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Submission: Review of Canberra Health Services Initial Management, Assessment and Intervention for a Person Vulnerable to Suicide Procedure.

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This submission has been prepared by the ACT Mental Health Consumer Network (the Network) in response to the invitation from Canberra Health Services (CHS).

Acknowledgment of Country

We wish to acknowledge the Ngunnawal people as traditional custodians of the land upon which we sit and recognise any other people or families with connection to the lands of the ACT and region. We wish to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people may be reading this submission, and we recognise the ongoing contributions of all Indigenous peoples to ACT society and Australia more broadly.

The ACT Mental Health Consumer Network

The Network is a consumer-led peak organisation representing the interests of mental health consumers in the ACT in policy and decision-making forums. The Network is committed to social justice and the inclusion of people with experience of mental illness. Run by consumers for consumers, our aim is to advocate for services and supports for mental health consumers which better enable them to live fuller, healthier and more valued lives in the community.

General comments

The Network welcomes this opportunity to contribute to the CHS Initial Management, Assessment and Intervention for a Person Vulnerable to Suicide Procedure (the Procedure).

The Procedure should ideally be written in plain language and should include illustrations such as flow-charts etc.

Consumers approved of the Procedure as an indication of CHS's commitment to make sure that all CHS staff have clear guidance regarding the support and care of persons vulnerable to suicide. The principle of ensuring that all CHS staff are trained to be observant of risk-factors will increase the likelihood that at-risk consumers will

be identified and referred to appropriate supports and services before their distress escalates to the point of a completed or attempted suicide.

With this in mind, consumers identified four points of concern in relation to Section 1 of the Procedure that would benefit from small, but important, rephrasing prior to finalisation. Specifically, consumers observed that some statements in this section are phrased such that they imply some stigmatising notions about the process of accessing mental health supports that could prove counter-productive in practice. While discussions of each instance where this occurs are detailed, these are ultimately easy adjustments to make.

'Recent psychosocial stressors'

The first point relates to the list of Suicide Vulnerability Factors (p. 3). Here, consumers noted that the list includes 'Recent psychosocial stressors' and provides some examples. It was observed that this list of examples should include 'severe physical and/or psychological trauma'. Survivors of traumatic injury and experiences may present to a health service for the treatment of physical injuries, health complications or recovery without a prior history of engagement with mental health services. Due to this, it is important that health workers are mindful of the psychological impacts that severe trauma can create and that such incidents may precipitate suicidal ideation and planning.

'Poor engagement in services/no help seeking'

The second point also concerns the Suicide Vulnerability Factors list (p. 3). Specifically, consumers highlighted the second to last factor of, "[p]oor engagement in services/no help seeking" (ibid.). While consumers understood that the inclusion of this factor is intended to be a strictly factual consideration, they nevertheless argued that this phrasing replicates stigmatising assumptions about people with mental health conditions. For instance, this phrasing elicits stigmatising notions about some people being 'treatment resistant', 'wilfully non-compliant' or even 'unwilling to help themselves'.

Consumers emphasised that the issue with this phrasing is that it may lead health workers who do not specialise in mental health to overlook care-relevant information. For instance, if a health worker assumes that a person who is at-risk simply lacks the willpower or desire to 'get help', then there is a risk that they will not ask the person

about obstacles to formal support that may have prevented them from accessing local services. Yet, there are many reasons why a person who is at-risk may have had limited engagement with services. For example,

- they may be unable to afford to access services that are local to them;
- they may live in a region where local services lack capacity to provide care (i.e., understaffed, no linguistic support, no specialists, etc.); or,
- they may have previously experienced discrimination, ineffective treatment or stigma when engaging their local services.

Barriers to access such as these are directly relevant for the purposes of determining the best means for supporting a person who is at-risk. As such, using phrasing that encourages health workers to enquire with, rather than make assumptions about, a person would reinforce the overarching purpose of the Procedure. Consequently, consumers recommended that changing this factor from '[p]oor engagement in services/no help seeking', to 'Material and/or holistic barriers to accessing local services', or something similar that avoids the aforementioned negative connotations.

'*Willingness to engage and seek help*'

The third point of concern arises the Strengths and Supports subsection of Section 1 (p. 4). This issue follows from the previous issue, albeit in a different context and implying a related but different assumption. In the list of Strengths, Resilience and Coping Strategies, consumers highlighted the phrase, '[w]illingness to engage and seek help'. Again, consumers noted that this phrasing carries connotations about accessing mental health supports that may lead non-mental health specialised health workers to overlook care-relevant information.

There are many reasons why a person may have been unable to access supports and services or decided against doing so. For instance, a person may be sincerely willing to engage with services, but their local mental health services could be inaccessible, unavailable or unaffordable. In such cases, willingness alone is insufficient to enable them to engage with local mental health services. Conversely, a person may have sufficient resources to access local services, but have previously experienced stigma, discrimination and ineffective care when they've engaged with their local services. In such cases, the obstacle they face is not a 'lack of willingness' but rather 'a lack of holistically safe services'.

To combat this, consumers recommended changing this phrase from '[w]illingness to

engage and seek help', to 'Material and holistic enablers to engaging supports and services', or something similar that avoids the aforementioned negative connotations. Reframing this factor this way would encourage health workers to inquire with the person about the factors that they see as most important to facilitating their connection with a service. This will lead to specific and practical information about what a person needs to engage with services, rather than a momentary impression of their perceived 'willingness'.

'*Natural supports*'

The fourth point for feedback also stems from the Strengths and Supports subsection, and concerns the terminology of "natural supports" (p. 4). Consumers noted that none of the examples listed here could be reasonably defined as 'natural'. They are all fundamentally *social* and are organised according priorities and norms that are inclusionary for some people and exclusionary for others. For example, participation in sporting groups is often difficult or prohibited for many people who are marginalised due to financial barriers and/or gender and ability-based exclusions. Using the term 'natural' to describe inherently social supports risks normalising the idea that there are sites where anyone can be expected to be able to participate equitably. Unfortunately, this is not the case. Moreover, if a person has become increasingly socially withdrawn, then it is important that the health worker who conducts the initial management process avoids making assumptions about the 'natural supports' that the person 'ought' to have access to, and instead asks them about the supports that the person has or wants to have access to.

As with the prior points of concern from Section 1, the Procedure would benefit from the use of phrasing that discourages health workers from making assumptions and instead encourages them to enquire about the specific needs of the person. Consumers therefore recommend that the term 'natural supports' (pp. 4, 8 & 17) be replaced throughout the Procedure with the term 'social supports'.

Substantive Recommendations

Recommendation 1:

This examples for 'Recent psychosocial stressors' (p. 3) should also include 'severe physical and/or psychological trauma'.

Recommendation 2:

The suicide vulnerability factor ‘Poor engagement in services/no help seeking’ (p. 3), should be rephrased to either ‘Material and/or holistic barriers to accessing local services’, or another phrase.

Recommendation 3:

The strengths, resilience and coping strategy factor of a person’s ‘[w]illingness to engage and seek help’ (p. 4), should be rephrased to either ‘Material and holistic enablers to engaging supports and services’, or another phrase.

Recommendation 4:

The term ‘natural supports’ (pp. 4, 8, 17), should be replaced with the term ‘social supports’.

Editorial Recommendations

The following edits are recommended:

The References section of the Procedure (p. 20) should use a consistent, standard referencing style. Some items in the Reference section include a hyperlink but no url, while other items are missing key information such as the year of publication or doi reference.

There were several grammatical and typographical errors throughout the Procedure. The Procedure should be thoroughly proofed before finalisation. The editorial recommendations noted below are the most urgent corrections that need to be addressed, but are among many others:

- Title & Contents, p. 1:

  Section 4- Intervention…
  Section 6- Aftercare…
  Section 7- Support for staff…
  Section 7- Privacy and consent…
  Section 8- Staff training and resources…

  The numbering of sections in the contents table is discontinuous. This discontinuity persists in the main body of the Procedure.

- Section 2: Initial Management and Escalation, p. 8, ¶2:

  Please see Attachment Two: Attachment Two: Table of observable signs of suicidal behaviours.

  The referenced document title has been duplicated and an underline misapplied to part of the title.

- Section 2: Initial Management and Escalation, p. 11, ¶1:

  Please see Attachment Three: Attachment Three: Online/telephone resources.

  The referenced document title has been duplicated and an underline misapplied to part of the title.

- Section 4: Intervention, p. 15, ¶1:

  A safety planning intervention is a collaborative process with the person, clinician and family and carers wherever possible.

  This is a run-on sentence. It should be rephrased for clarity with text such as:

  A safety planning intervention is a collaborative process between the person, their clinician and, where possible and appropriate, their family and/or carers.

- Section 4: Intervention, p. 15, ¶1:

  The safety planning intervention includes identification of warning signs, internal coping strategies … and counselling on access to lethal means.

  This sentence presents a list of options to be considered for inclusion in a safety plan. However, the phrasing of the last option 'counselling on access to lethal means' implies that counselling regarding *how to* access lethal means is an option for consideration. Clearly, this is not the intention. As such, this sentence should be rephrased to clarify that this option concerns the offer of counselling for the purposes of *managing risks of lethal means accessible to the person at risk*. For example,

  The safety planning intervention includes identification of warning signs, internal coping strategies … and counselling for managing and controlling access to lethal means.

- Section 4: Intervention, p. 15, ¶2:

  Clear actions, roles and responsibilities for addressing access to lethal means are also be agreed upon in this process.

  This sentence contains a subject-verb disagreement and should be rewritten for clarity. For example,

  The safety planning process should identify clear actions, define roles and determine responsibilities for the management and control of access to lethal means. Through this process, the person, their clinician and, if relevant, supporting family and/or carers, must agree upon the completed safety plan.

Conclusion

Consumers and the Network appreciate the Procedure as an important step towards improving support for people who are experiencing elevated distress and who may be experiencing suicidal ideation or at-risk of attempting suicide.

These recommendations are based on consumer feedback and have been provided for the purposes of enhancing the Procedure.