 3- somewhat dissatisfied, 4- very dissatisfied, 5 – not applicable]

6. If very satisfied or somewhat satisfied, what do you feel was satisfactory about your experience?
7. If very dissatisfied or somewhat dissatisfied, what do you feel could have been improved upon?
8. How satisfied were you with the care your child received from community services prior to suicide? (*This includes helplines, charity and non-government organisations.*)

[Multiple choice: 1-very satisfied, 2- somewhat satisfied, 3- somewhat dissatisfied, 4- very dissatisfied, 5 – not applicable]

9. If very satisfied or somewhat satisfied, what do you feel was satisfactory about your experience?
10. If somewhat dissatisfied or very dissatisfied, what do you feel could have been improved upon?

11. Did your child have multiple issues relating to their mental health? How was this handled? How could this be improved?
12. Did your child experience disruptions to continuity of care due to staff turnover? If so, what impact did this have on your child? Do you have any suggestions as to how staff retention can be improved?
13. What was the experience with follow up care if your child had had contact with mental health services?
14. Was there any evidence of bullying involving your child? What was your experience in how this was managed? *(Please specify which services were involved.)*
15. What was your experience with being included in the care of your child by support services or organisations? *(Please specify which services were accessed.)* Could this have been improved upon and, if so, how?
16. Can you identify one factor that you believe would/could have saved your child from suicide?
17. What help or care did your child need that he/she didn't receive prior to his/her suicide?
18. What would an ideal response to suicidality look like to you?
19. In relation to suicide prevention, what do you want the government to do?
20. Given that it will take time for any changes to funding and service delivery to be implemented, is there anything that you think can be changed immediately to improve the way the mental health system works? *(i.e., strategies that do not require immediate financial or structural change.)*

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