

Metro Central

Monday, 13 August 2007
27 participants

The consultation was part of a state-wide consultation process to inform the development of a State Suicide Prevention Plan. Participants were also invited to make individual submissions to the Ministerial Council for Suicide Prevention at www.mcsp.org.au.

Organisations represented:

- Anglicare WA
- Cambridge Youth Service
- Canning Community Education Centre Support
- City of Cockburn
- City of Fremantle
- Communicare Inc
- DCP
- Joondalup Community Mental Health
- Lifeline
- Men's Advisory Network
- Mental Health Division
Office for Children and Youth
- Office for Seniors Interests
- Royal Perth Hospital – ED Mental Health
- Salvation Army
Child Death Review Committee
- Shire of Kalamunda
- South metropolitan CAMHS
- St John of God Health Care
- UWA Student Council
- WA AIDS Council
- Youth Reach South

APPROACHES TO SUICIDE PREVENTION.

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

(Professor Sven Silburn, Chairman, Ministerial Council for Suicide Prevention).

What's happening locally?

Dr Ann Hodge, Acting Executive Director, North Metropolitan Mental Health Services.

The 5 Key Areas of the Plan.

(Shawn Phillips Executive Officer, MCSP)

GROUP EXERCISE

Participants were 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=8)**
2. Strengthen prevention, promotion and early intervention in mental health and suicide prevention. **(n=20)**
3. Build community capacity for suicide prevention. **(n=9)**
4. Support planning within and between government and community sector agencies for suicide prevention. **(n=6)**
5. Build partnerships, professional and community capacity to address the high-rate of suicide among Indigenous West Australians. **(n=4)**

Participants were asked, if there was another key area missing (not specific strategies) to write it on an A4 sheet of paper.

Comments

Key Strategy 6 POSTVENTION (maybe covered under prevention)

Rename or demystify the concept of “Mental Health”

Community capacity is also about healthy and supportive communities and individuals in the community – not just agencies

Participants asked to put an X on any of the key areas for action they considered unnecessary. No Xs were recorded.

Participants were asked in small groups.

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

GROUP 1

- Homelessness, lack of appropriate accommodation
- Poverty
- Reduced ability to access services
- Lack of knowledge regarding services
- Literacy/C.A.L.D.
- Stigma regarding mental health disorders

- Substance Use
- Relationship breakdown- family, peer, intimate and access to children.
- Peer group pressure
 - Contagion
 - Pacts
 - Copycats
- Abuse – past and present
 - Physical
 - Emotion
 - Sexual
- Medicalisation / pathologisation of distress
- Sexual identity/orientation
- Financial losses/status
- Family history of suicide
- Social isolation – lack of connectedness

GROUP 2

- Mental health issues
- Social factors e.g. socio economic
 - Affluence can influence expectations of young people and families
 - Pressures on families who are struggling financially
- Social Isolation due to e.g.
 - Community disconnectedness – appearance of social/community connectedness, but a lack of real community connectedness.
 - Lack of social skills due to
 - Sexuality
 - Increased technology
- Poor family connectedness
- Substance use – including alcohol.
- Failure to deal effectively with the above.
- Gender specific risk factors – e.g.
- Female – social pressures, internalisation
- Male – decreased health – seeking behaviour
- Sexuality and gender diversity.
- Lack of visibility/education/awareness/resources for families regarding the above – sexuality/substance use/mental health.
- Over-prescribing/diagnosis of particular meds/issues

GROUP 3

- Dual diagnosis (Mental illness/drug/alcohol issues)
- Lack of suitable, adequate and effective service partnerships.
- Homeless/transient: Lack of social support
- Impoverished family units
 - Financial
 - Social skills

- Coping skills
- Ability to get help
- Social Isolation
- Homelessness
- Relationship Breakdown

GROUP 4

1.

- Loneliness
- Relationship breakdown
- Isolation
- Family Dysfunction - Family Breakdown
- Housing affordability
- Pressure to Succeed
- Changing social values – infrastructure not aligned.
- Reduction in family support
- Refugee and immigration status
- Childhood and adolescence pressures.
- Social alienation – Indigenous populations.
- Substance abuse
- Children in care.

2.

- Particular to Metro:
- Family
- Lack of reliance in traditional family supports.

2.1 WHAT IS ALREADY HAPPENING IN THIS REGION?

GROUP 1

- Increased services in ED
- Continuity of care post hospitalisation
- Collaborative care across services. Increased consult-liaison
- Men's Groups. Men's Sheds
- Hospital at Home
- Telephone Services (24 Hour)
- Internet –
 - Provision of information
 - Interactive
- Recognition of Dual Diagnosis/Co-morbidity
- Better access to mental health services – multi disciplinary) Normalises
- Medicare Rebate) Experience
- Increased rebate for psychiatry via Medicare
- GP Liaison –
 - Officers
 - Programmes

- Schools programmes
- MHERL & CERT's

GROUP 2

- Freedom Centre – funded as a suicide prevention program (Sexuality & gender)
- CAMHS – capacity building between Government Agencies/funding of Youth Reach South/Prevention. Also Acute Response Service.
- Agencies –
 - PICYS including Pillar – 1:1 support to young people in the community who have mental health diagnosis.
 - Youth Support Services in local areas.
- Men's Support Groups.
- Local level – Rotary group sponsoring information/resourcing forum – community.
- Church Groups.
- Emergency Dept staff – mental health trained staff/nurses
- Mind Matters
- Suicide Prevention and Mental Health First Aid Training increased (often required by agencies) – more – qualified staff.
- Greater acknowledgement of need for a prioritisation of services outside of basic/major medical/mental health agencies – broader understanding of response.
- Mental Health promotion increased including 'celebrity' involvement.
- Use of IT technologies for info, counselling – including phone services.
- Change in perception generally that it is not OK and needs to be addressed and funded.

GROUP 3

- Outreach programs
- Street Doctor
telephone Crisis lines (Lifeline, Salvos, MHERL, Samaritans)
- "Mindmatters" in Schools
- Gatekeeper Training
- Online Training (QPR)
- ED & Mental Health Clinics
- GPs
- Youthlink, Youth Focus, P.I.C.Y.S
- NGO Rehab programs (Palmerston, Bridge)
- Student Services (School nurse, chaplain, psychologist, social workers, participation officers).
- COAG (MBS – Mental Health)
- SAAP

GROUP 4

- Mental Health – First Aid (DVD)
- Social Support – Kalamunda Shire
 - Evening Meetings (HACC) Funded
- Lifeline
- Crisis Care
- Kids Helpline
- Other Helplines
- M.H.E.R.L. C.E.R.T.
- Relationship Australia and other NGO
- Education and Training Programs
- ASIST/Gatekeeper
- Counselling Services – General
- Program – Empower and support GP's Rural Areas.

2.2 WHAT MORE NEEDS TO HAPPEN?

Participants were asked to brainstorm in small groups and prioritize (three votes each). The number in parentheses (*) is the number of votes each suggestion received

GROUP 1

- Written information around service provision specifically for men. Increased services/broadening of scope existing services.
- Development of a “Men’s Health Works”. **(n=2)**
- Agreed clinical pathways. **(n=2)**
- Standardised approach risk assessment.
- Expand/develop services in South-East corridor. All areas **(n=1)**
- Improved focus on holistic family assessment. **(n=1)**
- Market segmentation for different target groups. **(n=1)**
- Promotion of wellbeing and use of education system. **(n=1)**
- Increased clinically relevant research directing practice and evaluation.
- Increase ‘mentor’ programmes/peer support across the board. Increase wellbeing.
- Create or incorporate substance misuse in a new or existing act.
- Increase resources relating to dual diagnosis/co morbidity. **(n=6)**
- Enhancing capacity of CAHMS services to reduce wait listing and allow provision of urgent responses. **(n=4)**
- Better use of information exchange.
- Improved supportive accommodation including accommodation for families. **(n=1)**
- De-mystifying and de-stigmatizing through the use of language e.g. well-being.
- Increased availability of 24 hour services. **(n=1)**
- Coordinated/partnered for service delivery. **(n=1)**

GROUP 2

LOCALLY

- Improve individual, community awareness of resources.
- Increase awareness in order to decrease stigma regarding mental health issues/suicide issues/intellectual disability. **(n=1)**.
- Increase access to specific groups/specific services. **(n=4)**
 - i.e. specific training –
 - sexuality and gender
 - homeless/street present
 - intellectual disabilities
 - co-morbidities
 - substance use
- Schools education/support and upskill people in education environ) (dedicated role fro youth Liaison people in each school). **(n=)**
- Parent education to increase understanding of mental health issues. Continuation of Rapid Response Teams
- Mentoring Programs/Supporting key community people.
- Improve pay and condition s in agencies to retain quality staff **(n=4)**
- Work place education re risk factors.

STATE

- Education
- Change in culture with a move to adopting a real whole of government and community approach (police, housing, child protection, education, connections/justice) **(n=4)**
- Cultural shift to embrace/improve men's health overall.
- Sustained funding/sufficient funding. **(n=4)**
- Attracting more males into service delivery. **(n=1)**
- More health promotion campaigns on a State level/social marketing.

GROUP 3

- In School Counselling
- Better Communication across Government. Specialised Crisis Accommodation (Youth/Adults) **(n=1)**
- Programs that assist in decreasing social isolation. **(n=4)**
- More residential services for those with mental health issues **(n=2)**
- Better State/Commonwealth partnerships.
- Evidence based practice. **(n=2)**
- Flexible mobile services **(n=4)**
- Reducing stigma. **(n=3)**
- Increase the rewards for those who work in the sector. (NGOs; increase pay) **(n=3)**
- Increase mental health resilience programs. **(n=2)**
- Developing youth appropriate material that is evidence based.

GROUP 4

- Coordination between medical and community interventions **(n=4)**.
- Early intervention team for assessment: referral. **(n=2)**
- Community and individual responsibility for well being. **(n=3)**.
- Maintain and expand existing services.
- Community Suicide resilience.
 - Fund Help Lines.
 - Face to Face Counselling.
- Bridge the Gap from Crisis intervention to sustainable longer term support. **(n=2)**
- Increase promotion eastern based philosophies. Physical, Emotional, Spiritual. **(n=3)**
- Role of GP as first line referral. Training of professionals and care staff.
- Cost of Care – e.g. fee for service/affordability. Keep balance between promotion and treatment.
- Attach social worker to GP practice.
- Need statistical data.
- Conduct Community Forums/Engage the Community **(n=1)**
 - Awareness
 - Signs and symptoms
 - Identify support possibilities
 - Identify local resources
 - Register/data base of resources
- Education in primary and high school **(n=2)**
- Local Government Community Development/Comm Prog

3. WHAT ARE THE 4 THINGS THAT WILL REALLY MAKE A DIFFERENCE IN PREVENTING SUICIDE?

Participants were asked to review their previous lists in light of the voting exercise given the following options

- **pick the ones that got the most votes or**
- **group a few (but keep it concrete!)**
- **re-state some points**

GROUP 1

1. Review existing model of CAMHS service provision with a view to improved service delivery i.e.
 - Less waitlists
 - Crisis response
 - Early intervention

2. Promote a coordinated approach to assessment, case planning, treatment and education in relation to individuals with co morbidity.
E.g.
 - Dual Diagnosis
 - Intellectual disability
 - Physical Health
3. Ongoing clinically relevant evidence based research and evaluation to direct practice e.g in relation to:
 - Holistic family interventions
 - Identified target groups
 - Supported accommodation
4. Capacity building in relation to emotional wellbeing

GROUP 2

GROUP 3

1. Need to develop a system that links all aspects of a care programme using a key worker/case manager – who stays with the person throughout the process –
 - Coordination of LT care programmes
 - Holistic/whole of life
 - Sustainable
 - Beyond (and before) crisis
2. More beds! Mixture incl. residential, independent and outreach, LT etc (other than hospital beds, esp post-admission).
3. More flexible access services.
 - Mobile Outreach with professionals including Youth workers, counsellors, community workers, chaplains, social workers with competency in the area.
 - Flexible/outreach follow-up.
 - Effective response to specific group who find it hard to access services. Eg. Sexuality/gender.
4. Attraction and retention of workers:
 - Govt : Non Government inequality.
Wages
 - Prestige and profile of profession.

GROUP 4

1. Co-ordination between medical and community.
Interventions – improve and evaluate existing models.
For example:

- Early intervention/prevention teams:
 - Easy access
 - Affordable
 - Responsive – action based –accountable.
2. Training More Development, Education
- For example:
 - Individuals
 - Community Care Staff)
 - Professionals) Agencies
 - Etc etc
3. Whole of Individual Approach
- For example
 - Well being
 - Physical
 - Emotional
 - Spiritual
 - Social etc.
4. Promotion of Positive Messages versus Negative.
NB Many agencies only operate in office hours.

Where to from here?

This report is the next stage in the process. Please let us know if we have missed anything important.

There will also be a summary document prepared of the whole consultation process and a draft plan, both of which will be circulated to participants at these consultation forums.

Individual written feedback is welcome at www.mcsp.org.au.

Meeting closed at 3pm.