

Youth Focus Inc

1. Promote professional community and consumer understanding of suicide, its link with mental health and effective strategies for prevention.

How can government and non-government organisations develop more sustainable approaches to training in suicide prevention?

Current training is piecemeal, targeting different audiences. There is a need for local mental health tertiary training, well being and suicide prevention could be specialist units. Specialist training targeting professionals should be linked to role and receive award/payment recognition.

Mental health first aid could become a mandatory requirement under health and safety legislation, i.e. someone trained must be available on site.

As with first aid, community based adoption of mental health first aid should and could be promoted.

Use of mentors and coaches.

How could the evaluation of government and community-based suicide prevention programs be evaluated more consistently?

Development of good practise principals would be helpful eg similar to those developed by LIFE

Government agencies hold a lot of expertise and resources in this area, would be helpful if they would act as mentors, coaches and advocates for smaller agencies such as ourselves who are interested in this field.

I would like to see more cross agency evaluation of treatment methods other than CBT and DBT.

How should existing epidemiological surveillance systems be managed to enable their more effective utilisation?

Wider understanding of what and who they are. Easy access to current data eg: On line access.

Lag time in release of data is significant, this results in blind planning and strategy development for organisations who are not in the 'know'. Access to epidemiological trends and patterns would assist our organisation in its short and long term planning.

Consultation with the sector as to what data would assist them in this planning process would also be helpful.

How can high quality information relevant to the needs of different professional and community groups concerned with suicide prevention be more effectively disseminated?

Electronically. Access to on line data sources eg: clearing house perhaps similar to ASPIRE. Distribution of electronic newsletter. Local conferences/forums/workshops.

2. Strengthen prevention, promotion and early intervention in mental health and suicide prevention.

What needs to be done to ensure that the Council strengthens its links with key stakeholders (media outlets, community leaders)

Clarity of its role and function. Promotion of this brand. Development of relationships and if relevant partnerships with key stakeholders.

Council structure needs to be reflective of its role with community and political support.

Council representation and membership must also be reflective of its purpose. Key organisations such as ours must have a formal and regular communication process with the Council.

What investment is needed to build a coordinated and sustained approach to mental health promotion across the state?

Across government and bi partisan support. For agenda to be implemented there must be financial incentives for buy in. This must then follow through community funding avenues. In time this would create a change in culture.

Strategy or plan must translate to implemented practise. Unless there is some form of doing this at a grass roots level, no action will occur.

Should media-based community education strategies be developed to reduce stigma and promote awareness of avenues for securing help with mental health problems?

100% yes. Community attitudes must change to that of help seeking. Must be done in partnership with service providers and existing educators eg beyond blue

What practical strategies are needed to improve men's help-seeking behaviour and enable services to be more accessible to men?

Community education promoting a message that it is masculine and okay to seek help. Would be ideal to see more of this in TV programs and from media personalities which men can relate to eg sports etc..

Target campaigns similar to post trait cancer need to be adopted.

However, services must be available. Research conducted as to why men aren't accessing services eg MCSP, needs to be implemented.

3. Build community capacity for suicide prevention

What is needed to enable different local groups to come together, share information and develop strategies for working together?

At one time Population Health, Wellington St provided a quarterly networking event. One or two guest speakers would present followed by a morning tea. We found this event extremely useful as it was attended by senior personal across all areas of suicide prevention, opportunity to hear about what was going on in the state and an excellent opportunity to network. Also provided a focal point if you where looking for

an opportunity to publicise new developments as well as sourcing potential partners. We would like to see this event or sometime similar occurring.

The development of strategies to work together or partnership activity is resource intense and as such requires financial and practical support. We have found there is often a will and desire for this to occur however, activity soon falls flat as organisations simply don't have the additional time and resource to support. In addition, the process can often become politically sensitive with a need for external support, guidance and coaching.

The creation of a support team which the wider community could access would be ideal. The functions of the team would be around: provision of administrative support, coordination of meetings, coaching, facilitation and mentoring. The aim would be to promote proactive activity as opposed to reactive eg: currently it tends to only happen in response to funding opportunity.

How can 'infrastructure' such as innovative fuse of new technologies be created to support networking?

Target only WA service providers only (be focused)

Establishment of electronic data base of service providers, carers and users who want to be involved

Establishment of a list of people, who are willing to offer their expertise and assistance free of charge for others to use. (not service delivery but rather peer support, mentoring)

Diary of local events (current sources cover the world and can be too timely to look through)

Creation of discussion blogs

Regular time tabled discussion eg: 9 - 11am Professor XX will be available to answer your questions on...

Make it easy to use - i.e. straight to the point

How can organisations that have a shared interest in suicide prevention, be supported to build alliances to Reduce key risk factors?

Greater use of partnership activity with population health and universities.

Increased consultation in the development of funding and government initiatives.

Strengthen protective factors?

as above

4. Support planning within and between government and community sector agencies for suicide prevention.

How should current suicide prevention initiatives be aligned with the New State Mental Health Plan

As indicated earlier for the plan to be meaningful it must translate into grassroots action. As such it must tie in with the realities of life and stem from existing activity. The plan would be most efficient and effective if it were able to start from what is already occurring, address gaps and development of future strategy and planning.

What is needed to ensure that risk assessment procedures, referral processes and support mechanisms are developed by different groups and agencies and the reciprocal relationships between agencies are clarified?

There is a need to maintain the delicate balance between best practise principals and bureaucracy. There is vital role in government taking a lead role in the identification and promotion of best practise and provision of investment and support to ensure the community adopts. Once again we believe that there is opportunity for local delivery of tertiary studies in this area.

Many tools currently exist. A process of support and expert assistance in selection of what works best where and when would be helpful.

Should each State Government department be encouraged to develop its own strategic action plan (including a training plan) for suicide prevention?

YES. This needs to be tied to finances otherwise there is the risk that implementation will not occur.

What should be done to strengthen the communication between the Commonwealth and State governments with regard to suicide prevention in WA?

Often it appears that there are polarised views and lack of coordination. Need for greater synergy of activity and direction.

How can networking between 'resilience building' and other community-based projects be facilitated by use of new information technologies and communication systems - particularly for more geographically isolated communities?

See earlier comments regarding use of internet, blogs, on line discussion, support groups, mentoring and coaching support and access to expertise. ARACY's teleconferencing (grids) is another good example of the use of technology in bringing together geographically distant parties.

Are there specific legislative considerations needed to enable the timely exchange of relevant information between departments in situations of heightened suicide risk (eg suicide 'clusters' or teenage pacts)?

We have had no experiences when legislation has restricted timely exchange of information.

What organisational mechanism is required for government accountability in the implementation so the WA State Plan for Suicide Prevention?

An executive group is required to oversee implementation and that KPO's/KPI's are met. This group must have authority above individual departments and ability to direct funding relating to Suicide Prevention. Without supporting financial incentives it is unlikely that implementation will occur. Support for the Plan must be obtained from the highest level of government. Bipartisan support would be the ideal.

5. Build partnerships, professional and community capacity to address the high-rate of suicide among Indigenous West Australians

What is required to support the re-establishment of an Aboriginal Suicide Prevention Working Group to support the participation of Aboriginal community agencies and to build collaborative relationships with mainstream mental health and other human service providers?

It is imperative that Indigenous, CALD and refuge needs are identified and met in the development of a State Suicide Prevention Plan. It is important to be clear as to why the working group previously disbanded, and to learn from this experience, in addition it is imperative that representatives from these groups be consulted and for these groups to address their own way forward.

Given that reducing suicide in Indigenous communities is of one of the 'headline' indicators of COAG's Overcoming Indigenous Disadvantage strategy, what priority should be given to Aboriginal Suicide Prevention in the implementations of the State Mental Health Plan and the State Suicide Prevention Strategy?

Reduction of suicide across the whole community needs to be a focus however, economic rationalism dictates that resources are directed to priority groups. Current service delivery practise does not tend to be exclusive to Aborigines and other minority groups but not inclusive. We would like to see the universal adopt of more inclusive practises.

Health indicators for Indigenous Australian must be raised to the same level as non Indigenous Australians.

What investments are needed to build partnerships with Aboriginal and mainstream service providers in training and support for managing critical incidents and suicide clusters?

Best practise principals in the assessment, response and management need to be developed and then turned into local responses. Centralised resources to support and assist community based agencies to undertake this task would be helpful.

How can the work already being done by communities and Departments in universal prevention in building community capacity be best supported?

Increased links with service providers.

1a. Do you consider any of the 5 key issues unimportant?

No

1b. Do you think an key areas for action are missing? If so, what are they?

Development of state plan must be linked to Health Plans as well as bereavement.

2. What are key factors that may be contributing to suicide risk in your local area?

Disjointed referral paths. General public unsure where to go for support. Long waiting periods. Lack of affordable quality service provision. Lack of family support. Lack of peer support.

3a. Thinking about the 5 key areas for action, what is currently being done, locally, about one or more of these actions?

Plenty, a mapping/scoping exercise is required to record this activity.

3b. What important actions are not occurring locally?

Coordination of activity and presences of a peak body. Role clarification of MCSP needed - is it a peak body, clearing house, centre of excellence in information provision, research agency, service provider, quasi government department, does conflict of interest exist?

3c. What more would you like to see done to prevent suicide.

i) at a state level?

5 yr State Suicide Prevention Plan and supporting action plans. Supported and adopted across government. Clear identifies and resourced targets.

ii) local level?

Increased service provision. Youth Focus is unable to meet demand.