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WA State Suicide Prevention Plan

Consultation paper response sheet

This document is designed to prompt respondents to address the issues raised in the consultation paper. Additional copies of the consultation paper are available from www.mcsp.org.au.

Feel free to use any or all of these headings or to structure your response in any way that makes sense to you. All comments will be considered, regardless of the format.

Reply by: 15 August 2007

Submit by Email

Identifying yourself will enable us to contact you and clarify points you may make. Identification is optional. Identified submissions will be posted on the MCSP website. If you do not want your submission posted please let us know. Unidentified responses will not be posted. If you want to have your submission posted but do not want identifying information publicly displayed please contact us.

Organisation: Oats Rehab Facility, Brightwater Care Group

Position: Care Manager

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?
Train "presenters" in all/many organisations to keep the skill levels high as the turnover of staff means this training needs to be repeated regularly for new staff and to maintain skill levels of existing staff. This means that the functional approach to suicidal behaviour becomes a part of the culture. Addressing mental health issues in a similar manner will support people so that the "drift" to suicide as a solution is slowed. Cost of training is an issue, especially for smaller organisations. As well as cost of the course, there is a replacement cost for staff attending the training.

How could the evaluation of government and community-based suicide prevention programs be evaluated more consistently?
Seeking data from a wide range of community organisations to evaluate the level of suicidal behaviour that never gets to hospitals or doctors may well reveal hidden data! Many are effectively managed within the organisations. A high number of suicidal and/or self harm behaviour never gets anywhere near a hospital. Addressing coroners reports

How should existing epidemiological surveillance systems be managed to enable their more effective utilisation?
I don't know what epidemiological data is collected. There is certainly data available within my organisation which I believe doesn't get collected. Is there a way to input electronically as "self- reporting" from agencies?

How can high quality information relevant to the needs of different professional and community groups concerned with suicide prevention be more effectively disseminated?
Develop stronger links with Australian Psychological Society and other agencies/organisations. Email prompts and links to interested organisations so follow up of new information can be accessed. Electronic methods are the most accessible.

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)?
Support links through the training programmes.

What investment is needed to build a coordinated and sustained approach to mental health promotion across the state?
Mental health promotion across all areas of the state needs to be backed up with RESOURCES! There are times, places and situations when the resources are not available to deal with either a crisis or an ongoing mental illness. Invariably this places pressure on carers (paid or unpaid) who don't have the expertise. So, not just mental health promotion but promotion of the mental health resources. Recognition that mental health issues and suicidal behaviour can and do exist alongside other health and life issues- especially acquired brain injury- and treatment can be beneficial.

Should media-based community education strategies be developed to reduce stigma and promote awareness of avenues for securing help with mental health problems?
Yes. People know when something is wrong but not always where to go where assistance is readily available and timely. Promotion of the idea that mental health is another part of "health" not separate to "health". Mind and body are inextricably linked.

What practical strategies are needed to improve men's help-seeking behaviour and enable services to be more accessible to men?
Men's help seeking behaviour needs to be addressed with regard to their different approaches to health to that of women. We can't make men more like women! Centres and approaches that are relevant to men and are available in men's places- the programme that was running in a number of wheat belt towns (located in a mobile ute I think) was quite successful. A similar presentation at Bunnings perhaps?

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?
Money and resources along with strong leadership which actively seeks to build networks in similar work areas will go a long way. Most organisations and agencies struggle with work loads already so taking on leadership roles as well is not going to happen. Investment by MCSP in being the leaders will pay off!

How can 'infrastructure' such as innovative use of new technologies be created to support networking?
An electronic notice board for interested and involved professional. Posting of links. Ability to feed data in.

How can organisations that have a shared interest in suicide prevention, be supported to build alliances to:• Reduce key risk factors?
Ensure that community links are developed as part of a hospital discharge plan- initial links created whilst in-patient. More direct work by community and hospital agencies with organisations to support their work with discharged clients. It often feels like skilled support is absent once a person is discharged to a non mental health organisation in the community. This situation is very familiar to families also, especially those that are willing to take on the management of a family member with mental health issues. Their ability to cope and manage will be greatly enhanced with ongoing support- even if that is long term checking in with them as the ability to manage in the short term may be OK but diminish in the long term.

• Strengthen protective factors?
Direct support to families to strengthen their personal protective behaviours and skills. This may mean providing respite for families, group work, individual counselling. Education and training around mental health issues for families so that they can develop confidence and knowledge.

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?
Resources available in the community to support people and significant others after an attempt and when their is risk identified or suspected. Recognition by all government departments that the risk is across all service areas and that mental health issues co-exist in disability, education, youth, health etc.

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?
Coordination and standardisation so that effective data can be collected. Active leadership to develop networks so links can be maintained and used.

Should each State Government department be encouraged to develop its own strategic action plan (including a training plan) for suicide prevention?
An over arching plan across all government departments with tailoring for different groups- schools- primary, secondary, university and other tertiary- forensic, disability, youth, homeless etc

What should be done to strengthen the communication between the Commonwealth and State governments with regard to suicide prevention in WA?
Stop the funding disputes! It is an "Australia" issue! Not State or Federal!

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?
Ensure the technology is available in isolated areas. Buy it if necessary.

Are there specific legislative considerations needed to enable the timely exchange of relevant information between departments in situations of heightened suicide risk (e.g. suicide 'clusters' or teenage pacts)?There is overlap where relevant data is not communicated when it needs to be and in a timely manner. Between DET,DSC and DCP for instance.

What organisational mechanism is required for government accountability in the implementation of the WA State Plan for Suicide Prevention?
I don't know, it is not my area of expertise but it would seem necessary to demonstrate efficacy.

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?
Established sustainable links between Aboriginal agencies and other providers first and then address the suicide issues. With strong regard to aboriginal ways of communicating and relating and creating links into the mainstream on the aboriginal basis. My expertise is not in Aboriginal communities but observation of individuals(infrequent occurrences) in mainstream services

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 implementation of the State Mental Health Plan and the State Suicide Prevention Strategy?
Seeing suicide behaviours in Aboriginal communities as a reflection of community, socio-economic and society health. Particularly in Aboriginal communities these need a community approach because of the strong communal nature of some Aboriginal communities.

What investments are needed to build partnerships with Aboriginal and mainstream service providers in training and support for managing critical incidents and suicide clusters?
Time and sitting down with Aboriginal people to talk first to develop long term strategies rather than knee jerk responses to a particular event. And then translating mainstream knowledge and expertise into relevant and useful strategies which are able to be used on the ground by people in a way that is meaningful. Time investments!

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

1a. Do you consider any of the 5 key issues, above, unimportant? If so, why?
NO!

1b. Do you think any key areas for action are missing? If so, what are they?
Resource provision for acute and chronic mental health issues must be readily available to back the key areas of suicide prevention and mental health promotion. Currently this is not always the case. The dual and triple diagnosis situations need addressing- all too frequently the mental health/drug and alcohol/acquired brain injury combination provides challenges to service providers . A way to link the relevant areas, share expertise, provide joint case management would give better outcomes than current ones.

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

Lack of suitable service to address those whose suicidal behaviour may not be urgent at this moment but who may escalate the behaviour so force admission. A step in between for the less acutely suicidal may help. I work in acquired brain injury rehabilitation and mental health issues in this client group are frequently dismissed by mental health professional as "organic" and thus untreatable. This doesn't help with management of the suicide risk.

3a. Thinking about the 5 key areas for action, what is currently being done, locally, about one or more of these actions?
I am unaware of anything being done in the geographic area of my workplace or the general area of disability. We have done training for staff as a result of our own identified need.

3b. What important actions are not occurring locally?

3c. What more would you like to see done to prevent suicide:
i) At a state level?
More and more effective mental health resources across the state with recognition of the need for management of dual and triple diagnosis. A variety of supported living arrangements for people with issues of mental health which allows for changes in accommodation and/or support as the client need changes. Particularly in regional and rural areas. Life skills training to facilitate people with mental issues to live effectively in the community on a long term basis. Case management for complex situations- including those with good family support.

3c. ii) At a local level?
Local drop-in centres or leisure centres with skilled staff. Family support. Skilled staff to provide care similar to HACC services for those with physical disabilities.