Government of **Western Australia**
Department of **Health**
WA Country Health Service

KIMBERLEY MENTAL HEALTH AND DRUG SERVICE
Cnr Anne & Robinson Streets (PO Box 3475)
Broome, Western Australia 6725
Tel: (08) 9194 2640 Fax: Clinic (08) 9192 3489
ABN: 28 680 145 816

1 October 2009

Mr Elton Humphery
Committee Secretary
Senate Standing Committee on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia
community.affairs.sen@aph.gov.au

Dear Mr Humphery,

According to the Living is for Everyone (LIFE) Australian National Suicide Prevention Strategy, the groups who are at the greatest risk of suicide in Australia are Aboriginal and Torres Strait Islander people, men aged between 20 and 54, people with a mental illness and people living in rural and remote areas (Commonwealth of Australia, 2008). Compared to the rest of WA, the Kimberley region has the highest proportion of indigenous people (42.1%, ABS, 2006), the youngest population (median age of 30 compared to the state median of 37, ABS, 2006), a high proportion of people with a mental illness (3% compared to a state average of 2%, Department of Health WA), and the greatest number of remote Aboriginal communities (281, Department of Indigenous Affairs WA). These multiple risk factors combine in the Kimberley to produce the highest rate of suicide in the State of Western Australia and one of the highest rates in Australia, with more than 20 people per 100,000 taking their own lives each year (Commonwealth of Australia, 2008).

Kimberley Mental Health and Drug Service (KMHDS) is a public service that is part of the Western Australian (WA) Country Health Service, Department of Health WA. We are funded to provide community mental health and drug and alcohol services to the Kimberley region, which has a population of 35,000 and covers an area of 421,451square kilometres (Kimberley Development Commission). KMHDS provides a case management service for individuals with a diagnosed mental illness and a voluntary drug and alcohol counselling and support service. The recent Coronial Inquest into the deaths of 22 Aboriginal people in the Kimberley showed that, although in 2006 there were 21 self-harm deaths in the Kimberley compared to three in the rest of WA, only two of those who died in the Kimberley had a formal history of mental illness and were known KMHDS clients (WA State Coroner, 2008). This statistic points to the fact that the majority of people who suicide in the Kimberley region do not have a diagnosed mental illness and therefore do not receive any clinical

mental health assessment or coordinated suicide intervention prior to their deaths. However, it is also clear from the report that there are many behavioural, social, emotional, historical and economic factors that contribute to the high rate of suicide in the Kimberley region. With these factors in mind, please find below Kimberley Mental Health and Drug Service's response to the impact of suicide on the Australian community including high risk groups such as Indigenous youth and rural communities, with particular reference to:

a) the personal, social and financial costs of suicide in Australia;

We refer the Committee to the outcomes of the Blank Page Summit on Suicide (Billard Aboriginal Community, 2009) and to the Western Australian State Coroner, Mr Alastair Hope's Inquest into 22 deaths in the Kimberley region.

b) the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk);

There is a current difficulty in accessing accurate data on the number of suicides and suicide attempts in the Kimberley region. The State Coroner's database holds electronic records since 2000, however the time taken to add information to the database means that there can be lag of up to two years. Furthermore, the Coroner's database does not record instances of attempted suicide, which are a known predictor of future completed suicides (Oquendo, Galfalvy, Russo S, et al. 2004). The lack of accurate real-time data makes it difficult to identify when suicide clusters are occurring in particular communities. Without accurate and timely information we are unable to make targeted and evidence-based requests for more suicide prevention resources in the region.

Anecdotally, suicide as a phenomenon in the Kimberley has grown into what could be described as a 'behaviour culture'. In this culture, suicide is an automatic response to psychological distress brought about by life events that in other populations would normally not lead to suicide. There is a lack of resilience and alternative coping mechanisms for people in the Kimberley who experience multiple of acute and extended traumas. In this context, suicide is seen as the preferred way out. Culturally sensitive research is required to substantiate this observed trend and to provide recommendations for combating it.

c) the appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide;

Our view is that suicide prevention is everybody's business. All of the agencies involved require suicide prevention training (such as Mental Health First Aid) so that signs and symptoms of mental health problems can be identified at first presentation. Further, better coordination of agencies is

required to ensure that responses are effective and appropriate in the case of a completed suicide and so that there is improved continuity of care for those who have attempted suicide. Primary health care services would be significantly enhanced by being assisted to identify people at risk, and the roll-out of programs such as the Mental Health Nurse Initiative for remote communities and the addition of Emergency Department Mental Health Liaison Nurse positions in country hospitals will help to achieve this goal. We are looking forward to the implementation of the WA State Suicide Prevention Strategy, which provides public funding for a non-government organisation to develop suicide prevention programs at the local community level.

d) the effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide;

We are aware of the need for caution in public awareness campaigns about suicide. There is limited evidence to suggest that awareness campaigns are effective for low-prevalence behaviours such as suicide. As for volatile substance use (including petrol sniffing) awareness campaigns, raising awareness of suicide can be counterproductive in that they can lead to inadvertent promotion of the behaviour rather than reduction. There is a delicate balance between raising awareness within the general public to prevent suicide and promoting suicide as an option for coping with life, and campaigns can have both beneficial and harmful effects (Mann, Apter, Bertolote, Beautrais, Currier, & Hass et al. 2005). However there is evidence that educating primary health professionals, reducing access to lethal means and training responsible community members to recognise the signs of suicidal intent (e.g. Gatekeeper Training) are interventions than can prevent suicide (Mann et al. 2005). We suggest that any public awareness programs be evidence-based and that investment in suicide prevention be directed towards interventions with evidence of effectiveness.

e) the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk;

As noted above, there is evidence that suicide prevention training and support for frontline health and community workers is effective. In their 2005 review, Mann et al. found that educating primary care physicians and community members with the Gatekeeper program reduces suicide rates. Furthermore, primary care is the most effective level at which to target suicide prevention activities because the majority of people who suicide have been seen by a primary care service within a month prior to their death (Luoma, Martin, & Pearson, 2002). We fully support the provision of more training for frontline workers, particularly those in remote communities that lack specialist mental health services. When frontline workers are able to identify those at risk, they are then able to refer individuals to our service for monitoring and follow-up.

f) the role of targeted programs and services that address the particular circumstances of high-risk groups;

The Kimberley region has been the subject of a number of targeted programs and services for high-risk groups at the local, state and commonwealth government levels. Although some of the programs have been successful, the two major problems with such programs are lack of coordination and sustainability. The desire of governments to intervene and improve can often lead to community disempowerment, poorly coordinated programs that lack effectiveness and a lack of sustainable outcomes once resources are withdrawn. As stated at the Billard Summit, communities need to be empowered to create their own programs and solutions. We advocate a collaborative working model that is community controlled and driven so as to produce coordinated and sustainable improvements for high-risk groups.

g) the adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy; and

Research into suicide and suicide prevention in remote Aboriginal communities is scarce. It is our view that although there are come similarities in the causes and conditions for suicide across all communities, there is a particular set of circumstances that apply to remote Aboriginal communities. In our communities, suicide is just one of the many markers of dysfunction. Therefore to separate suicide on its own as a topic of research would be to remove it from its behavioural, social, emotional, historical and economic context. This point is illustrated by the fact that the recommendations from the 2008 Coroner's report into 22 deaths in the Kimberley spanned all of these contextual factors. We recommend culturally appropriate and targeted research aimed at taking all of the contextual factors that contribute to suicide in the Kimberley region into account.

h) the effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress.

The National Suicide Prevention Strategy will be effective in the Kimberley region if it embraces the principles of:

- Collaborative working with State governments, non-government organisations and local communities
- Improved data collection and evidence-based actions
- Sustained initiatives

Yours sincerely,

Dr Murray Chapman, Clinical Director
Mr Bob Goodie, Regional Manager Mental Health

Prepared by Dr Beth Wilson, Senior Project Officer

References

Australian Bureau of Statistics (2006). Census of Population and Housing. Online.

Billard Aboriginal Community (2009) Blank page summit on suicide communiqué 27 - 31 July 2009. Obtained 27 August 2009 from the Billard Learning Centre ask@billardlearningcentre.com.au

Commonwealth of Australia. (2008). Living is for everyone: Research and evidence in suicide prevention. *The Australian Government Department of Health and Ageing*, Canberra.

Department of Health WA Mental Health Information System, based on 2007 projected population data.

Department of Indigenous Affairs, http://www.dia.wa.gov.au/

Kimberley Development Commission, http://www.kdc.wa.gov.au/kimberley/ff_area.asp

Luoma J.B., Martin C.E., & Pearson J.L, (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. *American Journal of Psychiatry*, *159*, pp. 909-916.

Mann, J.J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., & Haas, A. et al. (2005). Suicide prevention strategies: A systematic review. *Journal of the American Medical Association*, *294*, pp. 2064 – 2074

Oquendo MA, Galfalvy H, Russo S, et al. (2004). Prospective study of clinical predictors of suicidal acts after a major depressive episode in patients with major depressive disorder or bipolar disorder. *American Journal of Psychiatry*, *161*, pp. 1433-1441

Western Australian State Coroner, Mr Alastair Hope (2008). Inquest into 22 deaths in the Kimberley region, Ref No: 37/07.