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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.

Name:

Organisation: Kimberley Aboriginal Medical Services Council Inc

Position: Mental Health Professional

Contact number:

Email address:

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?
Working in the Kimberley region and within an Aboriginal organisation, it is clear that many govt and non-govt organisations do not fully understand the historic significance of present day suicide in Indigenous communities and individuals. The existing Gatekeeper training program does not provide sufficient information about Indigenous suicide issues, their manifestations, means of identification and prevention strategies. The current Australian research concerning Indigenous suicide, by such notable figures as Professor E. Hunter, Professor Colin Tatz and Dr Tracy Westermann, clearly suggest that adapting a western concept of suicide and its prevention and applying it to Indigenous individuals is not only inappropriate but dangerous .It is essential therefore that an Indigenous model of suicide prevention be developed and used throughout the Kimberley as a training resource. The Kimberley Aboriginal Medical Services Council Inc, is at present producing such a resource and would no doubt be happy to discuss a collaborative interagency protocol with the Ministerial Council

How could the evaluation of government and community-based suicide prevention programs be evaluated more consistently?
By matching them much more consistently to the target audiences. Evaluation of training programs is often do poorly, and simple demonstrate what has been achieved in knowledge and attitudes on the training day(s) in question. Evaluation needs to be much more long term and extended into the application of suicide prevention strategies that have been applied in various communities. This is a long term strategy which is seldom attempted. Clearly evaluating suicide prevention programs for a mixed -race population requires not only different training strategies but also different evaluation processes

How should existing epidemiological surveillance systems be managed to enable their more effective utilisation?
The research evidence clearly suggest that Indigenous suicide data collection is poorly managed and that

the data is under-presenting the true extent of suicide occurrences. The whole process and methodology of collecting Indigenous suicide data requires a discrete working body with a strong representation of Indigenous health and welfare representatives. The Kimberley is for example well represented by Notre Dame University, Australia, Broome campus and University of Western Australia, who could both play a part in the development of such working parties. The deliberate self-harm databases can be further extended for use in Kimberley hospitals. Information resources for Indigenous families are almost non-existent and need developing. Using generic information resources for whole mixed race populations is not effective WA research, particularly provided by Dr Tracy Westermann does not appear to have been taken into serious consideration in developing hospital practice standards (which are largely European in style) and training resources. Gatekeeper trainers in the Kimberley who have undertaken training with the council and then attempted to incorporate an Indigenous focus have openly stated that the training does not equip them adequately to address Indigenous suicide issues. I believe the MCSP website needs to included all significant Indigenous suicide prevention materials, from throughout Australia covering both research and programs

How can high quality information relevant to the needs of different professional and community groups concerned with suicide prevention be more effectively disseminated?
See above comments. Clearly Indigenous suicide prevention is a separate entity as has been demonstrated in the research literature. If this distinction is not made and appropriate materials produced then there will be no high quality information being provided to different professional and community groups from an Indigenous viewpoint. It needs to be recognised also that almost 50% of the Kimberley population is Indigenous, whilst at the same time most of the service models being utilised are European and in many cases inappropriate

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)?
A genuine interest in exploring the issues and perhaps the creation of local stakeholder suicide prevention committees that are able to work in a collaborative relationship with the council. The council is very much seen as functioning and directing from a central Perth base and needs more long term formal links with remote and rural areas

What investment is needed to build a coordinated and sustained approach to mental health promotion across the state?
Remote and rural areas always recognise themselves as being understaffed and therefore overworked. This amongst other things also prevents sufficient collaboration between all agencies. The investment needed therefore is more staff and more funding NOT more suggestions! However the Strong Families model of govt and non-govt collaboration is in my opinion highly commendable as the model formalises the commitment of all agencies to work together. This should certainly be considered by others

Should media-based community education strategies be developed to reduce stigma and promote awareness of avenues for securing help with mental health problems?
Yes - the more in the open the issues are, the more normalised they can be made and the more user - friendly and race specific the better. The time for discreetness is over an open healthy awareness from school children upwards is needed

What practical strategies are needed to improve men's help-seeking behaviour and enable services to be more accessible to men?
Again very specific male orientated and male focused programs. Programs that can tap into the social and recreational needs of males, rather than up front treatment programs. Male health has been neglected in many ways. Broome for example has just commenced a Broome Men's Group who meet socially and recreationally but also gently introduce health topics

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?
See above 'what investment is needed' question and answer. Certainly cooperation, but this is sometimes not sufficient and so there needs to be other incentives, probably financial that will bring people together for collaborative projects. Relying on good will is not always sufficient
How can 'infrastructure' such as innovative use of new technologies be created to support networking?

We are all living in a world of new technologies both urban and rural/remote populations and have therefore grasped the use of new technologies well. For example the project being developed by the Kimberley Drug Use team of building an internet platform for all health providers and consumers to access throughout the Dampier Peninsula is an excellent example. The new technologies and their soft ware do indeed remove to some extent the tyranny of distance

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

• Strengthen protective factors?
ditto

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?
There is no reason why these initiatives cannot become and integral part of the state mental health plan as long as the plan itself recognises the need for specialist multi-racial services. The mental health plan clearly spells out the need to reduce the incidence of suicide and mental illness and drug use. As drug use and mental illness are clearly associated with incidences of suicide then these need to be incorporated into a single plan

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?
Recognition of the resources that exist already. Dr Tracy Westermann has for example produced the only risk assessment document specifically for Indigenous youth and is developing a further one for adults that covers, suicide, depression, anxiety and drug use. This document needs careful and full scrutiny. Once again the risk assessment processes will need to be different for different racial groups, as well as the referral processes and support mechanisms. These issues in a diverse region as the Kimberley need local groups to develop and coordinate

Should each State Government department be encouraged to develop its own strategic action plan (including a training plan) for suicide prevention?
NO - a collaborative approach is in my opinion the only way. Individual application within departments is a different matter but the strategic plan should be one plan that then allows different geographical areas to adapt to prevailing conditions

What should be done to strengthen the communication between the Commonwealth and State governments with regard to suicide prevention in WA?
Talk more - collaborate more, meet more!

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?
Most people reading this one won't understand it - neither did I

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)?
Yes - at the moment things are adhoc - critical incidence response teams are voluntary and often don't work well they need formalising and become mandatory

What organisational mechanism is required for government accountability in the implementation of the WA State Plan for Suicide Prevention?
Another tricky question - needs re-phrasing

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?
The Indigenous Suicide package presently being developed by KAMSC will address this issue in the Kimberley - develop of collaborative mechanisms and action plans are incorporated as part of the training. There definitely needs to be discrete working parties for all distinct communities - rather than an overall one stuck in a regional centre

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?
A very high priority which has not been realized thus far. The research is being ignored and there is NOT sufficient consultation

What investments are needed to build partnerships with Aboriginal and mainstream service providers in training and support for managing critical incidents and suicide clusters?
An honest commitment to long term planning a regular contact - a much deeper understanding of the cultural norms and taboos of Aboriginal culture - still not understand by mainstream providers

How can the work already being done by communities and Departments in universal (developmental)prevention in building community capacity be best supported?
More money - more staff - their is a predominant view in remote and rural areas that they are always neglected by mainstream govt

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?
NO

2. What are key factors that may be contributing to suicide risk in your local area?
transgenerational traumas; lack of opportunities in education, employment and youth support programs. Lack of control of petrol availability. lack of sufficient police presence to reduce drug trafficking

3a. Thinking about the 5 key areas for action, what is currently being done, locally, about one or more of these actions?
Promote professional community and consumer understanding of suicide - this is being addressed b y KAMSC from an Indigenous perspective building community capacity for suicide prevention - part of the above build partnerships - part of above project

3b. What important actions are not occurring locally?
The gatekeeper training has never provided sufficient knowledge and skills in dealing with Indigenous suicide at present there are no local suicide prevention teams - this will hopefully be addressed with the new KAMSC training

3c. What more would you like to see done to prevent suicide:
i) At a state level?
Mandatory system for govt and non-govt agencies to get together form alliances and working parties for all communities

3c. ii) At a local level?
As above