

# Albany

2<sup>nd</sup> July 2007  
1pm – 5pm  
xx participants

## Organisations represented.

- Public Health
- Silver Chain
- Headspace
- WA Police
- Men's Resource Centre
- Great Southern Mental Health
- The Lighthouse
- City of Albany
- Youth City of Albany
- Manager Men's Resource Centre
- Great Southern Grammar School
- Great Southern Local Community Partnership
- Commonwealth Respite & Carelink Centre
- Great Southern General Practice Network
- Great Southern Anglicare
- Rural Financial Counselling Service WA
- Southern Agcare
- Housing Services Southern Region
- Department for Community Development
- Office for Children and Youth
- WA Department for Health and Aging
- Community Justice Services
- Non Government Schools Psychology Service
- Young House

This Plan will influence the WA Government in its efforts at Suicide Prevention for the next 5 years. We are getting input from all regional's of WA: What key issues need to be fed into that plan. Individual written feedback is welcome [www.mcsp.org.au](http://www.mcsp.org.au).

## Approaches to suicide prevention.

Not just numbers that we are talking about, we are talking about people and peoples lives. Need to look at this in a full human context.

Realize that to make a difference to reducing suicide,, we need to address the full range of mental health. Any one time in the population, 15-20% of people have mental well being are flourishing – 50% moderate mental health, have good days and bad days, life happens and we deal with difficulties. 30-35% are not too happy in themselves and of those, 15-20% whose feelings of welling functional impairment, relationships, work and internal stress impairs functioning. Suicidal thoughts, suicidal behaviour and a relatively small proportion of people who end their lives through completing suicide. The strategies we use need to address all ends of the spectrum, looking at mental health promotion and mental health maintenance and focusing on

early intervention, treatment and relapse prevention. In suicide prevention we are not just looking at those in crisis, but to look at people throughout the spectrum to prevent people moving toward high risk. When looking at the acute end, all human services providers need a good knowledge of the progression of acute suicidal behavior – particularly in the last weeks or months of their life. 2/3 of cases, clear evidence of an active disorder, very commonly alcohol and substance use disorders which compound the problems. Stress event may overwhelm the person. the stress event in itself is not what we concentrate on, rather the way in which the person reacts to it. The acute mood change - - risk can be lessened by the links and support in their community which may buffer that and slower the mental state down. Where there is real risk is when a person has rigid thinking or an intense focus of one way to solve problems. Other social factors such as available method, being alone and recent exposure of suicide. Increased agitation is the point at which a persons risk is high

Need to look at ways and times in which we can intervene along this process.

## Brief overview of state trends, and how we compare locally.

per 100,000 state average. Great Southern sits at state average of 12.7 per 100,000

Nationally Great Southern is looked at for good intersectoral capacity.

Who in the community is at high risk? Pie chart looks at all of WA and Great Southern. Over the past 10 years, GS has accounted for 64 deaths of the 2,378 deaths in the state.

Age risk is now of most concern in those aged 25-44 years – our focus needs to shift.

Deliberate self harm to WA hospitals private and public. male and female non aboriginal female n=19,021; male 12,078 Aboriginal female n=1,585; male 1,329. Rate has remained relatively stable over the past decade. Looking at the Great Southern see a different story. The numbers for females has been trending downwards and males trending upwards. For males this may mean that more males are seeking help.

For WA the numbers for completed suicide for males and females has decreased over the past 10 years More deaths due to suicide than road deaths. It is encouraging that the suicide rates have decreased, however a sustained effort is required.

Completed suicide in the great southern also shows declines. ....from a rate of .. .to....

## What's happening locally?

Mark Henson Mental health

multidisciplinary team. 3 nurses, 2 psychiatrists currently contracting a 3d. 3.6 counselors. no waiting period for people who present as suicidal. Duty officer system also in place.

Major developments. commonwealth funding. rural support services. early intervention service for anxiety or depression. targeting populations 5,000 or less. very effective in reducing waiting list numbers.

better access counseling through Dev Gps. Have noticed less referrals having been coming through for mild to moderate cases.

Marie Dawes CAMHS early intervention officer

dedicated positions for EIO. staff dedicated in public health for prevention, promotion in mental health continuing RAP training. offered in Albany and Narrogin. HS teachers to prevent depression

Friends – anxiety and depression primary and high school level. provide training to teachers for year 4 students. also offer more intervention for children already showing signs of anxiety or depression or COMPI Healthy StRT. Mental Health literacy program. mental health promotion of primary school teachers and day care facilitators.

Gatekeeper training. run twice a year. been particularly useful.

Mental Health First Aid. Project between DI GP and Health, RCSS – funded through DOHA train 9 trainers. will deliver 15 courses.

Sandra Crowe Public Health

Mentally Health WA Project. funded by ....

social marketing campaign. Implemented in 6 communities in WA in country health regions.

Albany

Esperance

Northam

Act – mentally, physically and socially (go for a walk, cross word, coffee with friends, talk to your neighbor)  
Belong – join a club or participate in a community activity  
Commit – set goals about being physically or socially active, take a role in a club.

Deliver a positive mental health message. Think of positive aspects of mental health.

Paid advertising

unpaid publicity

18 months from Oct 05 to April 07

41 unpaid ; 17 radio interviews

conduct seminars and workshops. 30 events in last 18 months with ABC linked in.

awareness raising. to keep mentally healthy you need to Act, Belong Commit.

12 month report available. contact Sandra Crowe. Final survey to be done in Oct. Final results due in Jan 2007. 3 more years to support project.

## The 5 Key Areas of the Plan.

State plan has been part of the conversation for some time. The notion has been talked about as early as 2004. Have looked at state plans throughout Australia, particularly Queensland. Undertook to start thinking and looking at what a state plan will look like. What should a state plan for SP look like. A number of key themes continued to come up. 10 regional, 3 metro and now talking to Aboriginal organizations to look at how to inform this process. Gather together key themes and flesh out ideas and interests and let that be the starting point for discussion. This is the consultation paper.

- i Promote professional community and consumer understanding of suicide, its link with mental health and effective strategies for prevention  
Evidence based practice. Acknowledging that there will be a number of perspectives. need to get to a point where we have a shared understanding.
- i Strengthen prevention, promotion and early intervention in mental health and suicide prevention.  
raising awareness of reducing stigma help seeking
- i Build community capacity for suicide prevention.  
identify those resources, the strength and assets that can be mobilized and look at how to sustain these initiatives.
  - i
- ii Support planning within the between government and community sector agencies for suicide prevention.  
Integration, collaboration, cooperation, coordination, who is responsible. How do we stop people from falling through the gaps.
  - i
- ii Build partnerships, professional and community capacity to address the high-rate of suicide among Indigenous West Australians.  
Cultural appropriateness  
self determination  
and all other things that fit under the other 4 key action areas.  
parallel process to the mainstream consultation process.

## Group Exercise

**Participants asked to place dots: if we could only pursue 2 of these areas, which would they be.**

- 1 - Promote professional community and consumer understanding of suicide, its link with mental health and effective strategies for prevention (n= 10).
- 2 - Strengthen prevention, promotion and early intervention in mental health and suicide prevention (n=

- 21).
- 3 - Build community capacity for suicide prevention (n= 12).
  - 4 - Support planning within and between government and community sector agencies for suicide prevention (n= 1).
  - 5 - Build partnerships, professional and community capacity to address the high-rate of suicide among Indigenous West Australians (n= 10).

**Participants asked to put an X if you think any of these are wrong or unnecessary, put an X on it.**  
No crosses were put underneath any of the five key areas.

Not that Key area 4 received only 1 dot. Group asked to comment.

Feedback from group:

It was noted by the group that this area was less action oriented. This area is more looking at the planning that would need to support the other action areas. It was also noted that the Great Southern had a lot of interagency communication and support already. Group felt they wouldn't want to invest more time on this. It may be more appropriate to redirect current interagency time, rather than invest in new strategies.

**A4 sheets, another Key Area that has not been addressed. (not specific actions).**

Suggestion 1: Male specific prevention strategies.

Statewide and nationally, there seem to be no male specific health strategies, despite there being female specific health strategies.

MCSP Response: This may fit under point 2 of what practical strategies are needed to improve men's help seeking behavior and enable services to be more accessible to men. Note two issues, firstly looking at internal motivation and secondly the responsiveness of services to the needs of men. The issue of male specific strategies should also be incorporated under point 1 and point 3.

Suggestion 2: Adapt a political and economic focus.

The issue of resourcing was raised in the context of any plan that is developed needs to have money attached. When strategies are planned, this needs to be done in combination with where the money is going to come from.

MCSP Response: Minister concerned about this issue, this state plan is due to be submitted to him in time for the government's preparation of its forward estimates for its budget allocation over the next few years.

Suggestion 3: Support for workers who work in the area of suicide prevention

Suggestion 4: Need to target areas of greater needs, particularly focusing on Indigenous Suicide Prevention. Suicide Prevention Intervention Team for Great Southern is required that would enable flexibility where we can go out to the community. Indigenous population – suicide rate is unacceptably high. Indigenous mental health needs to be a priority as they are the people with the highest suicide rates. Need to deal with the issue of suicide from a historical context – recognition of the way that the Australian system has disenfranchised Aboriginal people. The Stronger Families program was recommended, drawing on the collaborative case management approach. The planning of the state suicide prevention plan should incorporate a parallel process that is brought together at some point with mainstream.

MCSP Response: Two senior Aboriginal people (Gloria Kahn and Neil Fong) have been involved in the state plan planning process so far. At their recommendation the Council decided to conduct a parallel consultation process for Aboriginal community members and services. It was acknowledged that the issues relating to Aboriginal people are absolutely paramount and may require different strategies. It was noted that capacity building and developing new partnerships will be required to enable this process.

# 1. What are particular factors that may be contributing to suicide risk in this region?

## Group 1

- Isolation
- Drugs – types (ice, meth)
- Family breakdown
- Transparency
- Unemployment
- Ageing Population
- Drought/wet - farming community
- Economic migration
  - Reality
  - Resourcing
- Copy cat – self harm
- Lack of resources
  - e.g Rehab
  - Boredom
- Work & Finances - Balance
  - “Social norm” to earn big \$\$
  - High disposable income – spend rapidly
- Lack of services (youth in particular)
  - waiting lists
  - accessibility
- High amount of un access e.g. farms
- Policing with regards to alcohol use
- Reduced social cohesiveness

## Group 2

- Drugs & Alcohol (Ice)
- Lack of help at desperation level even on Help lines!
- Lack of support post suicide – for families
- Lack of employment (Including farmers)
- Isolation
- Family Breakdown
- Racism & Internalised racism
- Stigma of M.H.  
makes people weary of seeking help

## Group 3

- Increased isolation – economic decline of small towns .
- (Schools, hospitals) loss of community
- Bigger gap socio-economically. Poor moving out to small centres
- Impact of bad years on peoples welfare
- Absence of pro-active leadership to protect the most vulnerable
- Conservatism in the medical profession – medical vs recovery models
- Amphetamine use escalated v. suddenly
- Psychosis – sudden increase in incidence  
“Silo-mentality

## Group 4

- Economic Hardship/Failure – Farming
- Feeling of Despair/Hopelessness

- Isolation – geographic/social
- Population decline/relocation
- Economics decline
- Environmental declined
  - Linked/and
- Substance usage
- Family/Relationships Problems/Breakdown
- Rising Housing Costs for people excluded from boom
- Impact of new technology – promotes isolation
- Access to GP's – inland areas

#### **Group 5**

- Transient Community/Seasonal
- Isolation (Practitioners)
- Drugs & Alcohol
- Sexuality/Gender
- Social Relationships
- Mental health disorders
- Financial hardship
- Finding one's place
- Language/Cultural barriers
- Indigenous

## **2.1 What is already happening in this region?**

#### **Group 1**

- RCSS – Rural Community Support Service
- G Ward
- GSMHS
- Strong Families
- Local Police
- Rural link –after hours phone service
- School Ed – KAP, FRIENDS
- Art & Drumbeat – Noongar specific
- Clontarff Footy Academy
- Bouncing Back (partners sessions)
- Young Dads
  - (Noongar - Spiros )
  - ( - Tony )
- Anglicare
- Depression forums
- Not much happening in smaller communities

#### **Group 2**

- Inter-agency co-operation
- Strong families – DCD
- Support Group for Survivors/Bereaved – Light House initiative
- AG – Belong – Commit - \$
- Best Beginnings – DCD & Health

#### **Group 3**

- Mental health promoter – Beyond the Blues Forums
- Mentally healthy project (ABC)
- Mount Health Partnership. Model
- Mental Health First Aid
- Friends and R.A.P.
- Better Outcomes Project – one pilot region

- 'Can Do' Programme
  - RCSS programme
  - LTF
    - First regional men's health
    - Corporate collaboration
- Mediation for youth. Open Access Project

#### **Group 4**

- Beyond Blue
- Awareness
- Training programmes
- Government & NGO Services/Responsibility
- Good networking by the Agencies
- Partnerships with business/employers
- ACB Program ETC
- Prisons/Juvenile Justice

#### **Group 5**

- True Colours
- Strong Families
- Community Bus Service
- School based resilience programmes
- A-B-C
- Communities for Children
- Community development programmes
- Bouncing Back
- Increasing public awareness
- Gate Keeper

## **2.2 What more needs to happen**

### **i locally?**

#### **Group 1**

- Risk assessments for early intervention
- Cellular approach based on numbers rather than geography – telephone and personal counselling (free) (1)
- Suicide intervention team that is responsive and mobile and culturally sensitive. Referrals through GP's and MH professionals. (5)
- Continuation of MH prevention and promotion programmes. (5)
  - Availability to smaller communities.
  - Including TV programmes/Advertisement e.g. PPP
- Outreach services for prevention and intervention to small country towns and communities. (1)
- Registry of services that is available.
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#### **Group 2**

- Services targeting Men (1)
- Services for survivors and families
- Bereavement Outreach Service (2)
  - Quickly and far spread as possible
- Strengthen Noongar Culture (3)
  - Due destruction of ID
- Strengthening of Youth Sub-Culture

**Group 3**

- Better drug and alcohol education, counselling.  
(Like the ABC programmes) (2)
- State level co-ordination of mental health promotion. (2)
- Mental health crisis team – (After hours). (1)
- Regional suicide prevention co-ordinator (1)
- Men's crisis accommodation. (1)
- Infrastructure to accommodate people in crisis. (4)
- Strong community leadership ... local forums. (1)
- More fully resource the early onset psychosis project.
- Networking with other rural and interstate projects. (1)
- Mental health education extended into work places including highlighting economic value to employer. (3)
- State based research focussed on regional issues and environments. (2)
- Decentralisation of industries so that there is employment in rural areas.
- Encouraging other skills in community than agriculture and mining.

**Group 4**

- Sustained training strategy for agencies etc. (1)
- Community fully embracing issue – whole of Community approach. (3)
- Identify areas of most need and developing strategies specific to these issues.
- Psychiatric Emergency Team/Out of hours and mobile. ) (1)
- Outreach – mobile. (2)
- Keep building on current preventative strategies. (2)
- Suicide Prevention worker for advice/information.

**Group 5**

- More consultation at grassroots level.
- Plan to service increases in population. (4)
- Greater support for sole practitioners. (1)
- Gatekeeper or similar to continue.
- Facilitate better access to services for Indigenous, CALD, disabilities, and young people. (2)

ii at a state level?

**Group 1**

- Better mental health training for Police/Aboriginal Health Workers (2)
- Resiliency and life skills in schools (4)
  - Parenting
  - Budgeting
- Mental Health Education e.g. T.V. programmes/Advertising
- PPP on Television

**Group 2**

- More money for Mental Health (3)
- Under funded services
  - Vital to Suicide Prevention

**Group 4**

- Keep funds for prevention going. (1)
- Less duplication – support local initiatives. (2)
- Co-Ordination of current services.
- Collaboration, interagency co-operation (not competition).
- State/Commonwealth Co-operation.

- Promotion of family (i.e. Family first aid). (3)

**Group 5**

- Reconsider funding – needs ongoing funding (FTE). (5)
- Education and support for those on the ground. (5)
- Facilitate better service provision for minority groups.
- Focus on Early intervention for children.
- Mentally healthy workplaces (industry etc).
- Encourage more nurses and community workers to undertake more intensive training. (1)

### 3. What are the 4 things that will really make a difference in preventing suicide?

This Plan will influence the WA Government in its efforts at Suicide Prevention for the next five years.

**Key area 1**

- Education and support for service providers (sole practitioners, supervision, Evidence Base training.
- Better training for police and Aboriginal mental health workers
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**Key area 2**

- Mental Health education extended into workplaces making sure MH education extends into tertiary and vocational settings (key area 5 and 2)
- State level coordination of Mental Health Promotion including demographics research about regions.
- Better drug and alcohol education and counseling. More encompassing, schools and communities – like ABC in terms of broad reach.
- Mental health promotion and prevention for smaller communities ie PPP and MH (TV ads and programs)
- Implementation of bereavement outreach services in all areas.
- To build on current prevention programs.
- Increase outreach and mobile services especially in rural areas.
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**Key area 3**

- Infrastructure to accommodate for people in crisis
- Building accommodation in which a therapeutic – homelessness as well as supervision for people feeling unsafe.
- Plan to service effectively for existing and projected increases in population.
- Resilience and life skills training in schools. More specific skills such as parenting, relationships, budgeting.
- Emphasis on promotion of the family and family first aid.

**Key area 4**

**Key area 5**

- Local suicide intervention emergency team that is mobile - capacity to get to a crisis – referrals through GPs
- Strengthening Noongar culture – enhance cultural identity
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**Outliers**

- improve funding for mental health

## 4. How will these fit with the State Plan?

### Full group feedback.

Building community – councils etc changes in demographics with regard to greater divide and what leads people to feel engaged.

Making belonging easier.

Effective communities – how do we run a caring council.

Not just about the people but also about creating a greater sense of connection to the earth, people.

What is it about a community that allows people to become isolated.

Belonging to the community – underpins a range of strategies and agendas. Is this a given or a strategy. This message will go up through this consultation process. \*\*\* Major issue\*\*\*

The role of protecting the Environment as being a protective factor for people who are suicidal.

Being active rather than reactive. Look at building on the strengths of the community.

Underestimate the power of young people and what they have to offer.

Economics – beyond blue have done some unique economic modeling – economic rationalization needs to be done for suicide.

### Where to from here?

Thank you for your time. We are dedicated to this consultation process. All data will be recorded. This will be written up within a week. This process will happen throughout the state so your feedback is valuable.

Will collate the information. Important lessons – different needs that need to be catered for.

2 documents. Overall discussion paper recording all feedback from all groups.

Draft report for the Minister is required for the end of September. We will make this available prior to going to the Minister. If you have any feedback we want to hear from you. We want to represent your views.

This is an opportunity for the Government to hear your views. Sven will also be providing feedback and views to the MHN.

Consultations to specifically explore Aboriginal perspectives. We will be coming back to consult with Aboriginal community members and relevant services.

Individual written feedback is welcome at [www.mcsp.org.au](http://www.mcsp.org.au).

**Close** (4.35pm)