



SUPPORT AFTER SUICIDE

**“We were fighting the system
as well as the illness”:**

Family perceptions of how Victoria
responds to people at risk of suicide
and their loved ones



**Jesuit
Social Services**
Building a Just Society

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We acknowledge the Traditional Custodians of all the lands on which Jesuit Social Services operates, and pay respect to their Elders past and present. We express our gratitude for their love and care of the land, rivers and seas.

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Who we are

Jesuit Social Services is a social change organisation working for more than 40 years to deliver practical support and advocate for improved policies to achieve strong, cohesive and vibrant communities where every individual can play their role and flourish.

We work to build a just society by promoting the health and wellbeing of disadvantaged people, families, and communities. We value all persons and seek to engage with them in a respectful way that acknowledges their experiences and skills and gives them the opportunity to harness their full potential.

As a social change organisation, we seek to *do* and to *influence* by working alongside people experiencing disadvantage and by advocating for systemic change. Our service delivery and advocacy focuses on the following areas:

- **Justice and crime prevention –**
people involved with the justice system
- **Mental health and wellbeing –**
people with multiple and complex needs and those affected by suicide, trauma and complex bereavement
- **Settlement and community building –**
recently arrived immigrants and refugees and disadvantaged communities
- **Education, training and employment –**
people with barriers to sustainable employment.
- **Gender Justice -**
providing leadership on the reduction of violence and other harmful behaviours prevalent among boys and men and building new approaches to improve their wellbeing and keep families and communities safe.
- **Ecological justice -**
inviting discussion on what practices, policies and actions can be taken within Australia to build an ecologically just society.

Warning about Content

We understand that some of the content in this report might be distressing for some readers. The following services provide support.

- If you are not in immediate danger but you need help, call **NURSE-ON-CALL** on **1300 60 60 24**.
- For crisis support contact the **Suiceline** on **1300 651 251** or **Lifeline** on **13 11 14**.
- If you are looking for a mental health service, visit betterhealth.vic.gov.au.
- **For situations that are harmful or life-threatening contact emergency services immediately on triple zero (000).**
- **Call Support After Suicide on (03) 9421 7640**
Email: aftersuicide@jss.org.au

Acknowledgements

This report would not have been possible without the 140-plus Victorians who allowed us to represent their experiences of Victoria's mental health system. Thank you for trusting us with your stories. Our special gratitude goes to Wendy, one of our family members at Support After Suicide, whose son took his own life. Her generous donation funded this research project. We express our heartfelt thanks to her.

The idea for this report began a couple of years ago with a chat at a team meeting. We were reflecting on the work we do at Support After Suicide and sharing our stories. We thought how wonderful it would be if we could share these stories with others outside the meeting room. We want people who are bereaved by the loss of a loved one to suicide to know they are not alone. We want to provide a platform for these stories in support of positive reform.

At Jesuit Social Services, our values are welcoming, discerning and courageous. We are welcoming, striving to form strong relationships with everyone with whom we work. We are discerning, reflecting on all we do. And we are courageous, standing up boldly to effect change.

We think this report represents these fundamental values.

We thank all our program participants for their support and encouragement, and we thank those who helped turn a chat over a cup of tea into a concrete piece of work that unites and lifts up the voices of family members who have lost a loved one to suicide.

Finally, we extend our deep gratitude to our supporters, donors, staff and volunteers who stand in solidarity alongside us, and alongside those with whom we work.

Defining Victoria's mental health system

Victoria's mental health system is complex. In fact, this is one of its features as described by our survey respondents. In this study, we applied a broad definition of the mental health system to avoid restricting the participants' descriptions of the services accessed. In this report, Victoria's mental health system encompasses any service that people attended in relation to mental health and suicide. Many of these services provide treatment for physical health concerns, but we were focussed on the extent to which they provided adequate assessment, prevention and treatment services for people with mental health issues who were at risk of suicide.

This included services that provided mental health support, such as a GP, psychologist or emergency department of a hospital, as well as broader health, social and community systems that people might have had contact with, such as Victoria Police and schools. Our definition includes Commonwealth-funded services. It is therefore broader than, but not inconsistent with, that used by the terms of reference of the Royal Commission into Victoria's Mental Health System outlined below:

Any mental health services that are funded (whether wholly or in part) by the Victorian government that support mental health and respond to mental illness. This includes clinical services delivered by area mental health services and community-based services that focus on activities and programs that help people manage their own recovery and maximise their participation in community life. It also includes consumer run services, forensic mental health services, as well as specialist mental health services¹.

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Executive Summary

“The system broke down at almost every turn. And so that leaves you with a feeling of great guilt that you didn’t manage to negotiate the system better and just deep hurt and despair that he was the victim of a very poor system.”

The grief and despair these words express, from a mother whose son took his own life aged 30, is why Jesuit Social Services has produced the current report *“We were fighting the system as well as the illness”: family perceptions of how Victoria responds to people at risk of suicide and their loved ones.*

Unfortunately, this mother’s experience was not an isolated one. In this report, her voice joins with more than 140 other Victorians who have lost a loved one to suicide and are now calling for significant change to Victoria’s mental health system.

Background

“Support After Suicide was one of the best places we found and still participate in, as understanding grief in this manner with a group of people who are in a similar place, really does help.” (Mother of son, 17)

Support After Suicide is a suicide bereavement counselling service established in 2004 and run by Jesuit Social Services. It currently works with about 1000 people each year.

As a result of its work with Victorians who are grieving the loss of a loved one to suicide, the psychologists and counsellors at Support After Suicide have heard both positive and negative experiences of Victoria’s mental health system. Over time, our counsellors noticed a pattern. Families told them over and over again that their loved ones had sought help from the system but had not received it. They told us that they felt the system had excluded them from care plans or had refused to share critical information about what was needed to keep their family member safe. Many families believed that if the mental health system had responded more effectively, the death may not have occurred. And after their

loved one died, they felt that the mental health services for themselves were not available or were inappropriate.

We understand that there are a range of contributing factors that may lead to someone taking their life. In this report, we focus on the mental health system and its failure to prevent suicide. We raise the voices of the loved ones left behind – these voices need to be part of the story.

As a result of these stories, Jesuit Social Services decided that we needed to support these family members to contribute to an important conversation about preventing suicide in Victoria – a conversation where those with experience of the mental health system are at the heart of the discussion.

Purpose of this report

This report explores the perspectives of family members of people in Victoria whose loved ones took their own lives. It describes how they viewed Victoria’s complex mental health system, both in how it responded to their loved one and to themselves.

The report has three research aims:

1. To identify family members’ perceptions of support provided by Victoria’s mental health system to a person before they died, and to identify any gaps in that support;
2. To identify what information, support and inclusion of family members was offered by Victoria’s mental health system so they could appropriately care for a person at risk of suicide, and identify any gaps in that support;
3. To identify what support was provided to family members after the death, and any gaps in that support.

Research process

We surveyed 142 former and current participants of Jesuit Social Services' Support After Suicide counselling service whose loved one had died between three months and five years previously. Each respondent refers to a unique suicide and no question was compulsory. As a result, different questions have different sample sizes. From this survey sample, 28 people were interviewed in depth to provide a rich qualitative insight on their perceptions of Victoria's mental health system.

Findings

Many family members reported their loved ones had been experiencing abusive events, such as family violence, abuse and neglect, and bullying. Bullying, especially at work, school or online, was associated with a concerning 41 per cent of the 142 suicides in our survey sample, as reported by a family member. More than one in five of those people who experienced bullying did not seek help, according to their loved one.

One third of the people who died were recently separated from their partner. A large majority (89%) of people who ended their lives had a mental illness, as identified by their family member. About half (47%) were experiencing either unemployment and/or financial stress, and one half (47%) were known to have attempted suicide in the past. Almost 70 per cent of those who took their own lives had previously sought help from a health professional, most commonly a GP. Many made several attempts to seek help.

1. Family perspectives of services provided to the person who died

“Over the journey it was pretty much a token service. I don't honestly believe that the public health system has enough resources to actually be serious about what they want to do.” (Mother of daughter, 29)

The 142 people represented in our survey who took their own lives had accessed services 3.5 times before their death (ranging from none to 11 times). Almost 20 per cent of men did not access services at all before they died, while 10 per cent of women accessed no services.

Family members expressed mixed views on the quality of services provided to their loved one. Public psychiatric hospitals, Victoria Police, public psychiatrists, hospital emergency departments and Crisis Assessment and Treatment (CAT) teams received the most “poor or very poor” ratings in percentage terms, while private general hospitals, relationship counsellors, GPs and private psychiatric hospitals received the most “good to very good” ratings. It should be noted that the services that received the lowest ratings were also those most likely to be encountering people in acute or crisis situations.

In interviews, 27 of 28 family members expressed concerns that mental health professionals did not appear to have the skills to recognise that their loved one was at risk of suicide or to complete an adequate treatment plan. Five family members reported positive experiences with the mental health system, specifically in their dealings with the CAT teams, Victoria Police, psychologists and psychiatrists. Nineteen family members reported repeated negative experiences across one or more of the five following areas:

- Admission and discharge from hospitals or psychiatric units
- Support and treatment while in care, including communication between services
- Follow-up care and support
- Staff skills and knowledge
- Medication error or misunderstanding of medication.

2. Family perspectives on support to help them care for their loved one

“... the family is totally ignorant. We were ignorant because they wouldn't tell us anything. But you are also ignorant of what to do ... we don't know our way around a health service.” (Mother of son, 17)

“I tried to get help for my daughter ... but they would not speak with me because of privacy, which means their service is just about useless. How can an acutely unwell or medicated person speak for themselves?” (Mother of daughter, late 20s)

Seventy-nine per cent of the 142 family members surveyed said they felt the mental health system put up barriers to accessing information or help in caring for their family member. More than half stated that health professionals cited privacy as the reason for excluding families while more than one quarter said they were not told of their loved one's level of suicide risk.

Of the 545 individual services accessed by a family member (many people accessed more than one service), no information or support was received on 375 (68%) of those occasions. For those who did receive support, responses were mixed. For example, of the 85 family members who visited a GP, 63.5 per cent reported they received no information or help relevant to the care of their loved one. Consistent with this finding, of 50 family members who approached a hospital emergency department, almost 63 per cent said they received no information or support and were excluded from the care of their loved one.

Every one of the 28 family members interviewed identified at least two ways they felt the mental health system failed in helping them provide the best care for their loved one. Families also consistently reported that they found the mental health system complex and difficult to negotiate, and several felt this factor alone put their loved one at risk of substandard care.

Twenty-seven of the 28 family members interviewed told us they were often left uninformed or under-informed about how best to care for their loved one, even when the mental health system had diagnosed them with a psychiatric illness or identified them as being at risk of suicide.

Some family members felt the system treated them as playing no role in the care of a suicidal person, even when they were the primary carer or had the most significant relationship with them.

Family members reported that:

1. They did not know how to navigate the mental health system
2. They felt elements of the mental health system did not listen to them
3. They felt they were not supported in caring for their loved one
4. They experienced negative attitudes
5. They felt they were not informed about their loved one's care, especially in relation to diagnosis, treatment plans and/or discharge.

Some family members were concerned that a seriously ill person was being released into their care. They felt that while they were loving family members, they lacked professional skills and so felt unsupported and uninformed in caring adequately for their loved one.

3. Services provided to family members after death

“There is not a lot of support for parents of children who have suicided ... I was shunned and seen as an object of pity. Not many people knew what to do or say to me. There is little information about the traumatic grief that occurs, its effects and what to expect.” (Mother of son, 20s)

Prior to contact with Support After Suicide, families reported difficulties accessing information and support. Overall, 80 per cent

of the 129 family members who responded had been offered some kind of help after a loved one took their own life. They reached out commonly to GPs (who mostly offered condolences), and psychologists (who mostly offered a meeting), as well as Victoria Police. Other services contacted were: psychiatrists, welfare agencies, hospital emergency departments, telephone crisis lines, relationship counsellors, community health centres, the CAT team, drug and alcohol counsellors, and a school counsellor.

Twelve of the 28 family members interviewed highlighted how a lack of support in the time after their loved one's death contributed to a decline in their own mental health. Thirteen family members told us services were available but not helpful. Eight told us services for family members were not available at all, while six reported a positive experience with post-suicide support services. All 28 reported that services such as Jesuit Social Services' Support After Suicide program were helpful.

Implications and next steps

The findings from our survey and interviews suggest the mental health system is not providing the level of service required to move people away from suicide. The report also highlights systemic problems that result in the exclusion of family members from knowing about a loved one's mental state.

Four significant implications for Victoria's mental health system arise from the report:

1. There may have been situations where weaknesses in Victoria's mental health system failed to prevent a person taking their own life
2. These weaknesses may still be affecting Victorians currently at risk of suicide
3. There may be Victorian families currently feeling a lack of confidence to advocate for their loved one in the mental health system because they don't feel supported or informed enough to do so

4. There may be hundreds of family members currently not receiving the support and information they need as they experience the significant grief and trauma that comes when a loved one takes their own life.

Jesuit Social Services envisions a simpler and more family and person-centred mental health system, where people at risk of suicide and their family members are communicated with respectfully and in a way that preserves their human dignity. Family members and carers must receive support and be informed of strategies to reduce the risk of suicide occurring.

As importantly, the needs of families bereaved by the suicide of a loved one can no longer be overlooked. They should be referred to post-suicide support services – and those services need to be properly funded.

It is time for the family members of people who have taken their lives to be allowed to join the conversation about how to make Victoria's mental health system as strong and as effective as it can be.

We need a well-functioning mental health system that truly meets the needs of those at risk of ending their lives and supports families in helping them reduce the risk of suicide occurring.

With this in mind, we make the following ten recommendations, derived from the experiences of family members who participated in our study and by Jesuit Social Services' own professional practice and insights.

RECOMMENDATIONS:

The safety and care of people at risk of suicide must be at the heart of any response. To achieve this, we recommend:

1. More training, resources and targeted support for health practitioners to extend their knowledge and skills in relation to conducting risk assessments, and caring for and supporting people at risk of suicide.
 2. Ensuring the outcome of risk assessments results in an appropriate level of care that is also communicated to family members and primary carers.
 3. Strengthening community responses to ensure an integrated continuum of care for people at risk of suicide that matches their clinical need. More responsive and accessible care in the community would provide more appropriate responses for people at risk of suicide and reduce pressure on emergency care settings. Such responses might include:
 - a. Welcoming and easily accessible entry points to mental health support services across the spectrum of response – prevention, early intervention and treatment. Such a model, which might be an expansion of current community health centres, must be effectively promoted, be co-designed with people with lived experience, and may include:
 - i. immediate crisis support and coordination of longer term support, including assessment and triage with multiple agencies
 - ii. risk and needs assessments and direct assistance, including GPs, counselling and case coordination for people at risk of suicide and their carers
 - b. Therapeutic residential care for people who are at risk of suicide and in need of intensive treatment and support. Such care would provide relationship-based support and counselling and connect to family and peer support.
- Families must be empowered and supported to advocate for loved ones at risk of suicide and, wherever appropriate, to be involved in treatment and support decisions. To achieve this, we recommend:**
4. A review of how confidentiality practices and protocols may be preventing professional staff from providing families with information and guidance on appropriate care, and may also prevent families from providing relevant information to professional staff. Any review must include a consideration of how these barriers might be overcome.

5. Specialised training for mental health and other health practitioners working with people at risk of suicide to ensure families form part of a holistic and continuing care response team and are not inadvertently excluded due to misunderstandings of existing privacy legislation. Recent training initiatives related to family violence and child information sharing schemes, as recommended by the Royal Commission into Family Violence, could serve as useful models in this regard.

Suicide-bereaved people are at a higher risk of suicide themselves and can experience complex grief and trauma. To support them, we recommend:

6. That the Victorian Government provide secure, long-term funding for statewide post-suicide services for suicide bereavement, including the Support After Suicide service provided by Jesuit Social Services. This would also include increased access to suicide bereavement services for people in regional and rural areas.
7. That the Federal Government increase its current funding to Support After Suicide and streamline funding arrangements.
8. Establishing consistent reporting and evaluation requirements across Primary Health Networks, as recommended by the Productivity Commission. Jesuit Social Services has built strong relationships with the various Primary Health Networks (PHNs) that fund Support After Suicide to deliver services in Victoria. The PHN model works well to enable organisations to deliver key services to meet local

needs. However, each PHN has different reporting and evaluation requirements, which places a sizable administrative burden on Support After Suicide. Consistent reporting requirements across different PHNs would help ensure greater efficiency for service providers with limited resources as well as comparable data across PHN catchments.

Any system that seeks to intervene in a person's health care must be underpinned by a strong evidence base. To help achieve this we recommend the Victorian Government provide dedicated funding to develop an evidence base on:

9. The impact and the effectiveness of suicide prevention and intervention services in the Australian and Victorian contexts.
10. The impact of suicide and the effectiveness of post-suicide services in the Australian and Victorian contexts.

Introduction

More than 700 Victorians take their own lives each year. Every life lost is a tragedy that brings deep grief to the people who loved them and starts a wave of sadness that moves through families, friends, workplaces and communities. For family members there is the loss that comes with the death of any person who is loved. But when death comes by suicide, they are also often filled with feelings of guilt and anguish and a sense of responsibility. Families who have had contact with Victoria's mental health system before a suicide are left with many questions. Did the mental health system provide enough care for my child, my sibling, my partner to get the help they needed? Would better care have made a difference?

Suicide is complex, with no single cause. We know that family violence, child abuse, bullying, drug and alcohol use, mental illness, discrimination and stigma are risk factors. We know that some people who contemplate ending their lives feel too ashamed or embarrassed to ask for help. For many, suicidal feelings are taboo and can trigger fears of being shunned or stigmatised or being seen as a personal failure. Stigma and feelings of shame can also extend to family members who are grieving the loss of a loved one through suicide yet may face a wall of silence and awkwardness from others who don't know how to respond.

In 2004, Jesuit Social Services began supporting people whose loved ones had died by suicide. Our Support After Suicide program offers counselling, group work, peer support and online support – all provided by psychologists, social workers and counsellors. In 2018, we helped more than 1000 adults, young people and children who were bereaved by suicide. In the past 15 years, we have helped thousands of Victorians respond to the trauma of a loved one's death by suicide and are one of the few services in Victoria to do so.

Our work involves conversations and counselling with family members, and over the years we began to notice a pattern. **Families told us over and over again that their loved ones had sought help from the mental health system but had not received it.** Families told us they had directly warned mental health staff their loved one was at risk of suicide but were ignored or had their concerns dismissed.

They told us the system had excluded them from care plans or had refused to share critical information about what was needed to keep their family member safe from suicide. They told us they believed that if the mental health system had responded more effectively the death may not have occurred. And after the person had died, they told us they were not told what mental health services were available.

We understand that there are a range of contributing factors that may lead to someone taking their life. In this report, we focus on the mental health system and its failure to prevent suicide. We raise the voices of the loved ones left behind – these voices need to be part of the story.

There is a perception among some in the community that people who ended their own lives were intent on doing so and that no help or intervention would have or could have prevented it – that it was somehow inevitable. This perception is not true. Timely and effective interventions do help people move away from suicide. Experts consider suicide a preventable death. **That is why, when our families told us over and over again their individual stories of asking for help that came too late or not at all, despite specific requests, we knew we had to act.**

As a result of these conversations, we decided there was an urgent need to describe the experiences of families, to give them the voice they felt they did not have, to corroborate their experiences and to empower other people to advocate for their loved ones' health care. This need has resulted in the present study "*We were fighting the system as well as the illness*": family perceptions of how Victoria responds to people at risk of suicide and their loved ones.

We understand that some of the stories and case studies in this report might upset some readers. All case studies are de-identified (names have been changed). For many family members, this is the first time they have told their story outside the safety of a counselling session. They have been included with their permission, in the hope that they help the community and decision-makers understand the personal pain that sits behind the statistics, and motivate them to change things for the better.

Chapter 1: Suicide in Victoria

1.1 Current Situation

1.1.1 Prevalence of suicide

In 2018, 720 Victorians took their own lives² while more than 7000 were admitted to hospital for self-harm³. According to the Australian Bureau of Statistics, the current rate of suicide in Victoria is 9.1/100,000 people.⁴

On the assumption accepted by the Royal Commission into Victoria's Mental Health System that every suicide touches 135 people, including family members, friends and colleagues, up to 97,000 Victorians are impacted every year by the suicide of someone they know. Suicide rates are higher among men, while a higher rate of women attempt suicide⁵. The average annual suicide rate in almost all age groups for males was notably higher for those who reside in regional Victoria than in metropolitan Melbourne.⁶

1.1.2 Current research

Most suicide research necessarily centres on people who have attempted suicide rather than on the situation where someone has died. Nevertheless, attempted suicide studies offer some insight into systemic issues.

Hunt et al (2009) reported from the UK that 43 per cent of suicides among 238 psychiatric patients discharged from hospital or a mental health facility occurred within a month of discharge, with 47 per cent of those occurring before the person's first follow-up appointment.⁷ Stokes (2012) reported that people admitted to hospital in Western Australia for self-injury were 20 times more likely to eventually die by suicide, while a failure to provide outpatient follow-up care after a suicide attempt is associated with a subsequent attempt and eventual suicide.⁸ Further, failure to provide outpatient follow-up care after a suicide attempt was associated with a subsequent attempt and death through suicide.⁹ Consequently, intensive support is most critical in the time immediately after discharge from a mental health facility.

Similarly, Defayatte et al (2019)¹⁰ reported in a cohort of 13 to 18-year-olds who had attempted suicide, that a younger age at first attempt and lack of mental health treatment afterwards were associated with multiple attempts. These findings highlight the importance of mental health interventions and parental psychosocial education among at-risk adolescents after a suicide attempt.

Not every person who takes their own life has a diagnosed mental illness – between 2009 and 2015 77 per cent of people in Victoria who died by suicide had a diagnosed (54%) or suspected (22%) mental illness.¹¹ This still leaves one in four people who did not have a mental illness. Mental illness is recognised as a risk factor, but it is not the only one, and might not even be present.

A research paper from the Australian Bureau of Statistics (2019) revealed that 63 per cent of those who took their own lives had at least one psychosocial risk factor, such as relationship difficulties and a history of self-harm.¹² Other studies show that people who take their lives, whether or not they have had a mental illness, are likely to be experiencing several risk factors at the time of their death. These include:

- Personal – concerns about difficulties with sexuality, isolation, abuse
- Interpersonal – family or partner conflict
- Situational – concerns with work, finances, legal issues, bullying, use of alcohol or other drugs¹³
- Exposure to suicide – for example, of a family member or close friend.¹⁴

There are also factors that reduce the risk of suicide, such as good mental health care, a safe and supportive school and community, and connectedness to family, community, and social institutions.¹⁵

Studies of patient and family perspectives of mental health services are scant. In a national online survey of 112 people who had attempted suicide or had cared for someone who had

attempted suicide, less than half (47%) felt that the help they were offered immediately after the most recent suicide attempt was adequate¹⁶.

Reasons for dissatisfaction included poor staff attitudes towards the patient, time-poor staff, inadequate staff knowledge about suicide, being discharged too rapidly, not being followed up after discharge from hospital, and not having their emotional distress attended to. In addition, a majority of caregivers of people who had attempted suicide said they had received inappropriate information on the condition of their loved one, on treatment options, the likely effects of treatment and updates on treatment progress. More than half of caregivers said they were given no information about their loved one's care. Victorian Department of Health and Human Services data measuring patient and family satisfaction across mental health services shows 82.5% reported they usually (20.6%) or always (61.9%) had opportunities for family and carers to be involved in their treatment or care if they wanted¹⁷. 63.4 per cent of people with a mental illness reported a care plan developed with them that considered all their needs was very good (23.3%) or excellent (40.1%)¹⁸. However, it should be noted these findings refer to all mental illnesses, not only for people contemplating suicide.

Despite these contributions to the literature, there remains little research on the quality of services for those who subsequently died by suicide, and an understanding of how the mental health system functioned for them. The Royal Commission into Victoria's Mental Health System heard evidence that about 60 per cent of people who died by suicide had contact with a public or private health service for mental-health related problems in the preceding 12 months, and about 50 per cent had contact with a health service in the six weeks preceding death. These included GPs, hospital emergency departments, psychologists and psychiatrists or other mental health practitioners.¹⁹

We know that people bereaved by suicide are themselves at a higher risk of suicide, are more likely to experience adverse effects on mental health and wellbeing, and experience higher rates of disruption to functioning, such as in employment and community engagement²⁰. There is also limited information on the help that family members receive to support their loved one and prevent the death from occurring, as well as the support they receive after the death to manage their grief and adjust to their lives without their partner, child, parent, sibling or friend. This study aims to help fill these gaps.



1.2 Public health policy response

Suicide is a significant public health issue for both State and Federal Governments. Victoria's Suicide Prevention Framework 2016-2025 (the framework), which is part of Victoria's Ten-Year Mental Health Plan, aims to halve Victoria's suicide rate by 2025, investing an initial \$27 million from 2016/17 to 2019/20 to test an integrated "systems approach" recommended by the National Mental Health Commission. One of the framework's principles for preventing suicide includes codesigning services and systems in partnership with people who have experience of suicide attempts or who have been bereaved.

The plan sets out five objectives to achieve this goal, three of which relate to this report:

1. Care for the suicidal person
2. Learn what works best
3. Help local communities prevent suicide.

The framework's approach includes "assertive outreach" for people who have attempted suicide in the short period after leaving a hospital emergency department or mental health facility, as well as place-based community programs to improve overall resilience and a Centre for Mental Health Workforce Development. In 2018/2019 the Victorian Government funded six hospital emergency department hubs across the state for people with urgent mental health and alcohol and other drug issues. It also funded the Hospital Outreach Post-suicidal Engagement (HOPE) program, first in six health services, and now expanded to twelve.

This suicide prevention work links with other public policy reforms, especially in the delivery of universal services and systems of support. These areas include the Royal Commission into Family Violence, the Roadmap for Reform: Strong Families, Safe Children, the Education State and closing the gap in Aboriginal and Torres Strait Islander life outcomes.

The Victorian Government, with the Australian Government and other State and Territory Governments, also approved the fifth national mental health and suicide prevention plan in August 2017. The plan's implementation strategy is due to be endorsed by all governments in 2020.

Also, in the Federal sphere, the Productivity Commission's draft report into mental health calls for a "generational shift" in how Australia thinks about mental health and long-term system reform, finding that the mental health system is largely "tacked onto" a system designed to treat physical ailments²¹. Preliminary recommendations include:

- prevention and early intervention for mental illness and suicide attempts
- closing of critical gaps in healthcare services, including lack of critical care beds and 24-hour services
- investment in services beyond health, such as housing
- assistance for people with mental illness to get into work and enable early treatment of work-related mental illness
- fundamental reform to care coordination, governance and funding arrangements.²²

At the time of publication, the Productivity Commission's work was still in progress.

Finally, the Royal Commission into Victoria's Mental Health System is investigating, as part of its broader remit, how suicide prevention and support services function in Victoria. More than one-third (37%) of 3267 submissions to the Royal Commission addressed suicide prevention.²³

1.3 Current support for people bereaved by suicide – Jesuit Social Services’ Support after Suicide

Support After Suicide (www.supportaftersuicide.org.au) began in 2004 in Melbourne. It is based on Jesuit Social Services’ Our Way of Working practice framework, which underpins all the work we do with individuals and communities. Support After Suicide provides counselling, support groups and online resources to assist children, young people and adults bereaved by suicide. It also trains health, welfare and education workers. The team comprises psychologists, social workers and peer support volunteers whose day-to-day work focuses on preventing suicide among the bereaved by supporting their mental health and grief and re-engagement with the community. It provides services in Richmond, Epping, Sunshine, Dandenong, Frankston, Mornington, Wantirna, the Melbourne CBD and Geelong, and also offers counselling by phone or Skype to people living in rural and regional areas.

Support After Suicide helps more than 1000 people each year. It is one of the few services in Victoria to support those bereaved by suicide.

Support After Suicide was one of the best places we’ve found and still participate in, as understanding grief in this manner with a group of people who are in a similar place really does help. This service could be expanded as it is a real benefit to what is already an awful experience. (Mother of son, 17)

There are so many questions when a family member suicides. I tended to withdraw from everyone, although I tried to support my husband and children. I received my support through the Support After Suicide Program and only wish more families could receive the same. (Mother of son, late 20s)

Support After Suicide and Victoria Police were my saviours. Thanks to VicPol for the SAS referral. (Partner of male, 30s)

Support After Suicide plays such a huge role for the survivors. I wouldn’t even know where I would be. I don’t know what I would have done without having that place, or a space that was created for people to go to, and if they have questions, and for someone to listen. I think it would not be very good. You’d probably have a lot more people taking their own lives. Because we all understand now, when a loved one does take their lives and how that ripple effect can trigger other people. (Female partner of male aged 44)

While half of its referrals come from Victoria Police, Support After Suicide remains significantly underfunded and does not have the resources to meet the current need for support, especially in rural or regional Victoria. It is currently funded by the Commonwealth Department of Health through the Primary Health Networks. The program receives no State Government funding and there is a lack of certainty regarding ongoing Federal Government funding.

Jesuit Social Services endorses the comments of the Royal Commission into Victoria’s Mental Health System that there is a need for more post-suicide services so people significantly affected by the loss and grief of a loved one’s suicide are properly supported.²⁴

Support After Suicide: our approach to healing for individuals

Counselling

Experienced counsellors with expertise in grief, trauma and suicide assist the bereaved to learn to manage the intense and complex experience of losing a loved one to suicide. Sessions can provide a greater understanding of people's experiences and those issues unique to their situation. Counsellors meet with children, young people and adults individually or together for counselling. Information and resources are also provided.

Group Programs

Many people benefit from being in a support group with others bereaved by suicide. The program conducts several groups each year for those recently bereaved and provides specific programs for children, young people, parents, partners, siblings, adult children and men.

Eight-Week Support Group

This group is for those who have been bereaved between three months and two years. It is a small group meeting in a confidential environment. Participants may be parents, partners, siblings, adult children or friends of the one who has died.

'Serious Fun' - An Activity Day for Suicide Bereaved Children

This program runs in the school holidays. Primary-school-aged children can:

- Get to know others who have also lost someone significant to suicide
- See how other children have been going and have been feeling
- Learn different ways to act and talk about what has happened.

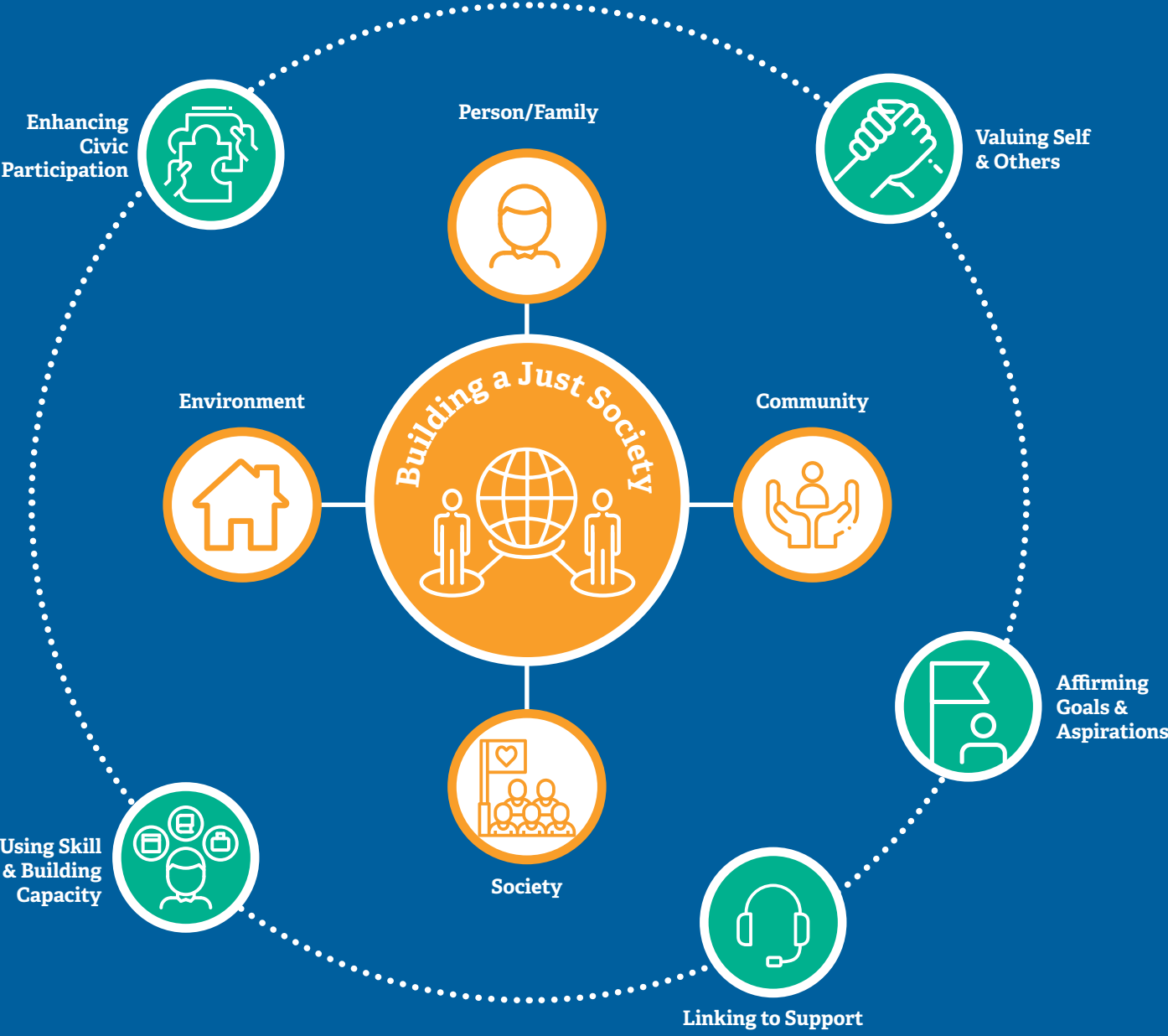
Young People

Support After Suicide has developed a program specifically for young people. The program includes adventure camps and other activities.

Supervisory and Secondary Consultation

Consulting with other professionals who are helping those bereaved by suicide. This can be face-to-face meetings, or telephone and Zoom consultations.

Building a Just Society



Jesuit Social Services Practice Framework: Our Way of Working

Our Way of Working underpins all Jesuit Social Services doing and influencing work with individuals and communities. The framework speaks to the inherent humanity of each individual and every community, and their capacity to envisage and achieve a more positive and engaged future, no matter their current circumstances. It articulates the dynamic interplay of five components, which work together to help people reach their full potential and become active participants in their communities.

The five domains in the *Our Way of Working* framework

- **Valuing self and others:** practising and encouraging respect so that those with whom we work enhance their capacity to establish and maintain meaningful and respectful relationships in their personal lives and respect for the environment, recognising the interconnectedness of all life.
- **Affirming goals and aspirations:** engendering hope through envisioning new futures and the establishment of supportive and reciprocal relationships. Accompanying people as they explore new ways of working collaboratively and sustainably.
- **Linking individuals and communities to relevant supports:** assisting people to realise their potential, to improve their mental, physical and emotional health, and to remove the barriers they face in achieving social and economic inclusion through access to services, supports and resources.
- **Using skills and building capacity:** delivering education, training and therapeutic programs that develop living skills and improve pathways to further education and employment, and by working collaboratively with communities to build social cohesion and shared outcomes.
- **Enhancing civic participation:** where individuals and communities build 'communities of justice' and exercise their right and responsibility to create a just, inclusive and sustainable world.

Our vision of building a just society is central to *Our Way of Working*. The fifth domain in the framework, enhancing civic participation, reflects our understanding that it is through relationships and participation that people are most fulfilled, are able to create shared futures, and become active players in advancing a just society; a society where the answers to environmental and social concerns are inextricably linked through ecological justice.

Chapter 2: Background

2.1 Purpose of this report

We want to contribute to an important conversation about preventing suicide in Victoria – one where the experiences of those most affected by the system are at the heart of the discussion.

This study will not cast blame upon any particular organisation or group of individuals and seeks to record positive and negative experiences. This issue is bigger than any specific service delivery unit. The purpose of the research is to examine the barriers to, and facilitators of, care for people contemplating suicide and then use this information to determine how the whole mental health system might be improved to prevent loss of life through suicide. We hope this report inspires effective and ongoing consultation with the families of people who have ended their lives in order to improve the mental health system so more lives might be saved, and other families need not experience the same devastating loss.

2.2 Research aims

1. To identify family perceptions of support provided by Victoria's mental health system to a person before they died, and to identify any gaps in that support;
2. To identify what information, support and inclusion of family members Victoria's mental health system offered so that family members could appropriately care for a person at risk of suicide, and identify any gaps in that support;
3. To identify what support was provided to family members after the death, and any gaps in that support.

2.3 Methods

In January 2019 an online survey was sent to 491 former and current participants of Jesuit Social Services' Support After Suicide service whose sibling, partner or child had ended their own life in Victoria between three months and five years previously. Those invited to participate in the survey were over 18 years, able to provide informed consent and not currently affected by mental health issues.

Of those invited, a self-selected sample of 146 completed the survey between April and May (71 parents, 46 partners, 22 siblings, four children, two friends, one adult child). Where more than one respondent referred to the same person, the more complete of the two records was used for the study and the other excluded. Two respondents were friends rather than family members but were not excluded because of their intimate care relationship with the person who had taken their life. Using this approach, 142 responses were analysed, each referring to a unique suicide. Respondents were not required to answer every question. This means particular research questions may vary in the number of respondents. Eighty-four per cent of respondents were female. Sixty-one per cent were between the ages of 45 and 64. In total, 86 per cent of respondents lived in Melbourne, while the remainder lived in regional or rural Victoria. Four respondents lived interstate, though they were living in Victoria when their family member died.

Ninety-six survey respondents agreed to also participate in in-depth semi-structured interviews designed to elicit more detail on the three research aims. Purposive sampling was then used to select 28 participants (22 parents, five partners and one sibling) from this group to ensure the cohort included male and female family members and parents, partners and siblings. The sample included participants who had both positive and negative experiences with the mental health system to explore the breadth of quality of care. Their responses to the online survey provided the basis for this sampling.

Interviews were between 40 and 60 minutes and enabled us to explore in more depth some of the experiences that families had with Victoria's mental health system. Interviews were conducted by a researcher with no prior professional relationship with the participant. Support After Suicide staff were available to participants after the interview. Interviews were content analysed for emerging themes. A conservative coding method was adopted, with a positive result entered only when an interviewee explicitly mentioned an issue or spontaneously identified a concern at least once.

Results are structured and reported separately under each research question, with survey responses described first, followed by more detailed insights gleaned from the 28 family interviews.

2.4 Defining Victoria's mental health system

Victoria's mental health system is complex. In fact, this is one of its features as described by our survey respondents. In this study, we applied a broad definition of the mental health system to avoid restricting the participants' descriptions of the services accessed.

In this report Victoria's mental health system encompasses any service that people attended in relation to mental health and suicide. Many of these services provide treatment for physical health concerns, but we were focussed on the extent to which they provided adequate assessment, prevention and treatment services for people with mental health problems who were at risk of suicide. This included services that provided mental health support, such as a GP, psychologist or emergency department of a hospital, as well as broader health, social and community systems that people might have had contact with, such as Victoria Police and schools. Our definition includes Commonwealth funded services. It is therefore broader than but

not inconsistent with that used by the terms of reference of the Royal Commission into Victoria's Mental Health System outlined below:

Any mental health services that are funded (whether wholly or in part) by the Victorian government that support mental health and respond to mental illness. This includes clinical services delivered by area mental health services and community-based services that focus on activities and programs that help people manage their own recovery and maximise their participation in community life. It also includes consumer run services, forensic mental health services, as well as specialist mental health services²⁵.

Chapter 3: Life circumstances of people who took their own lives

This chapter presents the demographic profiles and life circumstances of the 142 people who ended their lives, as reported by a surviving loved one.

Seventy-five per cent of people who took their lives were identified by family members as male, and 25 per cent as female, with one participant not responding. No family member described their loved one by another gender identity. Unfortunately, the high number of non-respondents to a question asking the age of their loved one at death meant an age distribution could not be described with confidence.

A little over nine per cent were identified as LGBTQIA+, while a further 8 per cent of family members said they did not know. Eighty-two per cent of the people who died were born in Australia, with one identifying as Aboriginal or Torres Strait Islander.

Hanging was the most common method of suicide, with 61 per cent of people using this method. Drug overdose was the next most common method (11%), followed by carbon monoxide poisoning (7%), jumping from a height (4%), suffocation, (3%), cutting (2%), and firearm, drowning and immolation (each 1%).

A significant majority (89%) of those people who ended their lives were reported by their loved ones as experiencing a mental illness, including depression (82% of those with a mental illness), anxiety (67% of those with a mental illness), borderline personality disorder (19% of those with a mental illness), and bipolar disorder and schizophrenia (both 11%).

It is important to note that the vast majority of those people who died were not identified as having either an alcohol or other drug dependence – only seven per cent were known to have problems with alcohol, while 14 per cent were identified as having a problem with illegal drug use.

Sixty per cent were not in a relationship, with one in five of the whole sample having recently separated from their partner. More than one quarter (28%) were described by their family

member as having no close friends, while 67 per cent did have a close social circle. Almost one in five (22%) of the total sample of 142 had experienced family violence (though it was not recorded if this was as a victim-survivor, bystander or as perpetrator). Forty-two per cent were under financial stress, while just under half of people (45%) were unemployed at the time of their death and almost a quarter (24%) were experiencing legal issues. Of the 34 people experiencing legal issues, half (18 people) involved police, including criminal charges, while six involved property or financial settlements, and four each involved fines and debt or child custody.

Forty-one per cent of those who died by suicide were reported by their loved ones to have experienced bullying or harassment. Of this 41 per cent, more than a third (36 per cent) were bullied in the workplace, 26 per cent were bullied at school and 12 per cent were bullied online.

One third of those who died (49 people) were reported to have experienced abuse or neglect, with 15 of those known to be recent experiences, though the term "recent" is undefined.

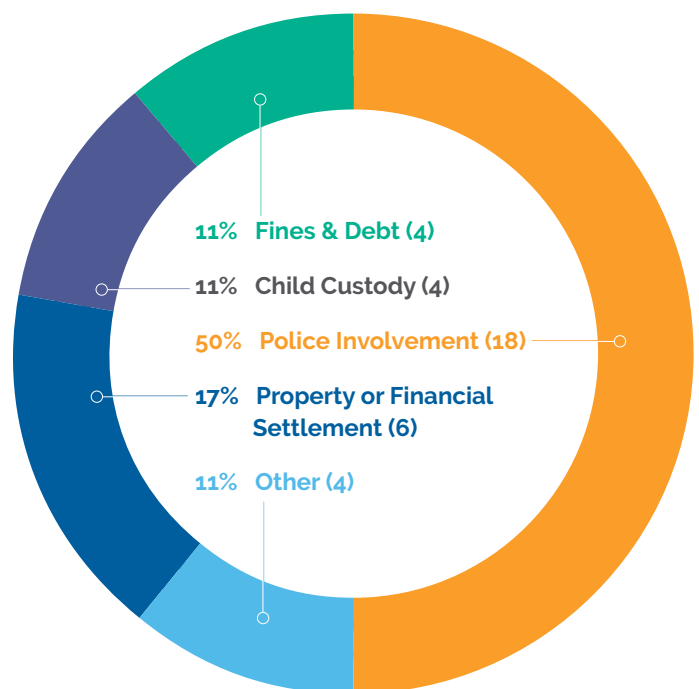


Figure 1: Types of legal issues named (n=34).

Did the person who died experience...

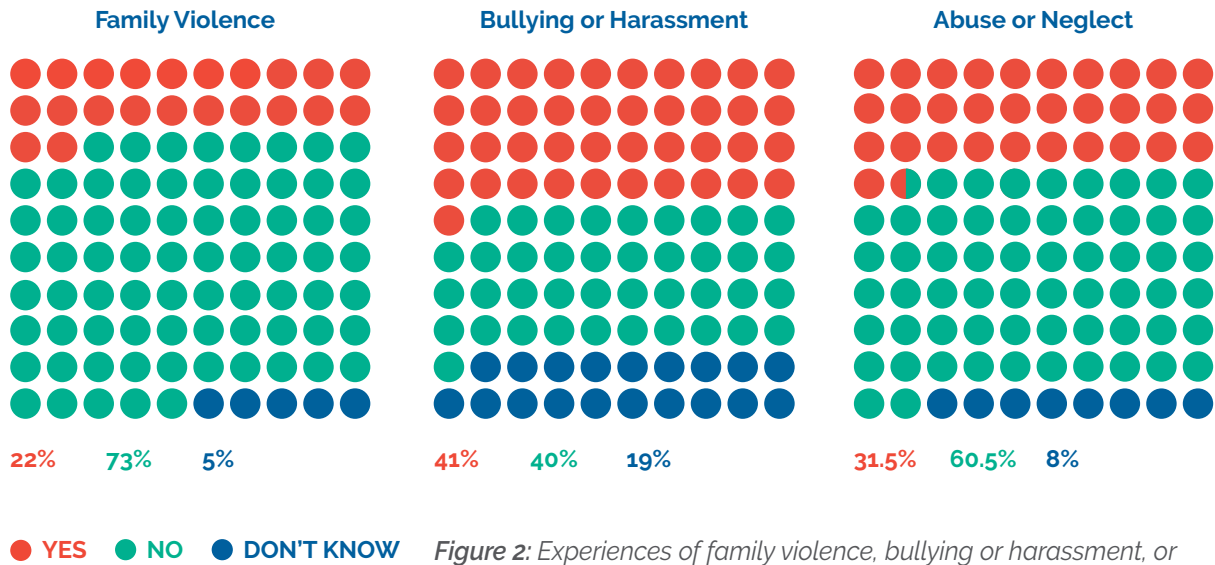


Figure 2: Experiences of family violence, bullying or harassment, or abuse or neglect among the people who died (n=142).

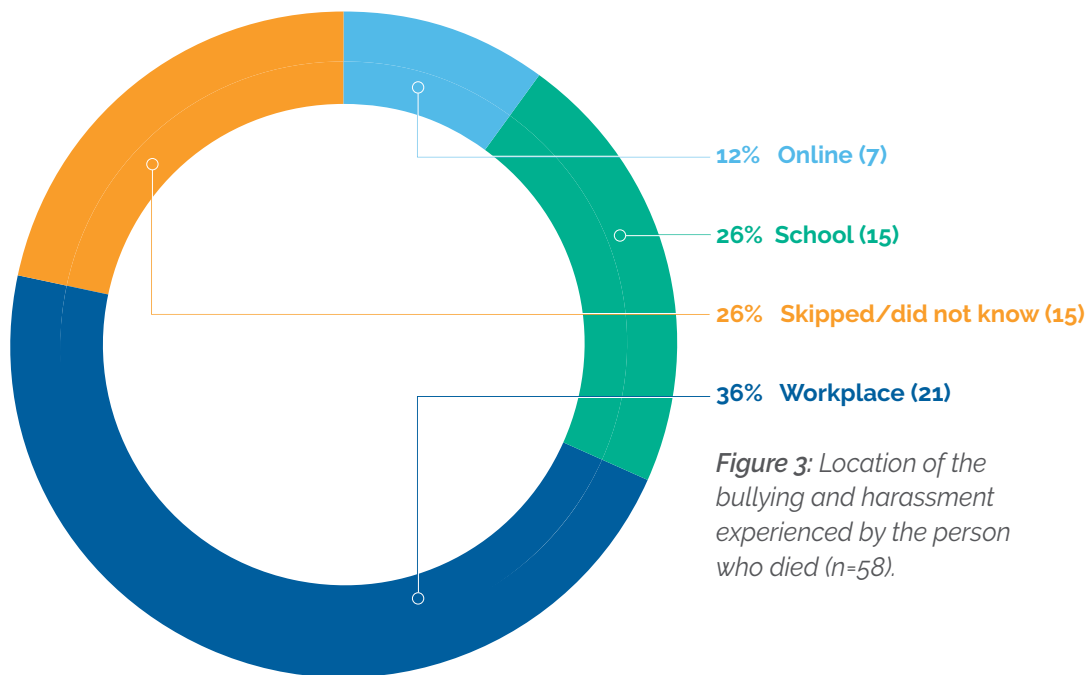


Figure 3: Location of the bullying and harassment experienced by the person who died (n=58).

Almost half (47%) of those people who took their lives were known to have attempted suicide in the past, while 15 per cent of respondents said they did not know. Equally of concern, 70 per cent of those who died had previously sought help from the mental health system, most commonly from a GP (67%), a psychologist (56%), or the emergency department of a hospital (33%). This figure is similar (71%) among those who were also reported to have had a mental illness. Those who had previously attempted suicide

were more likely to have sought help three or more times than people whose first known attempt ended in death. Seventy-two per cent of the 66 people who had previously attempted suicide accessed three to nine or more services, compared with 35 per cent of the 52 people for whom their first attempt ended in death.

This suggests at least some people knew they were at risk of self-harm and had expressly tried to arrange intervention by the mental health system to reduce their risk.

Case Studies

Elizabeth and Christopher

Helen and John

Greta and Cassandra

Caroline and David

Joanne and Max

Eleanor and Anthony



Elizabeth and Christopher, 18

(not their real names)

Christopher first became ill when he was 17. He presented to three different emergency departments over a few months. Each time they thought he was a drug addict, and they sedated him, and then sent him home.

We begged mental health services. We contacted the Crisis Assessment Team (CAT). They said, "We're frightened for our security, we're not coming". And we were, like, "What about us?"

It took until we were down at Mornington and he stole some alcohol and the police had him down there. By the following week he was admitted into the adolescent psychiatric hospital at a public hospital. He spent 59 days in that unit.

I think if he'd been able to get help earlier it would have been a much different outcome. He was on a really high dose of an antipsychotic drug. I didn't find out until after he passed away, but those drugs can make you quite suicidal. I didn't know that at the time he was taking them.

By the time he got into hospital he was so sick he never really came back. The person we got back was really a shell of the person he was.

Once he was discharged, they encouraged him to live with his dad because at the time he had this anti-me thing. Later he said, "I couldn't bear you to see me like that." This is a kid who'd gone from doing math methods in Year 11, doing really well at school, to jumping on the back on trains. It wasn't like him at all.

Once you turn 18, if you have to go to any sort of in-patient facility, you go to where everyone else goes. You're not with other people of your age, you're with people in their 40s, 50s and 60s. For an 18-year-old, that's a very difficult thing.

The night he went missing I rang the CAT team. We found him, an hour after he went missing, in the back yard. Three hours later I got a phone call back. What's the point of the crisis bit? It's so under-resourced and under-funded. It's not their fault. They're probably inundated and need another 10 workers.

I think the initial early assessment was the biggest problem. The first time he went to emergency, if he'd been properly assessed and had a psychiatrist come and review him, they would have found that there was a problem.

If you have a broken arm, you go to an ED and it gets treated. But when it comes to mental health we don't have that same sort of system.

Helen and John

(not their real names)

I became concerned about John in June 2017. He was obviously suffering from depression. He was involved in a business venture that was not going well. I asked him to go to the GP and the GP told him that it was natural he should feel sad.

They didn't give him medication, they just said, "You're fine." In July we were in the kitchen and he said, "I want to die." I said, "That's not good, that's not right." I got him to talk to a community mental health service and he didn't find it helpful.

I took him to another GP and got anti-depressants straight away. On the following Tuesday I got home and he wasn't there. I was worried. I rang the police and put in a report.

Then at 3am I got a message from him, saying, "I'm on my way home." He said he'd been in Yarra Glen and tried to kill himself. He was really sad and depressed. He just curled into a ball in the bed.

The next morning, I rang the Crisis Assessment Team (CAT). They came out, assessed his medication, [and] changed it.

He was getting more irrational. He wasn't eating and he wasn't drinking. The things he was saying were deluded, they didn't make sense. He wasn't looking after himself or interacting with anyone.

The CAT team would meet him but wouldn't talk to me. They didn't talk to me about my concerns or how they could help me help him. I was becoming increasingly frustrated with them.

I was saying to them, "I think he needs to be in hospital. He's getting worse, not better. I'm not making this up in order to get him out of the house. I just want him well. He's not well. He will kill himself."

"I felt like they thought I was hysterical. There wasn't any sense of being part of a team, you know, the family being supported.

On the Sunday morning he gave the kids a hug. He didn't hug me and he wouldn't look at me. And then he took his own life that night.

They should have listened. He should have been in hospital. I could have had him admitted if someone had said to me, "you don't need the CAT team to approve it." I didn't have a sense of what the options were.

The CAT team sent flowers. We met the head of the team and the psychiatrist that had seen him. I asked them what conversations had been had about my feedback, and why he was not in hospital, and what records did they keep of conversations and alerts by the family.

They didn't have any. They didn't come with anything other than a smile and a pat on the shoulder. I said, "I want you to go away and review it. Because he's dead. Your intervention did not work."

Greta and Cassandra, 35

(not their real names)

Cassandra was 35 when she died. When she was 15 years old, and overseas, she was raped; this at times made her mental health fragile, however, she had never been admitted to hospital. She had never been in hospital for anything. It was really in the last 12 days that she reached out for help.

She went to her GP and took a friend, who's a nurse, with her to make sure her GP understood the strength of her suicidal impulses. The Crisis Assessment Team (CAT) interviewed her over the phone, didn't see her face to face. That afternoon she attempted suicide – 12 days before she actually died and six days before she went into a private mental health clinic.

She had a great fear of being in a hospital psychiatric clinic. At the interview for the clinic, the psychiatrist assessed her as moderate to high long-term suicidal risk. The psychiatrist assured her she would not be put in intensive care, but she was.

She found her experience in ICU very disturbing. It undermined her trust in the clinic and the psychiatrist straight away. All the people around her were heavily medicated. She had all her possessions taken away from her, her clothes, wasn't allowed to write. She felt as though she'd lost all her agency.

Given the guidelines, the way medication was used in the clinic increased [her] risk of suicidality and impulsivity. It's a drug where people are meant to be closely medically monitored in the first month of administration. Because it was changed twice while she was in the clinic, the dosage, that increases all these risks.

Cassandra was in the clinic for only six days and tragically she took her life less than eight hours after being released. She did not see any doctor or psychiatrist before she was allowed to be discharged. There was no assertive or proactive after care. There was no care plan. She was driven home to an empty house by a friend. Her partner wasn't even there. When he did come

home, he left again; when he was rung by the clinic he hadn't been told that she was at risk. And then she took her life.

I've only learnt some things since the coronial inquiry. Two years after she died, in a meeting, I asked how could she be discharged with nothing put in place? When she'd been assessed as medium to high long-term risk of suiciding? Her psychiatrist said the clinic did not treat people who are suicidal. They treat depression. She explained if a patient was suicidal they would be sent elsewhere. Where? I don't know.

I've acknowledged the rage I feel inside me - it's not just grief and trauma. There's no acceptance of responsibility for her lack of treatment and care.

Joanne and Max, 17

(not their real names)

We are an average family. Max was home-schooled, had an active sports life and a strong family and friends around him. He was bright, funny and articulate. We moved from Sydney to Melbourne, where Max started high school. Things went well for two years, but then something happened that we know nothing about. Max didn't have his tight family group around him. He moved schools, where he got himself involved with the wrong people, and got in trouble doing typical adolescent acts. He was quickly shunted to a couple of different schools aimed at "problem" children. At one school he got into drugs. Ice. It was quite frightening when he was on ice – when the drugs came he changed.

Max started seeing a psychiatrist at 15 – one evening he told us he wanted to do more to himself so we took him to a children's hospital. He happily attended a program there for a year once a week. He got along really well with his person there – John* - but one day he was told he was OK and didn't need to come back. As his parents, we were told nothing – there was no consultation or discussion about how, or if, he was better. After this he started to go downhill. His behaviour became more erratic and he was using serious drugs.

Sixteen months after he first left the children's hospital program, we took him back to the same unit and John was shocked at how much he had changed. He was a different child. He told us he couldn't diagnose him as he was so messed up – but that he clearly had some form of psychosis. That was just three weeks before Max died.

In between those times, Max got in trouble with the law, but their way of treating him was different. People with a mental illness can turn to drugs to numb the pain, and then it gets out of control. I'm not condoning it, but it meant he was treated more like a criminal and a drug addict than a child with a serious mental illness. He ended up going into Parkville (Youth Justice Centre) at one stage – not for any serious crimes but because his rap sheet was so long. But he

was utterly in the wrong place. He was there when they had the riots and they had to rescue him – he was sitting in his room chanting the Lord's Prayer. We think that sent him downhill.

He wanted to be clean, to be well, to be on Centrelink or to go back to school. At one stage he had been clean for two months and only taking medication his psychiatrist had prescribed him. He was making plans – then the justice worker called and said he had to go to court. When he heard, he just sat on the couch talking to whoever was in his head. He was just too mentally ill, just not capable of fronting up to court. He became distraught because he thought he was making headway. People with mental illnesses aren't like you or me who have committed a crime – they need to be dealt with quite differently.

Max was admitted to a children's hospital psych unit but was kicked out twice. There was another child there with a mental illness who was talking incessantly, which bothered him. Apparently Max was being disruptive and threatening, and they were quite prepared to kick out a child who clearly had mental health issues on the street with nowhere else to go because he didn't fit their profile. One time he was kept in a psych unit over the weekend because the doctors weren't back until Monday. But he couldn't comprehend what was happening to him.

Another time he was in the adult centre of a major public hospital – locked in a room, heavily medicated, under guard for four days because he was a threat to himself and others. At no stage did any senior doctor see him or contact us. We spent a lot of time in these places with him because we didn't want him to be alone. In the end he was at home all the time – he felt safer and he wouldn't cooperate with medical staff.

I can't say there wasn't support but it was sporadic and disjointed. It was like he was in the too-hard basket – but he was a 16, 17-year-old child for heaven's sake. We were moved from pillar to post – every time we went somewhere there was another referral to a drug centre

or service. There was never a single place for him, and for us as parents, to get the help we needed as a family. And the waiting list was a massive obstacle – six to ten weeks. A child in crisis doesn't want to wait two minutes. It's all guesswork because you are moving between practitioners.

If you have got cancer you start with your GP and then move up to a series of specialists. You are moved quickly through that system. For mental health, you don't have that same linear movement. There are some very well-meaning people, but the system is broken for them, too. They are hamstrung by processes and structures and skills. They themselves don't know how to cope with this awful disease that is so rampant at the moment. I wonder: Does there need to be long-term comprehensive residential care for people like Max? Either way, Max's diagnosis never got done.

At the end of the day, we just weren't taken seriously. He tried to kill himself four times in two weeks. The first time I caught him just as he was setting up. I called the Crisis Assessment Team (CAT) and he told them he was all right, and they accepted that. But he was not all right. I would sit up all night watching and listening. I caught him the second time. The third time we took him to hospital overnight – and the next morning the psychiatrist said it would be best for him to go home again. We agreed because we thought he was right – he was the expert – and the next morning Max took his own life. His father found him.

No one from mental health or a medical field walked into my house. Ever. I've had the police here a lot, justice workers, but not one person from mental health, the CAT, the hospitals walked into my house and asked: "How is your son? Let's talk to him. What are we doing to help him get well?" I'd want to think someone made more of an effort. A police officer and one of the specialist officers came to Max's funeral – she and Max had a special little friendship – and the youth justice ladies. But from the mental health system? Nothing.

Max was a minor – 16, 17 – yet in the system he was able to make his own decisions and not have his parents involved in some of that. But for someone who was so unwell, he didn't know what to do with those choices. And I didn't know how to advocate for my child.

I wasn't given the opportunity. If I didn't think something was right I would have to find the answers myself. I had no advocate in the health system or the legal system. I was on my own, and I spent hours on the internet looking for how to get help. That is what we are intent on fixing. None of this will bring our son back, but we hope it will save another child.

Caroline and David, 17

(not their real names)

David was 17, and I was looking after him. The night before he died I didn't want him discharged. I told the private hospital psychiatrist I was afraid something terrible would happen. She told me I had to take him, that I was responsible for him. I was really worried, upset. And then something terrible did happen. He died the day I picked him up from hospital.

He had accessed supports. Emergency departments. Psychiatrists. A youth drug worker. GPs. Different hospitals. Sometimes it was a good experience. My GP, and the police and ambulance were fantastic. And sometimes, like the emergency departments (EDs), it was terrible. I was going to ED because I needed him to be admitted. I needed him to be safe. I just don't think they knew how to manage David. I work in an ED. I understand the pressures – but our presentations were life-threatening. I was astounded they could be so flippant about our concerns.

We had a good experience when the staff were compassionate, and not judgmental. When they listened to points of view, when we weren't being pushed out the door quickly and when they understood that we were in crisis and genuinely tried to find a solution. I don't think I ever felt confident about his management – apart from one psychiatrist who, when David was really bad, rang ahead to the ED and told them I was coming in with David and he needed to be admitted.

There were individuals within the system who supported David. But I just felt like the system was floundering. And that left me floundering, too.

I understand the privacy laws, but David was 17 when he died. He had quite a complex illness and was taking a lot of medication. He was making decisions unsupported by his family. Then he would be discharged into my care and I'd be told, "You've got to look after him." It was really distressing, and it happened often.

Improvements have to start with staff. David had an addiction issue – but there is no role for judgment. And the system needs to include family members, especially in younger people. We are there because we want to help – not to be shut out and then told to look after him with no information about how to do it.

Eleanor and Anthony, 26

(not their real names)

Anthony had a fear of people of a particular religious faith. He was holding down a good job, but the business was owned by people of that faith and he thought they were out to get him. He thought his father was part of the same gang.

Anthony had told me he was suicidal. You can't get any more blunt than that. His father was ringing hospitals trying to get help but was told he needed to go to a GP first. Anthony was suicidal right then – but no one told us we could bring him to the emergency department.

The GP, not being a psychologist, didn't venture into the world he was experiencing. He referred us and we saw a psychologist quite quickly. The psychologist was on to Anthony because he was very calm, guarded. He wouldn't start the conversation unless he knew about her background - would it be confidential and would she sign a document? She was fantastic, but she realised Anthony needed a psychiatrist (I spoke with her beforehand, but we had to go through the process with her first because he was so distrustful). A psychiatrist I had seen referred me to a colleague. It was January and everyone was on holidays, but she rang a few contacts direct. We couldn't use some psychiatrists because they were of that religious faith, so that made it more difficult.

Anthony only talked about suicide with me. His father knew, but Anthony never spoke with him. I spoke with the psychiatrist beforehand – but he also needed to speak with Anthony. It didn't even get that far because Anthony closed down the meeting. Like the psychologist, he asked the psychiatrist to sign a document promising confidentiality because he didn't trust him. The psychiatrist said he didn't need to sign a document because he had professional ethics. But Anthony was not convinced and left the room to “ring” two other psychiatrists. While he was out, the psychiatrist asked if we should ring the Crisis Assessment Team (CAT). But I didn't know what a CAT team was then.

I told the psychiatrist in front of Anthony that I was worried about him, but I didn't say too much because he was ready to do a runner. I asked if he wanted to go back to the psychologist because he had liked her. And the psychiatrist just let him go. When we left I was sobbing in the car, but he was calm, cool as a cucumber. He died that afternoon.

Later I called Anthony, but he said he was walking and hung up on me. So, his dad rang the CAT team. The CAT team had to ring the psychiatrist. The psychiatrist had to ring the CAT team back and by this time, when the CAT team spoke to Anthony, he was already at the railway station.

I respect the psychiatrist. He's good – just not the right fit for Anthony. I think Anthony had already made up his mind he was going to kill himself. The week before he paid me \$50 he owed me and cleaned up his rooms.

I was desperate. But no-one seemed to understand, or they were on holidays because it was January. If I hadn't called my own psychiatrist we wouldn't have got in. There was no support for his father and me. I told the medical people he was suicidal. His dad is ringing hospitals. No-one would take him on and no one would listen to us or give us information about what to do in a crisis. If he'd been taken somewhere they might have realised there was something very serious about this young man.

Chapter 4: Family members' perceptions of services provided to the person who died

4.1 Survey results

The average number of times a person accessed services before their death was 3.5 times (ranging from none to 11 times). On average, women accessed services 4.7 times before death while men accessed services on average three times before death. Almost 20 per cent of men did not access services at all before they died, while only 10 per cent of women accessed no services. Just under a third of women accessed between six and eight services compared with 12 per cent of men.

More women than men accessed services (90 per cent vs 60 per cent) and did so more often (about one third of women compared with about ten per cent of men). Though there were gender differences in the type of service accessed, sample sizes were too small to draw any definitive comparisons.

Overall, family members' views of the quality of services provided to their loved one was mixed. This is not surprising given the large number of individual practitioners and organisations in each service sector. For example, 61 per cent of the 61 family members who said their loved one had gone to a hospital emergency department described the service as "poor" or "very poor" quality, while 23 per cent of family members said the service was "good or very good". For the 103 family members who reported that their loved one sought help from a GP, 34 per cent said the service was "good or very good" and 43 per cent said the service was "poor or very poor".

Overall, public psychiatric hospitals, Victoria Police, public psychiatrists, hospital emergency departments and Crisis Assessment and Treatment teams received the most "poor or very poor" ratings in percentage terms, while private general hospitals, relationship counsellors, GPs and private psychiatric hospitals received the most "good to very good" ratings.

In interpreting the results, it should be remembered that service ratings are not strictly comparable because some services were accessed more often than others. It should also be noted that Victoria Police are not generally equipped to provide specific mental health services, and their presence might represent a misunderstanding of their role. Overall, those services recording lower satisfaction ratings were also more likely to be responding to patients with acute care needs, and this should be taken into account when interpreting the results.

Services	Very Poor or Poor		Neutral		Good or Very Good		# of Responses
GP	44	43%	24	23%	35	34%	103
Psychologist	36	46%	24	30%	19	24%	79
Hospital emergency department	37	61%	10	16%	14	23%	61
Psychiatrist - private	24	49%	11	22%	14	29%	49
Psychiatrist - public	29	64%	9	20%	7	16%	45
CAT team	26	60%	7	16%	10	23%	43
Psychiatric hospital - public	26	67%	5	13%	8	21%	39
General hospital - public	16	46%	15	43%	4	11%	35
Police	17	65%	3	12%	6	23%	26
Telephone crisis line	13	52%	6	24%	6	24%	25
Psychiatric hospital - private	10	48%	4	19%	7	33%	21
Drug and alcohol counsellor	7	37%	5	26%	7	37%	19
Welfare agency	9	50%	4	22%	5	28%	18
Relationship counsellor	6	38%	2	13%	8	50%	16
School counsellor	8	57%	1	7%	5	36%	14
General hospital - private	2	33%	1	17%	3	50%	6
Gambling counsellor	1	33%	2	67%	0	0%	3

Table 1: How family members perceived the quality of service interaction for the person who died (Percentages may not add to 100 due to rounding).

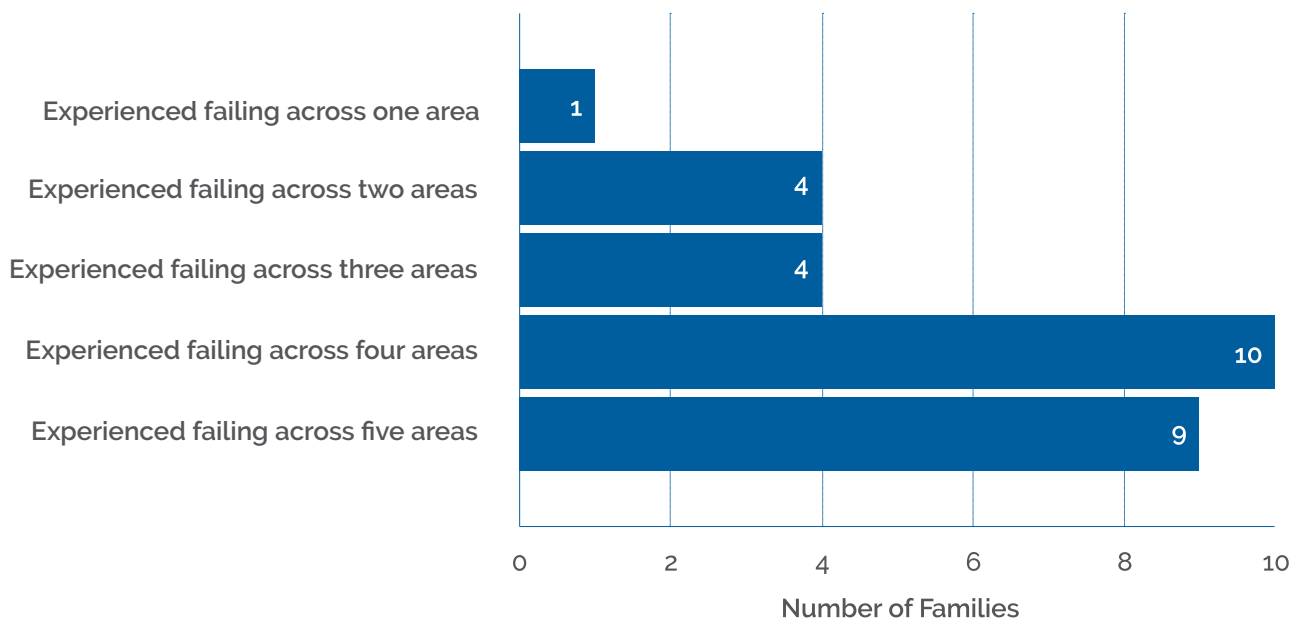


Figure 5: Family members reporting during interview two or more failings across the five areas (n=28)

4.2 Family interviews

In interviews, 27 of 28 family members expressed concerns that mental health professionals did not have the skills to recognise that their loved one was at risk of suicide or to complete an adequate treatment plan. Even where suicide was acknowledged as a risk, follow up was often perceived as inadequate and the person either was not admitted to an appropriate facility or they were discharged – sometimes to the street or hospital lobby – without supports in place.

Five key areas emerged from the interviews about the perceptions of care provided to their loved one before they took their life:

1. Admission and discharge from hospitals or psychiatric units
2. Support and care while in care, including communication between services
3. Follow-up care and support
4. Staff skills and knowledge
5. Medication error or misunderstanding

A majority (19 of 28) of family members reported having repeated negative experiences across these five areas, indicating Victoria's mental health system may have repeatedly failed some Victorians at risk of suicide. Nine families reported their loved one as experiencing failings across all five areas, while 10 families said their loved one experienced failings in four of the five areas.

Some families felt the system as a whole failed their loved one, which left people with a great sense of guilt that they had not been able to understand the system more effectively on behalf of the person they loved and were trying to support. Family members spoke of having to “traverse”, “negotiate” or “encounter” the system, or of being “bounced around” or getting “revolving door” treatment, with the implication being that the onus to advocate for a person's care was placed upon them. However, at the same time primary carers felt locked out of decisions relating to their loved one's care.

Five family members reported positive experiences with the mental health system, specifically in their dealings with Crisis Assessment and Treatment teams, Victoria Police, psychologists and psychiatrists. Several family members felt that many staff they encountered meant well and had good intentions, including many whose care was outstanding and genuinely caring. However, the design of the system itself was sometimes a hurdle too great to overcome and limited the impact and effectiveness of capable staff.

“... I felt like we were fighting the hospital system as much as the illness, and that's what I hope will change.” (Mother of daughter, 17)

“You have the feeling that the system broke down at almost every turn. And so that leaves you with a feeling of great guilt that you didn't manage to negotiate the system better and just deep hurt and despair that ... he was the victim of a very poor system.” (Mother of son, 30)

“Over the journey it was pretty much a token service. I don't honestly believe that the public health system has enough resources to actually be serious about what they want to do. For example, there were times when she was sent home with the Crisis Assessment and Treatment team supposedly visiting to see how she was – so she might have attempted suicide – they've arrived once at a time that was convenient to them. And they might visit her once and she'll never see them again.” (Mother of daughter, 29)

4.2.1 Admission and discharge from hospitals or psychiatric units

Eighteen of 28 families interviewed reported concerns with admission and discharge from hospitals or psychiatric units. **Several families told us that they only went to the emergency department in times of “absolute crisis” or when they were desperate or felt their loved one’s situation was life threatening.** Yet even so there was a feeling that physical injuries were treated as a priority in hospital emergency departments and mental health needs were not attended to. Examples cited include emergency department staff sending home - two hours after her arrival - a woman who had tried to hang herself, a man who was released after being bandaged for slashing his wrists, and a man who was given stitches after a serious suicide attempt and then released.

“If you got your child to an emergency department, they can be released with no real action taken. And then sit and wait for four months for an appointment. They don’t magically come out of emergency department, ‘I feel fine, I can wait a few months before I see someone’. It was, like, ‘Yep, we’ve made sure your liver’s still functioning fine, off you go’.”
(Mother of son, 19)

Other family members highlighted their experiences with having loved ones in hospitals or psychiatric units being discharged prematurely or family members not being told of the discharge until afterwards. This included a woman who was discharged after 24 hours as an involuntary patient despite her mother’s warnings – she killed herself a week later. Another woman was in a psychiatric unit for six days – she took her life less than eight hours after being released.

“When he was in hospital in various emergency departments, he would often self-harm, with deep cuts, he would need stitches. Someone from mental health or social services would come around and hand him a couple of pamphlets and that was that. That was the sum total of our help. If he was admitted to an ED after a psychotic episode, he would be released at 4am, 5am, 6am. He’d be standing out front of the hospital and ring us and say, ‘Come and get me. They’ve let me out’. That was just jaw-dropping. The worst was 4am. He said, ‘I’m standing out the front of the hospital, someone needs to come and get me.’ And this was after ... a major psychotic blow-up involving many police and ambulance. And they just let him go. And we just had to try to deal with it as best we could.” (Mother of son, 32)

4.2.2 Inadequate support while in care

Twenty-seven of the 28 family members interviewed described their difficulties with care when engaging with services, including finding an appropriate professional, inadequate referral information, and negative or judgmental attitudes. **Of these 27 family members, 23 nominated communication failures as examples of inadequate support – especially a perceived inability of one part of the system to link people with services in another part of the system and poor communication skills of professionals.** In one example, a mother and her son repeatedly tried to find an appropriate psychologist without success – one was a drug and alcohol counsellor and not qualified, while another told her after a 20-minute appointment that he was unable to help. Other families told us they felt mental health staff or hospital staff had not taken a suicide attempt seriously, and so didn’t respond appropriately.

Another parent related trying to bridge a gap she saw between physical and mental health in the case of her daughter, aged 17, who had an eating disorder and was suicidal. She reported that the hospital’s psychiatric unit would not

receive her as her blood pressure was too low (common in people with eating disorders) but the medical ward would not receive her because they said she wasn't physically sick enough. On this occasion, the mother and daughter were sent home. On another occasion, they waited 35 hours in the emergency department while the hospital decided where to admit her.

“(A health worker I contacted) called me back and said, ‘Sorry, this is out of my league. I’m going to forward it to somebody who will go see him’. I found out later no one saw him. This woman rang him up and told him to look on a website – just click on a website and read about that. ... I feel that everywhere I went I had to fight, I had to fight.” (Mother of son, 19)

“He was really dismissive – ‘Oh well, he’s probably just a drug addict’. And I said, ‘The tests have come back saying that he is not, so how can you say that?’ And then my son went missing. And this guy was just sitting there calmly, like this happens every day. I’m going, ‘Where is my son?’. ‘Oh well, they usually come back.’ I’m like, ‘But you’ve just rung me to say that he’s not here so where, where is he?’. Just really a lack of empathy. I just thought, ‘Oh mate, you are in the wrong job. My son’s really unwell, and you’re just sitting there as if it is his fault.’” (Mother of son, 19)

The mother of a 32-year-old man described how she felt her child was judged by workers because of personal hygiene and appearance.

“... nobody seemed to care at all ... he had multiple piercings, he often didn’t wash, so he was a bit smelly. His hair was raggedy. He just looked unhealthy and a little bit antsy and aggressive. So, I can understand from their perspective, but we were just judged so much. Even when we went to the ED, we would be judged because he smelled a bit and had self-inflicted gashes on his legs. But he was in so much pain, and then we were judged

on top of that, and it was just heartbreaking. They couldn’t see him from my perspective.” (Mother of son, 32)

“It was suggested that my son needed specialised counselling that would cost \$80 a session and was in metropolitan Melbourne, and he lived in a regional area one-and-a-half hours away and did not have a reliable car at that stage and money to fuel the car.” (Mother of son, 18, rural Victoria)

Two of the 28 families described instances of excellent support. The first was the GP of a 48-year-old man, whom his partner remembered as “in (her partner’s) corner, really trying to find the right things for him”. The mother of a 32-year-old praised a CAT team visit as “fantastic”, saying it was “good to talk to somebody and be treated like a human being. They cared, and they knew all about the mental health system”. But, the mother continues, “that was an isolated case that never happened again”.

4.2.3 Inadequate follow-up care and support

Eighteen family members believed their loved one received inadequate follow-up care and support. **For some families, services were so poor that they believed it amounted to negligence by inaction.**

“He went back into the emergency ward and tried to get back in the ward after being discharged. They said, ‘I’m sorry, your bed’s gone’. They sent him out with a piece of paper with a list of boarding houses that was two years out of date.” (Mother of son, 47)

One father said he first learned from the Coroner’s report that his son’s care plan involved either him or his son calling a psychiatrist if they had any concerns.

“In the report ... the psychiatrist said he had a plan in place. And reading that report I worked out that his “plan” was basically that either (our son) or us would contact him if we had any concerns. But that plan was not communicated to us. There was

no discussion about that. It was just an assumption from his part.”
(Father of son, 27)

In one tragic example, a sister told of her 42-year-old brother who had been treated by the same hospital after trying to take his life several times:

“He’s been to that hospital several times. They’ve got his records there. I just felt there was probably more they could have been doing. They never contacted us at all.”

After the man’s last hospital release he called 000 in a distressed state, repeatedly asking for a CAT team to help him.

“... he didn’t say, ‘I’m suicidal,’ but he was ringing them saying, ‘My head’s really out of control. I need the CAT team to come out’. And the operator said, ‘You’ve rung the wrong number, we don’t have the CAT team here’ ... he actually asked for the CAT team five times in that conversation. The operator terminated that call and didn’t do any exploration with him. Didn’t send anyone out to him. He took his life about an hour later.”
(Sister of brother, 42)

Family members deeply appreciated it when individual health professionals were understanding and consistent in their care, but “had the guts to say” when they did not have an answer. One mother commended the paediatrician who saw her daughter, 17, every Monday night for five years: “He was brilliant.”

Another mother despaired that her son, who had taken his life aged 19, was not supported when he was in his mid-teens, especially around his refusal to be treated.

“If there had been a lot more (support) when he was 14 or 15, and a lot more family guidance, we wouldn’t be having this conversation now. When a child says, ‘No, I don’t need any further treatment’, what’s

got to happen is that there’s got to be a discussion with the people that care for that child on a daily basis.”

4.2.4 Lack of skill or knowledge among health practitioners

Another issue raised by 27 family members interviewed was of encountering professionals they felt were not skilled enough to assist a loved one, especially in assessing suicide risk. **Families felt some GPs or younger staff did not have the training or experience to properly assess their loved one’s mental state.** One mother described how a GP consultation with her son did not uncover his real suicide risk, while another described young staff telling her how to parent her 17-year-old daughter.

“With a person like my son who was on guard and wary, he answered as much as he had to. But he didn’t disclose exactly that he was suicidal. GPs have a standard questioning. He answered very truthfully, but the GP ... didn’t venture into the world he was experiencing, because he was suicidal then.”
(Mother of son, 26)

4.2.5 Medication error or misunderstanding

Although interviewers did not ask specifically about medication, 17 family members spontaneously identified their perception that prescription of medication and its monitoring after discharge was inadequate. Yet, because they were often not part of the care plan, family members felt they were given no information on how to best manage medication or care needs. Whilst it is acknowledged that some medications prescribed for conditions associated with suicide can increase risk, and prescribers would be aware of this, some experiences reported by family members were concerning.

Two families felt their loved one was prescribed drugs that actually increased their suicide risk, while others said staff did not read or understand

the medication histories of their loved ones, including prescribing medications they had just overdosed on until alerted to the error by family members.

“You are sitting here dishing out medication, but you haven’t clearly read the notes. But that is why that person was in (hospital) because they actually took a whole packet of Valium and ended up being in a drug-induced coma.” (Sister of brother, 42)

One mother described how while her daughter, 35, was in a clinic she had been given a drug that was supposed to be closely medically monitored in the first month of administration. “Yet when her partner was rung, he was told nothing. As a result, she was driven home by a friend and dropped off at an empty home. Her partner wasn’t even there. And then she took her own life.”

Two family members spoke of the distress of feeling their GP did not understand or have mental health training to treat someone so seriously ill.

“Not many GPs would take him on in the end. And the ones that did just wrote script after script after script, and they didn’t really know the dangers of tranquilisers, the long-term dangers. Or antidepressants or anti-psychotics. They just kept writing them, which was really heartbreaking.” (Mother of son, 32)

“The GP just gave him pills. Switched him from one antidepressant to another, and also prescribed him sleeping tablets. And the sleeping tablets were a big factor in his death ... he wanted to find a GP who would just get him in and out and give him pills.” (Partner of male, 21)

Finally, some family members reported that health practitioners did not explain what was happening to their loved one and what this meant for their risk of suicide. In one case,

the wife of a man, 44, who took his life felt the mental health system did not educate her that her husband’s diagnosis of psychosis meant he was at a higher risk of suicide. Nor did she feel educated about the medication her husband was taking.

“... our family was not educated on the fact that a psychosis means people taking their own lives, and that people who get into a psychosis, how very easily they slip into them again. That’s where I get frustrated because no one really educated us.” (Partner of male, 44)

Chapter 5: Family perspectives on support to help them care for their loved one

5.1 Survey results

Seventy-nine per cent of the 142 family members surveyed said they felt there were barriers to them accessing information or help in caring for their family member. Of these, 52 per cent said privacy and confidentiality were cited by health practitioners as the main reason they were not included in any care plans, while 26 per cent said they were not informed of the level of risk. Others said they were not included in meetings (9%) or did not know they could ask questions or seek information (6%).

Of the 545 individual services accessed (many families accessed more than one service), on 375 of those occasions (68%) the family member received no information or support, including guidance on caring for their loved one and reducing the risk of suicide occurring. Information or support was defined as providing information about their loved one's mental health, providing information and support to help in supporting a loved one, and including the family member in discussions about care.

Of those families who asked services for help, rates of assistance were consistently low. For example, of the 85 family members who visited a GP, 63.5 per cent reported they received no information or help relevant to the care of their loved one. Of the 70 family members who sought help from a psychologist, 74 per cent reported receiving no assistance. And for 51 family members who approached a hospital emergency department, almost 63 per cent said they received no information or support and were excluded from the care of their loved one.

For the minority of family members who were supported by services, most were included in discussions about care. Even so, of the 81 respondents who described what type of contact they were offered to help them protect their loved one, 33 per cent said no support was offered, 37 per cent were offered a meeting, 17 per cent received a phone call, and four per cent received online information or a referral.

Of the 100 families who answered a question regarding the barriers they faced in being included in their loved one's care, 52 per cent cited patient confidentiality, 26 per cent were not told the level of suicide risk, 9 per cent were not included in meetings, 7 per cent reported they did not seek support, and 6 per cent didn't know they could ask questions.

Comments from the survey

“More often than not information was shared with me after he had been discharged. They didn't notify me that he was admitted to hospital and told me one or two days later after discharge.” (Mother of son, early 30s)

“We got no information at all, let alone any advice to assist our son. We could only guess at what was going on in his life living with bipolar disorder due to the Privacy Act. We only found out after that he hadn't the money to pay for his psychiatrist for two years or to pay for an effective medication not on the PBS (Pharmaceutical Benefits Scheme).” (Mother of son, late 20s)

“We were given no assistance from the psychologists seeing our son or given a warning that we should be on suicide watch.” (Mother of son, early 30s)

“It would have been helpful to have had a professional explain to me the risk of a person completing suicide when they, as my husband did, become calm prior to his death.” (Partner of male, early 50s)

Services	Provided a service to family member to care for the person who took their life		Did not include you in care or provide any information		Total respondents who had had an interaction
GP	31	36%	54	64%	85
Psychologist	18	26%	52	74%	70
Hospital emergency department	19	37%	32	63%	51
Psychiatrist - private	19	45%	23	55%	42
Psychiatrist - public	15	38%	25	63%	40
Psychiatrist hospital - public	21	54%	18	46%	39
CAT team	16	42%	22	58%	38
General hospital - public	13	39%	20	51%	33
Welfare agency	12	40%	18	60%	30
Other	11	48%	12	52%	23
Psychiatric hospital - private	4	18%	18	82%	22
Police	3	15%	17	85%	20
None of the above	7	41%	10	59%	17
Drug and alcohol counsellor	5	31%	11	69%	16
Telephone crisis line	6	46%	7	54%	13
Relationship counsellor	3	30%	7	70%	10
School counsellor	6	75%	2	25%	8
General Hospital Private	0	0	4	100%	4
Gambling Counsellor	1	25%	3	75%	4

Table 2: Services that offered family members information, support or included family member in care (Percentages may not add to 100 due to rounding).

5.2 Family interviews

All 28 family members interviewed identified at least two ways they felt the mental health system failed in helping them provide the best care for their loved one. In fact, several family members told us they felt that gaps and failures in the system that excluded them from caring for their loved one had contributed to the circumstances that had ended in suicide. A consistent theme was that they found the mental health system complex and difficult to negotiate and that several felt this factor alone put their loved one at risk of substandard care. More specifically, six family members told us they felt strongly that an overemphasis on patient confidentiality hampered their ability to care for their loved one. They told us they believed the lack of information sharing may have elevated suicide risk because families were not supported to provide appropriate and well-informed care.

In our interviews of family members' perceptions of how mental health system supported them to care for their loved one, five key areas emerged.

Family members reported that:

1. They did not know how to navigate the mental health system
2. They felt elements of the mental health system did not listen to them
3. They felt they were not supported in caring for their loved one
4. They experienced negative attitudes
5. They felt they were not informed about their loved one's care, especially in relation to diagnosis, treatment plans and/or discharge

Twelve of 28 family members told us they felt the mental health system provided inadequate services and support. They felt that if the appropriate support had been available it might have prevented their loved one's death. Seven family members reported two instances of inadequate care or support, while six families reported three instances. Twelve of the 28 family members reported that they experienced failings in four of the key areas that emerged from interviews.

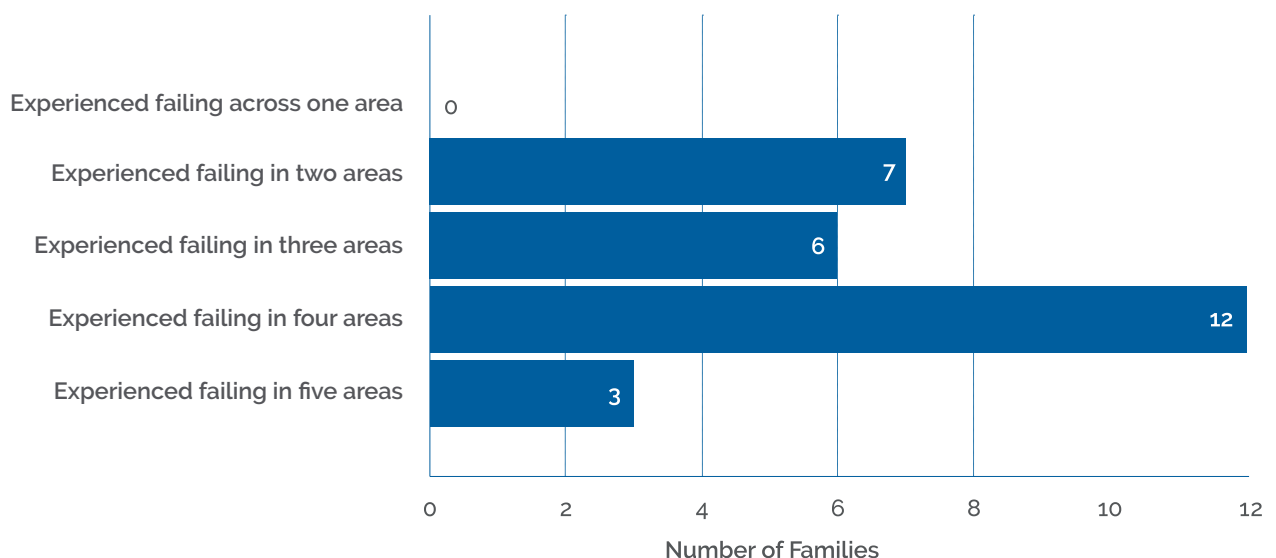


Figure 6: Numbers of family members reporting at least two failings across five areas (n=28)

5.2.1 Families did not know how to navigate the mental health system

Ten family members expressly told us they did not know how to navigate the mental health system as a whole. **Families felt they were ignorant of their loved one's illness, circumstances or care or of how the mental health system operated more generally – and that this sometimes affected the level of care received and the degree to which they were able to advocate for their interests.** Families in crisis were often told their method of help-seeking was not appropriate or to use a different process. For example, one man was told by a psychiatric hospital's reception that he needed a referral from a GP before his son could attend hospital, even when the man said his son was currently suicidal. Several family members told us they had not known what services were available to them. For example, the female partner of a male, 52, described how she thought her only way to get help was by calling the CAT team. "If somewhere someone had said to me, 'You don't need the CAT team to approve it, to get him in hospital. Just do it,' I just would have. I would have done it. But I didn't have a sense of what the options were."

"I think the big thing that happens is that the family is totally ignorant. We were ignorant because they wouldn't tell us anything. But you are also ignorant of what to do ... we don't know our way around a health service." (Mother of son, 17)

Another mother, of a 19-year-old, described how "getting through the system" was problematic, even though the care her son received once he was eventually admitted for more than 50 days to a unit as an involuntary patient was good. To begin with, her son attended three different hospital emergency departments over several months. She goes on, "... each time they thought he was a drug addict, and they sedated him and then they sent him home ... he was very ill, and we begged mental health services, we contacted the CAT team. The care once he got

in there was quite good, but I found trying to get through the system was really problematic. I think if he'd been able to get help earlier it would have been a much different outcome."

5.2.2 Family members felt elements of the mental health system did not listen to them

Sixteen of the 28 family members interviewed said they felt the mental health system did not listen to their concerns or to the information they tried to provide about the suicide risk of their loved one. This included one mother who told us she felt her 19-year-old son's psychologist treated her like an "interfering mother" and refused to accept background notes that she had made about her child's language and behaviour, including burning his furniture and repeated threats to kill himself and others with a gun. He also refused the son's request that his mother attend sessions with him. "... This guy said to him, 'Don't be a baby ... your mum can wait out here.' (My son) said: 'No, I want my mum in with me.' And he said, 'Well, if mum comes in she's not allowed to say anything.'" The next session the mother was refused entry altogether. "(My son) didn't tell him much. But then (my son) just refused to go. He said, 'Mum, he's not even listening to me.' We stopped going. That would have been in the August. He killed himself in the October."

These family members felt the system treated them as playing no role in the care of a suicidal patient, even when they were the primary carer or had the most significant relationship with them. Family members recognised that this was partly due to concerns about patient privacy, but:

"I just think if someone could have believed me. Why does a mother ring up and say her son is suicidal? All they did was pass me on to someone else, pass me on to someone else, pass me on to someone else." (Mother of son, 26)

The wife of a man, 52, who took his own life told us she tried repeatedly to warn CAT teams over seven days that her husband was extremely vulnerable to suicide and needed to be in hospital, but she was told his behaviour would eventually change because “the medication takes a while to work”. She continues: “They’d come, and they’d meet with him. But then they wouldn’t talk to me ... I could sit in when they talked to him. But they didn’t talk to me ... about what any of my concerns were or how they could help me help him.” She told us when she called the CAT team again to express her deep fear that her husband was likely to take his life, she was told that he was not in immediate danger because she was there to stop him. After a second visit, she said they decided not to admit him because he was eating and had answered all their questions satisfactorily.

“I said, ‘I’ve known him for 20 years. I’m sure he was lying’. And they just said, ‘Well, you’ve got to trust him’ ... I said, ‘I just really feel he should be in hospital.’ And then he took his own life that night. I shouldn’t have trusted them. I should have gone with what I thought.”

Comments from the survey

My information about the mental state of my husband was, I believe, not seen as a risk factor even though I voiced my concerns.” (Partner of male, late 40s)

“The system does not treat carers as part of the treating team.” (Father of son, late 40s)

“I tried to get help for my daughter ... but they would not speak with me because of privacy, which means their service is just about useless? How can an acutely unwell or medicated person speak for themselves?” (Mother of daughter, late 20s)

Some family members remembered being surprised that mental health professionals had decided to allow their loved one to return home from care in a hospital or mental health facility, but felt they had no choice but to accept the decision. One father described that he and his son’s mother were “taken by surprise” when the psychiatrist recommended their child go home – “... he just said, ‘OK, meeting is over ... off you go.’ We were so surprised by that decision we were not able to react”.

A mother described how she felt excluded from decisions about her 17-year-old daughter’s care:

“My daughter would be wheeled in to sit in front of all these people and then they would discuss whether they would allow her to leave and go home. Mostly, I listened. Mostly, I wasn’t included. They already knew before we came in whether she was going home or not. There were discussions about what her observations were and progress she’d made. To me, that wasn’t including me in the decision-making at all. It was very intimidating.”

5.2.3 Family members felt they were not supported in caring for their loved ones

Twenty-seven of 28 family members interviewed told us they were often left uninformed or under-informed about how best to care for their loved one, even when the mental health system had diagnosed them with a psychiatric illness or identified them as being at risk of suicide. In practical terms, this included family members being given no guidelines or information on how to best support loved ones who had just been released from a hospital psychiatric unit, a lack of follow-up after discharge, and little or no advice on safety or suicide warning signs.

One mother of a 32-year-old who took his life found herself excluded from her son’s care once he turned 18: “I was given no information on what was discussed, and he wouldn’t tell me.

... As his main caregiver I should have had an input into what was being discussed and any treatment offered."

The partner of a 52-year-old also recounted that there was never any sense of being part of a team: "There were these people coming into your home and doing whatever they did and then leaving. There wasn't any sense ... of the family being supported."

This feeling of a lack of support frightened some family members who felt their loved ones were released into the care of people who loved them yet were left ill-equipped and untrained to deal with their serious mental illness.

"There was absolutely no follow-up. ... This guy is seriously, critically ill and you are leaving him with us? It's a bit like if someone's had a torn artery and you're leaving them with people like us who don't have any idea what to do. We should have been given a lot more support to enable us to act appropriately and give him some chance of accessing the best healthcare instead of floundering around and us getting more and more frantic and him getting more and more frantic." (Mother of son, 30)

In one case, a father's lack of knowledge meant he didn't know that his attempts to cheer up his 25-year-old daughter or encourage her were inappropriate responses: "I was so excluded from her care I used my way to help her, but my way was not the right way. Actually, it was wrong."

Two family members told us the lack of guidance and advice on how to protect their loved ones continued even after attempts were made at suicide.

"Following his suicide attempt we were not given any advice on safety. Or any warnings." (Father of son, 27)

"We were the ones that were going to be looking after him because his wife had left him. That was what caused (our son) to go into the deep depression and try to take his own life. The psychiatrist would not talk to us. And we were left with the responsibility of looking after him, and all we got was a phone call. From a man that we had never met. There was no feedback at all at any time." (Mother of son, 45)

The partner of a 48-year-old male who took his life described how her experience was different to that of a friend whose husband had cancer. "There's never any question that she will be at every appointment. I know with mental health it is different that it may be they want to talk about the person, but there is a real sense that as family you are not part of the system ... I just found it really hard to get information."

5.2.4 Families members reported that they experienced negative attitudes

Fifteen of 28 family members interviewed said they felt they experienced negative attitudes from mental health professionals towards themselves and/or their loved ones. **A common theme among parents was that they were overstepping their parental boundaries. One mother of a 19-year-old told she was made to feel like an "interfering mother" when she continued to ask to be involved in her son's care after he turned 18:** "I wasn't. I was just a mum who knew her son was at very high risk of suicide, and I just tried everything in my power to do what I could do."

Another mother said her 30-year-old son's psychologist made her feel as if she were enabling her son's behaviour by financially supporting him instead of encouraging him to get a job. "She just saw it as wilful behaviour that was being supported by parents who should probably be saying, 'Come on, go and get a job.' That turned out to be completely wrong."

“We had a really bad psychiatrist. He told us that we needed to hold her down and put the food in her mouth and when she spat it out to scoop it back up and put it back in her mouth, and do that until every single thing was eaten. I was saying that I don’t know how I’m going to do that ‘cos it’s quite a stressful physical and awful kind of thing to do as a mother. He said to me that I needed to go into therapy to find out why I couldn’t save my daughter’s life.” (Mother of daughter with eating disorder, 17)

“He was 20 when he killed himself. For many years he had mental health issues like depression and anxiety. He was borderline Asperger’s ... I exhausted myself looking for support for him and at every point, because he was over 18, I was made to feel that I was an interfering mother and that if my son had mental health issues he would tell a psychologist. I felt very, very helpless ... I contacted organisations, and a lot of them just fobbed me off.” (Mother of son, 20)

5.2.5 Families reported that they were not informed about their loved one’s care, especially in relation to diagnosis, treatment plans or discharge

Twenty-five of the 28 families interviewed described their frustration at the mental health system for not informing them of the diagnosis, treatment or discharge of their loved ones, especially when they were the primary carer or most significant relationship. Like the previous section, there was a broad understanding that this reticence might be due to patient privacy requirements. **Nevertheless, family members still felt this lack of information sharing undermined their ability to give their loved one appropriate care and support and to advocate for them in the mental health system when they were too ill or vulnerable to do so themselves.**

In practical terms, for some family members, this meant they had no idea when their loved one was coming home, with, in one case, a husband walking home after being discharged

from hospital. Several family members describe psychologists or psychiatrists having no interest in speaking with them, despite fears their loved one was not telling their full history, either deliberately or due to incapacity. One mother described “totally operating in the dark” and becoming so desperate for information from her 30-year-old son’s psychologist that she tried to convince his colleague to glean information on her behalf: “That’s a good way of explaining how desperate parents get. You’d do anything for your kids ... that was just an example of the lengths you will go to ... we had no idea that he was suicidal or that he was schizophrenic.” The mother continues:

“He didn’t tell us the diagnosis. People who live with these people 24 hours a day, and they support them financially and as much as they can emotionally, we’re completely ignored when it comes to people who might see them once a week for an hour. They know everything and we know nothing. We are completely struggling with our lack of knowledge. We were always guessing. ... When you don’t know what is wrong you don’t know how to act.”

In the case of a 48-year-old man who took his life, his partner only found out after he died that there had been a difference of medical opinion between the hospital and the private psychiatrist about releasing him from hospital care. What made this particularly distressing for the man’s partner was she felt if she had known she would have contacted the dissenting psychiatrist when her partner became increasingly distressed in the days after his discharge. “I didn’t get the information from the hospital. I found out when the psychiatrist talked to me after (my partner) died. He was trying to help me understand why (my partner) might have killed himself, and that was when it emerged that there was a difference of opinion.”

Family members also expressed frustration that the mental health system seemed to block the possibility of a more holistic approach that included a loved one’s family in their care. While it was acknowledged this approach was not

appropriate in all situations, members of families with positive dynamics wished they had been allowed to play a greater role in their loved one's care.

“It’s like the family’s there to pick up the pieces. And the family’s there to cop the brunt of bad behaviour when things go wrong, but the family’s not included in any of the services and the discussions.” (Father of daughter, 27)

“With his siblings, they struggled accepting him when he came home and it was the fact they didn’t really understand it, I think.” (Mother of son, 19)

Comments from the survey

I understand that he was 17-and-a-half when he died. And he would often sign a document saying he didn’t want me to know about things. I would be spoken to like, ‘He’s in charge of this ‘cos he’s of that age.’ But he had quite a complex illness and he was taking a lot of medications. He was making those decisions unsupported by his family because of these privacy laws. And then he would be discharged into my care and I’d be told, ‘Well you’ve got to look after him.’ Which seemed contradictory. Even if you are an adult with a terminal illness you need your family around you, supporting you to make decisions about your health. A young person who is only 17, mentally unstable, how is it right that the family is shut out and then told, ‘Well, you’ve got to look after them.’ It was very distressing. (Mother of son, 17)

Chapter 6: Services provided to the bereaved after death

6.1 Survey results

Prior to having contact with Support After Suicide, families often reported difficulties in accessing information and support. Overall, 80 per cent of the 129 family members who responded had been offered some kind of help after a loved one took their life. This support commonly consisted of a meeting, provision of information or the offering of condolences.

Several families reported they needed to actively seek out assistance after the suicide of a loved one rather than help being automatically offered after death. They reached out most commonly to Victoria Police (who provided information), GPs (who mostly offered condolences), and psychologists (who mostly offered a meeting). However, the spectrum of services sought by respondents was broad – ranging from one family member who contacted a gambling counsellor to 65 family members who contacted Victoria Police. Other services contacted were: psychologists and psychiatrists, welfare agencies, hospital emergency departments, telephone crisis line, relationship counsellors, community health centres, the CAT team, drug and alcohol counsellors, and a school counsellor.

“The only time the hospital contacted me was after he had died, after I had desperately tried to contact them for three weeks.”(Partner of male, 40s)

“There is not a lot of support for parents of children who have suicided ... I was shunned and seen as an object of pity. Not many people knew what to do or say to me. There is little information about the traumatic grief that occurs, its effects and what to expect.”(Mother of son, 20s)

Community mental health services attached to hospitals do not provide the support they say they do. They very quickly refused to communicate with us.”(Mother of son, 30s)

Of the most commonly accessed services, Victoria Police were one of the highest ranked in quality, with 55 per cent of the 65 family members who dealt with them rating them as “helpful or very helpful”, including referrals to Support After Suicide services. This is followed by private psychiatrists, psychologists, GPs, and public psychiatrists.

In survey comments, family members described extremely limited assistance immediately after the suicide, or assistance that was inconsistent or ad hoc. Some reported that they felt the health service blamed them for the death, which intensified their already significant grief. In addition, some family members interviewed reported difficulties in obtaining information about their loved one. Several family members commented that they were given pamphlets or information but were experiencing profound grief at the time and needed more direct links to support. One family member struggled to find counselling support, especially for their children, while another waited two months for a psychiatrist whom she saw once before being referred to a contract psychologist “who couldn’t help me”. One family member said support from the mental health system amounted to a one-hour Skype with a doctor. “There was nothing else offered,” they said.

“I think more concrete services should be offered because I was so traumatised and in a state of shock. Lots to organise, including caring for our 16-year-old son, that I found it hard to breathe let alone reading a leaflet and making phone calls for an appointment.” (Partner of male, 40s)

“The GP needs much more education on how to assist the suicide-bereaved. The GPs I saw couldn’t get me out of their office fast enough. They were obviously very uncomfortable speaking about the subject. It made my grief more painful.” (Mother of son, late teens)

Services	Offered a Meeting		Offered Condolences		Provided Information		Total Responses
Police	4	6%	19	29%	42	65%	65
GP	12	21%	36	63%	9	16%	57
Psychologist	18	47%	13	34%	7	18%	38
Psychiatrist - private	8	57%	5	36%	1	7%	14
Welfare agency	2	15%	4	31%	7	54%	13
Psychiatrist - public	5	50%	4	40%	1	10%	10
Hospital emergency department	1	10%	5	50%	4	40%	10
General hospital - public	3	30%	3	30%	4	40%	10
Telephone crisis line	3	33%	5	56%	1	11%	9
Psychiatric hospital - public	4	57%	2	29%	1	14%	7
Relationship counsellor	4	57%	2	29%	1	14%	7
Community health centre	3	43%	3	43%	1	14%	7
CAT team	3	50%	3	50%	0	0%	6
Drug and alcohol counsellor	1	25%	2	50%	1	25%	4
Psychiatric hospital - private	2	100%	0	0%	0	0%	2
General hospital - private	1	100%	0	0%	0	0%	1
School counsellor	1	100%	0	0%	0	0%	1

Table 3: Types of support offered to respondents by services after the death of their family member. Note that half of all referrals to Support After Suicide come from Victoria Police, which may explain the high number of police encounters in this table.

Other family members in the open-comment section of the survey reported positive experiences with the mental health system after their loved one died. Several family members reported their appreciation of police referrals to Support After Suicide:

“Support After Suicide and Victoria Police were my saviours. Thanks to VicPol for the SAS referral.”

“The police who came to inform me of my partner’s death and to follow up were excellent. Calm, clear and informative. The private psychiatrist provided good information about what he thought had happened and was very kind.” (Partner of male, 50s)

“The GP was kind and sympathetic.” (Mother of son, early 20s)

“If I had not received counselling support, I would probably be dead now or at least not functioning.” (Partner of male, late 40s)

6.2 Family interviews

Twelve of 28 family members interviewed highlighted how a lack of support in the time after their loved one’s death contributed to a decline in their own mental health. Thirteen family members told us services were available but were not helpful. Eight told us services for family members were not available at all, while six reported a positive experience with post-suicide support services. **All 28 reported that services such as Jesuit Social Services’ Support after Suicide program were helpful.** For some, the lack of support was keenly felt and several blamed themselves, feeling that they could have done more to protect or advocate for their loved ones - even when they had already told mental health professionals their concerns. Overall, **family members told us their experiences of the mental health system left them feeling angry, disempowered and confused about what had happened. Information and support were rarely provided and family members felt a lack of understanding or empathy with their grief.**

“I don’t trust mental health services at all. I wish I had more knowledge. I blame myself to a degree for not pushing through when I knew in my gut he wasn’t well ... I blame myself for following their advice when it went against my gut feel, and in a situation where it was life and death.” (Partner of male, 52)

Several families told us of mental health services expressing sympathy for a loved one’s death but offering no support for grieving family members. One father rang his 36-year-old son’s three mental health professionals to tell them of the death - his psychiatrist, his doctor and the coordinator of a workshop his son had been attending - only to receive the same response from all three. “No offer of anything. Absolutely nothing. And in particular the thing that was most damning was they all knew there were children involved. There was no other support in any way, shape or form that was provided by anybody out of the mental health institutions. Nothing.”

Another family member described the distress of collecting her 42-year-old brother’s personal belongings at hospital and being handed a bag with parts of his skin still inside. The experience was highly traumatic. “I was just beside myself ... I can’t take this bag to my parents. I can’t give my parents this bag with his belongings and his skin attached to it.”

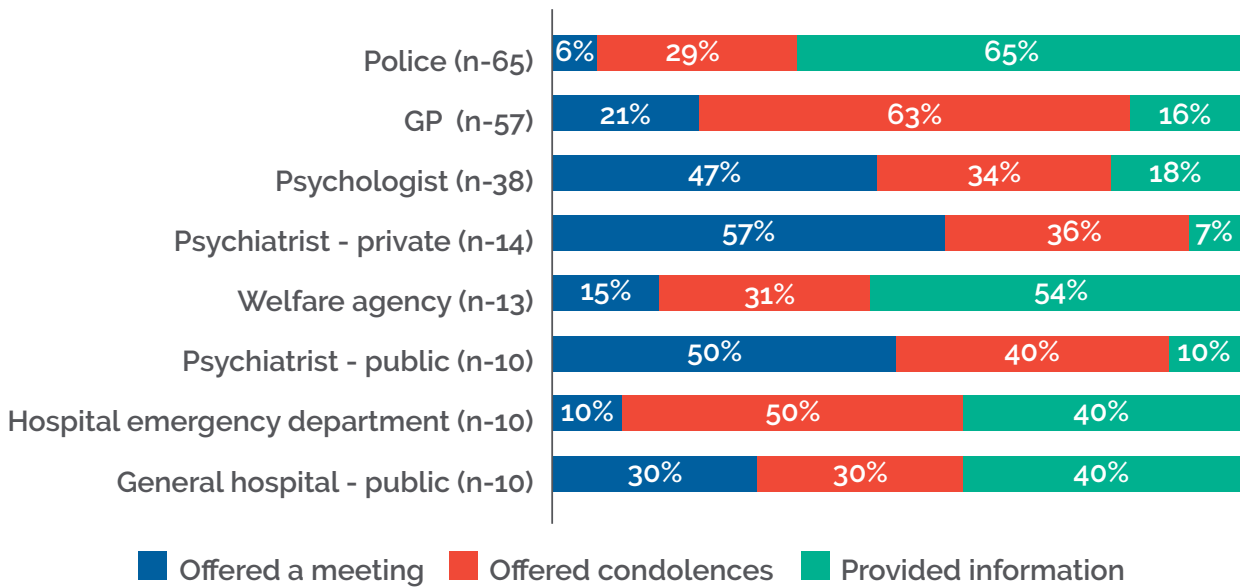


Figure 7: Types of support offered to respondents after the death of their family member.

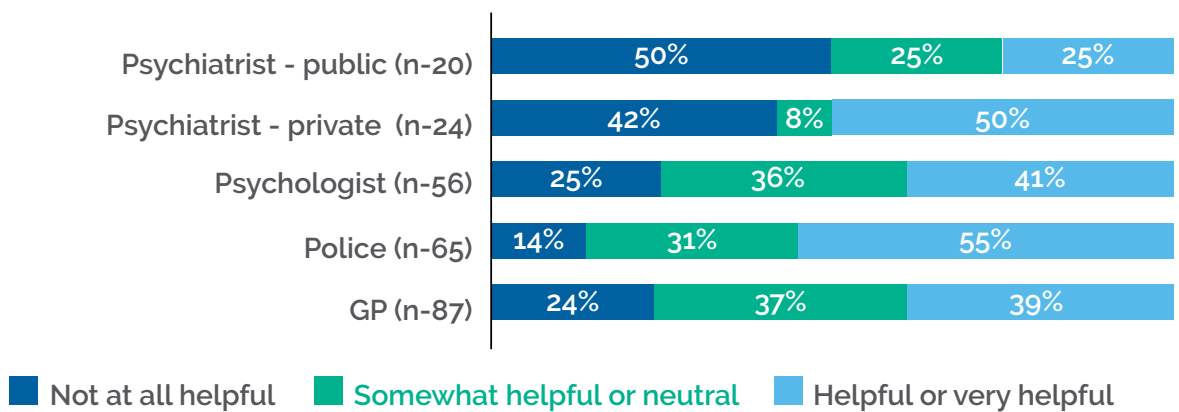


Figure 8: Quality of interaction with five services most commonly accessed after family member died.

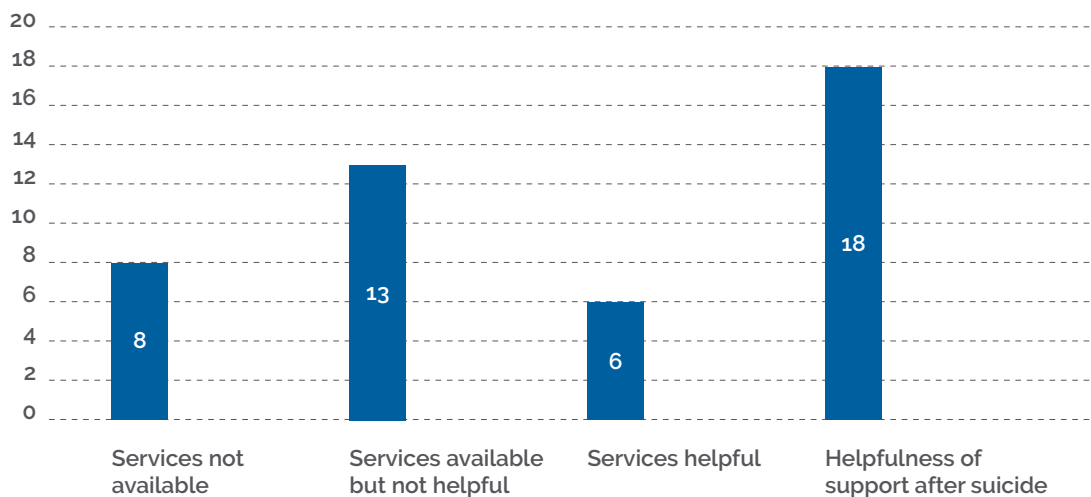


Figure 9: Family members' ratings of services after a loved one takes their life (n=28).

Chapter 7: Discussion and conclusion

This report describes the experiences of family members of people who took their own lives. As these people, tragically, are no longer here to speak for themselves, it attempts to give them a voice in the only way now possible – by asking a loved one to speak for them. This report also describes how those same family members experienced the system – both as they tried to keep their loved one alive and in the time after death.

This study collected data from 142 family members whose loved ones died by suicide between three months and five years previously. Noting that approximately 700 Victorians take their lives in Victoria every year, the data collected from our large sample enables us to highlight issues in the service system in Victoria with confidence. The qualitative data collected from a subset of 28 family members provides rich detail about their experiences of the mental health service system and highlights the perspectives and needs of a group whose voice is not often heard.

There are nevertheless limitations to this study that bear consideration. Importantly, our surveys and interviews were conducted with family members who have used the Jesuit Social Services' Support After Suicide service. We acknowledge that this report necessarily highlights these voices above others in the mental health system, who also offer an important perspective. By definition, it does not include family members whose loved ones were prevented from ending their lives. We believe these views are also a valuable contribution to understanding the successes and failings of Victoria's mental health system. In addition, resource limitations prevented specific examination of the experiences of Aboriginal and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds and emerging communities, LGBTIQ communities and regional and rural Victorians. These perspectives warrant specific exploration in future.

Although our sample carries some statistical caveats, it powerfully reflects the real experiences of family members whose loved

ones had interacted with the mental health system. We might never be able to quantify with certainty how failings in complex systems such as mental health contributed to the deaths, or failed to prevent the deaths, of people who take their own lives in Victoria every year. But we hope these stories show how we might make the system better.

7.1 A union of voices

As the voices of family members of people who have taken their lives are rarely heard in discussions about suicide in Victoria, we wanted to give them a platform. In doing so, we found a chorus of voices, all raising similar concerns based on similar experiences. Over and over we heard the same stories describing how the mental health system failed at specific points to adequately respond. Many of the people who died were reported as experiencing abusive events, such as family violence, abuse and neglect, and bullying. **It is extremely concerning that bullying, especially at work, school or online, was associated with a significant 41 per cent of the 142 suicides in our survey sample, as reported by a family member.** More than one in five of those people who experienced bullying did not seek help, according to their loved one.

One third of the people who died were recently separated from their partner, with the remaining two thirds either in a relationship or single. Two thirds of the people were reported as having a close group of friends. **A large majority (89%) of those people in our study who ended their lives had a mental illness.** About half were experiencing either unemployment and/or financial stress, and one half (47%) were known to have attempted suicide in the past. **Almost 70 per cent of those people who took their lives had previously sought help from a health professional, most commonly a GP.** Many made several attempts to seek help. This demographic profile is consistent with the current literature.

Family members in both the survey and the in-depth interviews consistently reported difficulties advocating for their loved one in the mental health system. Generally speaking, they felt they were not included in the care of the person who died, were not provided with information, felt a lack of support and felt that mental health professionals did not listen to their concerns.

The findings from our survey and interviews also suggests the mental health system is not providing the level of service required to move some people away from suicide. **The report highlights systemic problems that result in the exclusion of family members from knowing about a loved one's mental state.** We heard many examples of problems negotiating the mental health system, and people dying without accessing the services they required. Even if they were able to access services, the type of help provided too often did not match their needs. These findings highlight the significant difficulties of our mental health system in meeting the needs of those in our community who are contemplating ending their lives.

7.2 Implications

Many of the families surveyed reported positive experiences with caring and knowledgeable professionals. We at Jesuit Social Services often see in the work we do the daily kindness and skill of many healthcare staff. But in a system as large, complex and decentralised as Victoria's mental health system, we cannot ignore the reality confronted time and again in our counselling rooms that where we hear of good experiences we also hear of terrible experiences:

- A person at risk of suicide is unable to get the services they need
- There is a lack of awareness or understanding within the system that formal and informal support options, while technically on offer, are in practice unavailable or inappropriate
- A shortfall in the system is recognised but there are no resources to improve it

These experiences can leave family members distressed and lost inside a system they feel dismisses them.

The most tragic overall implication of this report's findings is there may have been situations where weaknesses in Victoria's mental health system failed to prevent a person taking their own life.

Secondly, these weaknesses may still be affecting Victorians currently at risk of suicide.

The circumstances that might give rise to this outcome are varied, but might include:

- A person in suicidal distress unable to get support in the community seeks help at a hospital emergency department, where staff might be unable to meet their needs
- Families being excluded from medication or care plans, even when they are the primary carer or the most significant relationship
- Family members' pleas for loved ones to be admitted into care not acted upon
- Physical injuries being treated at hospital emergency departments while mental illnesses are not prioritised
- Patients being discharged from care prematurely
- Mental health professionals declining offers by family members to provide background information on their loved ones
- Patient confidentiality preventing primary carers or partners being able to best care for their loved one. In extreme cases, this might include not being informed of the suicide risk of their loved one, which can lead to inappropriate parental and sibling responses
- Parents of teenagers with longstanding complex mental illness being locked out of care decisions as their child gets older
- Poor quality support services, including a lack of follow-up care, even when suicide was identified as a risk, and difficulty getting referrals

- Inadequate monitoring of medication after discharge or inappropriate medication prescribed
- Lack of support and resources for professionals within the mental health system to help them do their best work
- Care that does not take into account that older people and men who are suicidal are less likely to actively seek help or talk about their experience, and so may be overlooked

A third implication of this report is that there may be Victorian families currently feeling a lack of confidence to advocate for their loved one in the mental health system because they don't feel supported or informed enough to do so. They may not know how to navigate the mental health system, they may feel their views and concerns are dismissed, they are not being told how to care for their loved one or informed about their care, or they may be experiencing negative attitudes.

The final implication of this report is that there may be hundreds of family members currently not receiving the support and information they need as they experience the significant grief and trauma that comes when a loved one takes their own life. People bereaved by suicide are themselves at a higher risk of suicide and mental illness. They need understanding, support, and many will benefit from specialised counselling. It is clear from the survey and interviews that this is not always happening.

We believe these four key implications of our work with families' experiences of the mental health system are widespread, profound and deserve further investigation.

7.3 Next steps

7.3.1 A simpler family and person-centred mental health system

Based on what families have told us, Jesuit Social Services envisions a mental health system that is simple to access and navigate, and which supports and cares for all people at risk of suicide. People at risk of suicide, and the people who love and care for them, deserve to feel confident that the professionals they are dealing with have been specifically trained in assessing and treating them. This includes recognising risk factors and knowing how to minimise them, as well as building relationships and trust with people who are suicidal so they are more likely to feel comfortable discussing the real level of risk. People at risk of suicide must have access to a continuous model of care from initial presentation to long-term follow-up – both in hospital and in community settings. They require care that responds appropriately to gender and age differences in help-seeking behaviour.

People at risk of suicide must be communicated with respectfully and in a way that preserves their human dignity. They require a mental health system that gives them hope and builds their confidence that they will get better, without the taboo and stigma attached to seeking help. They need targeted and sustained interventions after a suicide attempt.

Family members also require respect. Their intimate knowledge of their loved one should not be dismissed or ignored, especially when they are also the primary carer or most significant relationship. Family members understand the strengths and weaknesses of their loved one and the nature of the stressors they are experiencing. It is often family members who are closest to a person once they are discharged from hospital. They need information, support and skills to help them keep safe the person they love and reduce the risk of suicide occurring. They must not be treated as overreacting or interfering parents or partners, or left to feel that the system cares more about preserving their loved one's privacy than it does about saving their life.

For example, Ryan's Rule is a patient, family and carer escalation process – a formal reporting pathway that was introduced into Queensland hospitals in 2014 in response to the death of seven-year-old Ryan Saunders, who died in 2007 from an undiagnosed streptococcal infection. Ryan's parents did not feel their concerns about their son's care were acted upon in time to save his life. The Ryan's Rule escalation process acknowledges that there can be a power discrepancy between patients and health staff that can affect concerns being heard.

Several Victorian hospitals have introduced or are in the process of introducing a similar "Ryan's Rule" escalation protocol into their organisations. We believe a similar protocol for the mental health system should be investigated as a way of reducing the inherent power inequality between a health professional and a patient, and providing patients and families with a formal escalation pathway if needed. This would be to the benefit of all Victorians and their families seeking treatment and care.

Finally, family members and carers must receive support and be informed of strategies to reduce the risk of suicide occurring. Most services did provide some level of discussion with family members, but not enough to help them effectively care for their loved one, even though they might be that person's primary carer or most significant relationship. This report clearly shows that in order to prevent further suicide attempts, a person's carer or family needs information at the point of discharge.

This includes information on the risk of suicide, on the treatment plan, and on the side effects of medication. It also includes information on how to care for and support the person, including harm minimisation techniques, how to help their loved one if they do become distressed and how to contact crisis or specialist services.

7.3.2 Supporting families after a loved one takes their life

The suicide of a loved one is a time of intense anguish for family members and their mental health can suffer greatly. They are likely to experience feelings of grief, guilt, loneliness, anger, regret, and hopelessness. They are likely to ruminate on the circumstances leading up to the death, as well as the death itself. They should receive compassionate and informative responses from the mental health professionals who treated their loved one to help them understand and process what has happened. Current literature reports that suicide-bereaved people are themselves at higher risk of taking their own lives. **They should be referred to post-suicide support services – and those services must be properly funded.** Family members should be respected and have the option of support and counselling. They must be automatically offered services that provide care in a way that is sensitive to gender-specific behaviours. They shouldn't need to ask.

It is time for the family members of people who have taken their lives to be allowed to join the conversation about how to make Victoria's mental health system as strong and as effective as it can be. Structural reform is not easy. We have seen the work the Victorian Government has done to fix the broken family violence system in order to protect victim-survivors - the first government in the world to do so. Similarly, we acknowledge the work of the Royal Commission into Victoria's Mental Health System and hope this report can contribute to its body of knowledge. We hope the family members who use our services will know that their voices have been heard and that their experiences will count towards saving future lives.

7.4 Conclusion

Governments appear to be recognising the need for a generational shift in how we structure our mental health system, including support for people at risk of suicide. The Productivity Commission and the Royal Commission into Victoria's Mental Health Commission are currently investigating this issue and are due at the time of writing to publish their final reports in 2020 and 2021. In addition, the Fifth National Mental Health and Suicide Prevention Plan implementation strategy was awaiting endorsement by Commonwealth, States and Territories.

The Victorian Government aims to halve Victoria's suicide rate over the next five years.

It is a commendable and ambitious goal.

Suicide has many causes – and its prevention and support for grieving family members are not the responsibility of the mental health system alone. The broader community, including service systems, workplaces, schools and recreational groups, can also play their role in reducing the risk factors for suicide.

There is no single action that will prevent suicide, but a systematic approach to reducing known risks and increasing sensitivity to the needs of the people who use the system would be a huge step forward. We need a well-functioning mental health system that truly meets the needs of those at risk of ending their lives and supports families in helping them reduce the risk of suicide occurring. For this to happen we ask policymakers and decision-makers to listen to the heartbreaking stories of those who offered their deep insights, and to act boldly to bring about the positive solutions they so clearly cried out for.

We make our recommendations with this hope in mind.



End Notes

- ¹ Royal Commission into Victoria's Mental Health System (2019) *Interim Report*, p. 68. <https://rcvmhs.vic.gov.au/interim-report>
- ² Coroners Court of Victoria (2019) *Suicide Data Summary 2009-2018*, cited in *ibid*, p. 279
- ³ Department of Health and Human Services (2017-2018 and 2018-2019) *Integrated Data Resource, Victorian Emergency Minimum Dataset*, (cited in *op cit* Royal Commission into Victoria's Mental Health System (2019) p. 282).
- ⁴ According to Dwyer J (2019), the rate of suicide in Victoria is 12.7/100,000 – a rate substantially unchanged for ten years. Data system changes in Victoria have led to discrepancies between annual coronial data and the latest Australian Bureau of Statistics figures. The Royal Commission into Victoria's Mental Health System reports that these are due to be resolved and adjusted in 2020. (Sourced from witness statement to the Royal Commission into Victoria's Mental Health System from Jeremy Dwyer, Manager Suicide, Mental Health and General Investigations, Coroners Prevention Unit, Coroners Court of Victoria, cited in the Royal Commission into Victoria's Mental Health System.)
- ⁵ *Ibid*.
- ⁶ *Ibid*.
- ⁷ Hunt, I.M., Kapur, N., Webb, R., Robinson, J., Burns, J., Shaw J., Appleby, L., (2009). Suicide in recently discharged psychiatric patients: A case control study. *Psychological Medicine*, 39, 443-449.
- ⁸ Stokes, B., (2012) *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/ services in Western Australia*, Department of Health and the Mental Health Commission <https://www.mhc.wa.gov.au/media/1288/mental-health-review-report-by-professor-bryant-stokes-am-1.pdf>
- ⁹ Meehan, J. et al., (2006) Suicide in mental health in-patients and within 3 months of discharge. National Clinical Survey. *British Journal of Psychiatry*, 188, 128-134.
- ¹⁰ Defayette, A. B., Adams, L. M., Whitmyre, E. D., Williams, C.A. and Esposito-Smythers, C. (2019). Characteristics of a first suicide attempt that distinguish between adolescents who make single versus multiple attempts. *Archives of Suicide Research*, <https://www.tandfonline.com/doi/abs/10.1080/13811118.2019.1635931?journalCode=usui20>
- ¹¹ Coroners Court of Victoria (2019), *Data Summary Prepared to Assist the Royal Commission into Victoria's Mental Health System*, p. 26 (cited in Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 325).
- ¹² Australian Bureau of Statistics (2019), *Research paper: Psychosocial risk factors as they relate to coroner-referred deaths in Australia*, <https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/1351.0.55.062Main%20Features32017?opendocument&tabname=Summary&prodno=1351.0.55.062&issue=2017&num=&view=>
- ¹³ Clapperton, A., Newstead, N., Bugeja, L., Pirkis, J., (2019). Differences in Characteristics and Exposure to Stressors Between Persons With and Without Diagnosed Mental Illness Who Died by Suicide in Victoria, Australia. *Crisis*, 40(4) 231-239.
- ¹⁴ Clapperton, A., Bugeja, L., Newstead, S., Pirkis, J., (2018). Identifying Typologies of Persons Who Died by Suicide: Characterising Suicide in Victoria, Australia, *Archives of Suicide Research*, (17) 1-16.
- ¹⁵ Suicide Prevention Australia, (2019), *Turning Points: Imagine a World Without Suicide*, p. 9 <https://suicidepreventionhub.org.au/wp-content/uploads/2019/10/2019-Suicide-Prevention-Australia-Turning-Points-White-Paper.pdf>
- ¹⁶ National Mental Health Commission (2018), *Care After a Suicide Attempt Project Report*, p. 41 <https://www.mentalhealthcommission.gov.au/monitoring-and-reporting/spotlight-reports/care-after-a-suicide-attempt-project-caasa>
- ¹⁷ Victorian Department of Health and Human Services (2018-2019), *Victoria's Mental Health Services Annual Report*, p. 80.
- ¹⁸ *Ibid*.
- ¹⁹ *Op cit*, Dwyer (2019), cited in Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 335.
- ²⁰ *Op cit*, Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 345-347.
- ²¹ Mental Health Productivity Commission (2019) *Draft Report into Mental Health Overview*, p. 2.
- ²² *Ibid*, p. 2-3.
- ²³ *Op cit*, Royal Commission into Victoria's Mental Health System, *Interim Report*, p. 19.
- ²⁴ *Ibid*, p. 346.



Bibliography

- Australian Bureau of Statistics, (2014) Causes of death, Australia, 2012: Suicide – key characteristics. ABS, Canberra
- Borges, G., et al., (2010). Twelve month prevalence of and risk factors for suicide attempts in the WHO World Mental Health Surveys. *Journal of Clinical Psychiatry*, 71, 1617.
- Clapperton, A., Bugeja, L., Newstead, S., Pirkis, J. (2018). Identifying Typologies of Persons Who Died by Suicide: Characterizing Suicide in Victoria, Australia, *Archives of Suicide Research*, 17, 1-16
- Clapperton, A., Newstead, N. et al., Bugeja, L., Pirkis, J. (2019). Differences in Characteristics and Exposure to Stressors Between Persons With and Without Diagnosed Mental Illness Who Died by Suicide in Victoria, Australia. *Crisis*, 40.4, 231–239
- Coroners Court of Victoria, *Data Summary Prepared to Assist the Royal Commission into Victoria's Mental Health System, 17 July 2019*, cited in the Royal Commission into Victoria's Mental Health System (interim report),
- Defayette, A. B., Adams, L. M., Whitmyre, E. D., Williams, C.A. and Esposito-Smythers, C. (2019). Characteristics of a first suicide attempt that distinguish between adolescents who make single versus multiple attempts. *Archives of Suicide Research*, published online.
- Department of Health and Human Services, *Integrated Data Resource, Victorian Emergency Minimum Dataset, 2017–18 and 2018–19*, cited in the Royal Commission into Victoria's Mental Health System (interim report)
- Dwyer, J (2019). Witness statement to the Royal Commission into Victoria's Mental Health System from Jeremy Dwyer, Manager Suicide, Mental Health and General Investigations, Coroners Prevention Unit, Coroners Court of Victoria.
- Hill, N.T.M., Halliday, L. and Reavly, N.J. (2017). Guidelines for integrated suicide-related crisis and follow-up care in Emergency Departments and other acute care settings. Sydney: Black Dog Institute.
- Hunt, I.M., et al., (2009). Suicide in recently discharged psychiatric patients: A case control study. *Psychological Medicine*, 39, 443-449.
- Meehan, J. et al., (2006) Suicide in mental health in-patients and within 3 months of discharge. *National Clinical Survey. British Journal of Psychiatry*, 188, 128-134.
- National Mental Health Commission (2018) Care After a Suicide Attempt. NHMRC Centre of Research Excellence in Suicide Prevention.
- Nock, M.K. et al., (2008) *Suicide and suicidal behaviour. Epidemiological Review*, 30, 133-154.
- Pirkis, J.P. et al., (2000). *Suicidal ideation and suicide attempts among Australian adults. The Journal of Crisis Intervention and Suicide Prevention*, 21, 16-25.
- Royal Commission into Victoria's Mental Health System Interim Report (2019)*
- Suicide Prevention Australia (2019), *Turning Points: Imagine a World Without Suicide*, September 2019, p. 9.
- Stokes, B. (2012). Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/ services in Western Australia. Department of Health, Western Australia and the Mental Health Commission, Perth W.A.
- Victorian Department of Health and Human Services, *Mental Health Services Annual Report 2018-2019*.



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