Submission to the Senate Enquiry

The impact of Suicide on the Australian Community

Introduction:

Thank you for the opportunity to provide this submission to the enquiry on the impact of suicide within the Australian Community. CAN (Mental Health) Inc is an independent not for profit, consumer run organisation based on the Northern Beaches, Sydney, NSW. The organisation is funded by the Department of Health & Ageing, Suicide Prevention Branch for the Community Connections Project. This project has 2 major components, these being:

- Phone Connections – a national telephone peer support line for people living with mental illness, operating 4 evenings per week. The evenings are: Fridays and Saturdays (6pm – 12 midnight) and Mondays and Thursdays (7pm – 11pm). Currently consumers from five (5) Australian states access phone connections. The peer support line is manned by people living with mental illness and its main aim is to decrease the social isolation of mental health consumers and draw people who require social connection from accessing mainstream crisis services, such as Life Line simply to have a chat.

  Phone Connections is the only telephone peer support service of its type in Australia and is based on the Warm Lines, in the USA. This service is also unique from other telephone support services, such as Life Line, Salvo Care Line and AA, as the peer support workers provides follow up phone calls to provide support rather than insisting consumers must ring in to receive support. The callers can opt to remain anonymous if they so wish, however if they do wish to receive regular support phone calls then a preferred name is requested.

  On average Phone Connections per quarter support over 60 consumers with over 300 follow up phone calls to support consumers are carried out. The feedback from consumers is they wish Phone Connections was available 7 evenings per week rather than the current four evenings of operation.

  Whilst the service operates four evenings per week, Thursdays evenings is funded via Clubs NSW to employ the peer support worker - whereas the Department of Health & Ageing have provided funding to operate the remaining 3 evenings per week, due to a reduction in the budget allocation for the period 1st August 2009 to 30th June 2011.

  Unlike the Hospital to Home service, consumers can access Phone Connections each evening the service operates and continue to contact or receive follow up phone calls on a continuous basis. For example some consumers have been accessing the service for over 2 years the service has been operating. Others elect after a period of time they no longer require the service. The consumer elects if and when to receive this service rather than the service making the decisions on if and when to provide support. The only eligibility criteria is the consumer must be aged 18 years and over and live with mental illness or mental illness and another disability.

There are no assessments or waiting lists applied for consumers to access this much needed support.

- Hospital to Home – provides practical assistance and peer support within the first 6 weeks of discharge from the Liverpool and Campbelltown psychiatric inpatient units in Sydney. Hospital to Home also employs people living with mental illness to provide this practical assistance and peer-support to mental health consumers. The Hospital to Home service in partnership with another NGO (non-government organisation) provides a monthly social activity to mental health consumers in the Liverpool area. This partnership, to our understanding remains unique in NSW in that 2 mental health NGO's each provide a staff member to run this activity.

  The main aim of Hospital to Home is to decrease the potential suicide rate and hospital readmissions as research highlights the first 28 days of discharge is the most vulnerable time for mental health consumers post crisis.

  The service was extended to provide practical assistance and peer-support within the first 6 weeks based on the feedback of consumers accessing the service. (Originally the support provided was only within the first 28 days of discharge from hospital).

  On average the Hospital to Home service provides practical assistance and peer support to 21- 37 consumers per month. The peer support workers also visit and speak to over 250 consumers each quarter who choose not to take up this service. This is especially important as many consumers admitted to inpatient units are very isolated during their stay and may not receive many, if any, visitors during their admission. The Hospital to Home service provides through visitations a much needed social connection and contact with the general community.

  The practical assistance provided is very broad indeed and can include, however not limited to: home visits, taking consumers shopping to obtain food, arranging for tradespeople to undertake necessary work within the home, taking consumers to visit a family member in gaol, taking consumers to visit their pets, transporting consumers to medical appointments, connecting or reconnecting consumers with available community services to provide ongoing support, and undertaking follow up phone calls of consumers during the daylight hours the service operates.

  Unlike Phone Connections, Hospital to Home is delivered for a specific time period of which the consumer can access support. There is eligibility criteria, i.e must be 18 years and over, live with mental illness and/or mental illness and other disability and risk assessments must be carried out by the public mental health service clinicians in order for the service to provide the support. A referral process is in operation, however consumers can and do make Self Referrals to access the service and the Hospital to Home peer support workers then obtain the relevant risk assessments from the treating clinicians. More than 90% of consumers who access Hospital to Home have completed the self referral process with the support of the service's peer support workers.

  The Hospital to Home service is the only one of its type in NSW and one of only two peer-support Hospital to Home services operating within Australia. However the South Adelaide Hospital to Home Service operates totally differently to its NSW counterpart and consumers who are suicidal are ineligible to receive their support. Whereas, our Hospital to Home service is open to consumers who are suicidal. Consumers who access the high dependency units within the

hospital are ineligible as well as those who have a high risk assessment of violence to another. As well as mental health consumers who live with the dual disability of mental illness and intellectual disability.

The ineligibility of consumers with the dual disability of mental illness and intellectual disability is primarily because people living with this dual disability require longer term support which the team is unable to provide as it has to withdraw the support provided within the six (6) week period. However, people living with this dual disability are eligible to receive the support from Phone Connections and this has been successfully undertaken with this population group as the support can be for a long as the consumer wishes to receive the support.

Hospital to Home also operates on a part time basis with the days being Mondays, Tuesdays, Wednesdays and Fridays and the monthly Saturday weekend social activity. Like its Phone Connections counterpart, the services' hours of operation were slightly reduced with the current funding due to the decrease in the overall funding allocation.

As the reader can ascertain both Phone Connections and Hospital to Home services do compliment each other. One provides after hours support and the other provides the practical assistance and peer support during daylight hours. As previously stated Phone Connections is national, whereas the Hospital to Home service is locally based.

The above outline of the peer support services provided under the Department of Health & Ageing, Suicide Prevention Branch is provided to give the inquiry the basis for the remainder of this submission's terms of reference. And, the recommendations put to the inquiry on how the impact of suicide within the Australian community, especially within the mental health community.

Recommendations:

- Increased funding to be provided to extend Phone Connections to operate 7 evenings per week, from 6pm – 12 midnight for mental health consumers.
- Funding to be provided to extend Hospital to Home service as well as replicate this service within other Area Health Services to test its efficacy in both metropolitan and rural areas.
- Funding to be provided to promote positive mental health messages to the Australian Community.
- Support and expectations of government that public mental health services provide crisis support services continue to provide clinical services to mental health consumers.
- A change in culture and perspective by clinicians that people who are suicidal are "seeking attention" rather than 'attention seeking'.
- Denial of mental health services is considered and promoted as a human rights issue therefore, providing a higher profile on people living with mental illness inability to have their human rights met.
- Funding to provide community and non-government organisations the capacity to provide person centred research and evaluation over the long term to contribute to the wealth of current suicide prevention research and knowledge base.
- Ongoing community campaigns and public discussion and debate about suicide, services that are available.
- Increased funding for community mental health service crisis teams to operate on a 24 hour basis.

Terms of Reference A: The personal, social and financial costs of suicide in Australia:

Suicide represents the ultimate act of a person considering not only is life no longer worthwhile, there is no hope that life will change for a more positive outcome, but also represents the total disconnection of the person with their family, friends and the general community. The impact on the person and their families and friends is simply too high to be measured in "real costs". However in stating this for a person who is suicidal the personal costs can be outlined as follows:

- The erosion of their self esteem, self worth and self confidence and spirituality is enormous.
- The erosion of leading a quality lifestyle of their choice as the person considers they can never ultimately achieve this.
- The erosion of their relationships with significant others, family members, friends, work colleagues and acquaintances become such that the damage is highly significant and may at time become beyond repair.
- The erosion of leading productive lives, including their careers creates huge barriers not only for the person but also for their employers and work colleagues. This erosion alone can reinforce to the person they have no hope of getting better, their life has no meaning and they become further entrenched in the low self esteem, self worth and self confidence cycle.
- Many people who are suicidal do not believe their life will change for the better; that they contribute to their relationships with partners, significant others, family or friends and to society in general.
- Many people believe people would be "better off without them".

For the individual who does seek help or counseling are assessed as "not suicidal enough" (or sick enough) to receive help, therefore are turned away by public mental health services. The impact on their belief system is enormous. They become further entrenched in the "victim" cycle and can lose any tenuous hope they were holding onto. Such a situation is commonplace within the public mental health system, especially within NSW.

The Emergency Department often is the first point of contact, and this system alone is notorious for sending people who are suicidal home without any support or further follow up contact with a mental health clinician. There is a saying within the consumer movement that it is like winning the lotto to actually receive help and be admitted to a psychiatric unit. Then if one is admitted, the likelihood of being discharged too early because the service needs the bed for someone else, its like having to win the lotto for a second time in a matter of days to be given a care co-ordinator (case manager) in order to try and sort out the issues and problems which created the suicidal thoughts in the first place.

The lack of services and/or the downright denial of services have an enormous impact on the individual who is suicidal. Nobody is prepared to listen to them. Nobody is prepared to help and support them. Nobody understands what they're actually going through. Therefore, they are all alone, feeling totally unsupported and life is simply far too difficult to positively negotiate.

This is what makes the Hospital to Home service CAN (Mental Health) Inc. is funded to operate and provide the practical assistance and peer support to consumers on discharge (if they're lucky enough to get into hospital in the first place) from hospital so important. As previously stated many consumers are discharged far too early from psychiatric inpatient units – oftentimes the cutting edge only has

been taken off the crisis however they are still experiencing the crisis, yet now have no further support to assist them. In our organisation's experience, we have learnt to take the suicidal self assessment of the consumer (which they provide as part of the self assessment referral form) as being the accurate assessment as many clinicians downplay the actual suicidal risk of the consumer, which can have disastrous and potentially life threatening consequences to the consumer.

Many consumers find themselves in the revolving door syndrome. For example: our Hospital to Home service literally found it nigh on impossible to support one consumer because the health service kept discharging the consumer who was highly suicidal way too early and within 1-2 days the consumer was constantly being readmitted. It took four readmissions within two weeks for the health service to consider the consumer required increased clinical support on discharge. Once this was provided the Hospital to Home team were also able to provide increased practical assistance and peer support to the consumer. Unfortunately for this consumer the support provided was too little, too late. The consumer ultimately committed suicide.

In many respects, the regular practice of public mental health services towards a person who is regularly and constantly feeling suicidal is to place the consumer in the "too hard" basket and consequently totally deny the person any support whatsoever. CAN (Mental Health) Inc have been contacted on numerous occasions where the consumer has been informed such will be the so.

One of the worst examples provided to our organisation was of a public mental health service (in a totally different area in Sydney) who wrote a letter to the consumer stating the mental health service would no longer provide any support. This health service didn't even have the decency, or caring, to talk to the person in person and ensure the person would be okay with this decision. Nor did they assist the person to put in any potential relevant strategies to assist them to cope with now being denied a service.

Many clinicians view people who are suicidal as "attention seeking" rather than the person "seeking attention". If this perspective alone was changed amongst clinicians we believe the support provided to consumers who are suicidal would be far more sensitive, far more caring and reflective of what the person is experiencing and more willing to provide the relevant support the person does require. This shift in thinking requires no funding - only a culture shift in thinking of the clinicians and of the service.

The personal impact on consumers who are forced through the revolving door syndrome, or denied a service, or denied community clinical support is enormous. It simply cannot be measured in financial costs. If the consumer has family supports, they are expected to be the clinical crisis service for the consumer. The drain on family relationships and resources again is beyond measure.

"Two consumers who participated in a consultation interview at the Sydney South West AMHS operated Flowerdale Cottage, shared very positive experiences of the Hospital to Home service. Both consumers were currently using the service. One consumer spoke very emotively about the value of the service, and indicated that it had reduced her admissions to hospital from sixteen admissions two years ago to four in the last year. She attributed the reduction of readmissions to the services and was keen to see the service maintain funding for continuation of services"
(External Evaluation Report, Community Connections, page 67).

- The financial impact costs both to the consumer, the community and to the mental health service can only be slightly quantified. The full costs, because of the complex matrix, are extremely hard to fully ascertain and measure. What cost does one put on another human being's life?

What CAN (Mental Health) Inc. can confidently inform the inquiry is outlined in the table below:

Peer Support Service (CCP)	Total Cost Per Day to operate the Service	Average No. of Consumers supported per day	Total Per Person to access the service per day	Psychiatric Inpatient Bed Cost Per Day per bed	Cost of Equal Number of Consumers to access inpatient bed per day.
Hospital to Home	$414.98	13	$31.92	$576.00	$ 7,488.00
Phone Connections	$528.54	18	$29.36	$576.00	$10,368.00
Both Peer Support Services	$943.52	31	$61.88	$576.00	$17,856.00

(Reference: External Evaluation Report, Community Connections Project, page 75, July 2009)

"The evaluators conclude from these findings that these services provide a low cost yet valuable support mechanism for consumers at vulnerable times in their recovery journey. The Phone Connections and Hospital to Home services are built on unique models that have evolved over the two year project period and as such warrant consideration for extension. Extension would provide a further opportunity to evaluate the medium to longer term impact of the services on the lives of consumers in particular and the mental health system in general"
(External Evaluation Report, Community Connections Project, page 13).

The financial costs to the community are again very hard to quantify. When one considers: the number of people who contact Life Line, and other crisis lines, to try and receive support and these organisations funding allocations to provide a crisis service.

In many respects, it appears we are all chasing our tails, trying to meet the increasing demands of people in crisis, or who require non-crisis support to either get over a crisis or stave off a crisis in the beginning, only to find that it's an all or nothing approach delivered by public mental health services. This, in turn, adds increased burden, stresses and strains on inadequately resourced non-government and community organisations to provide the support for people who literally fall through the cracks.

There is plenty of literature to support early intervention for all population groups and the whole of life age range, prevention and promotion which supports – get in early and the crisis will either not occur or have far less impact on the person to assist in recovery than get in late.

Phone Connections, whilst strictly a non crisis peer support line, does support to consumers who are beginning to either go in crisis or are feeling suicidal. The support provided assists consumers to potentially avert the crisis, assist them to seek out and put in the required supports they require.

Consumers have informed our organisation and the external evaluators for the Community Connections Project the peer support provided assists them to maintain mental health wellbeing. Surely this is a much better and cost effective usage of the funding dollar - than simply only provide support, if one is lucky, when one is in a full blown crisis?

In other words, put the funding in the community and the community has increased capacity to support people and avert the crisis in the long term, thereby decreasing the need for expensive hospital admissions.

The current recession which Australia has just managed to avoid is also making a personal and financial impact within our society. Yet, the federal government is more willing to provide Cashflow to businesses than to community organisations such as ours who are now dealing with the impact of job retention, loss of income, loss of the family home as a result, who subsequently end up being admitted to a psychiatric inpatient unit for the first time in their lives. Our Hospital to Home team has tried to support such individuals as the need arises.

Homelessness and people living with mental illness is another huge cost impact on the individual and society in general. Whilst the federal government is trying to address this enormous and complex issue, many mental health consumers who are admitted to inpatient units are discharged homeless. In the mental health system, the clinicians have what we believe is a derogatory and totally insensitive term for people who are homeless: “NFA” – no fixed abode. This totally strips away the humanity of the individual and appeases clinicians who otherwise might become sensitive to human condition and the situation homeless people experience.

In conclusion:

The individual and society will continue to bear the personal impact, the financial cost and the sheer hopelessness of having their needs met and living a quality lifestyle of their choice, when systems and governments continue their past and current failures to fully acknowledge, accept and negotiate for increased sensitivity in services being available to people living with mental illness.

Australia has some of the best mental health policies in the world, yet these constantly fail because managers and clinicians consistently refuse to implement these policies to the highest standards. Many of the policies do not require funding. What they require is a change in culture and attitude of mental health providers. Until this change takes effects, many people who feel suicidal will not receive the support they so desperately require.

CAN (Mental Health) and the Community Connections project is only a drop in the vast ocean trying to provide peer support and practical assistance as best as possible to a population group who in many respects have had their human dignity stripped away, their human rights constantly and consistently ignored and/or abused and denied access to high quality, sensitive and caring services. Do we make a difference? Yes, we believe we can and do. However, in stating this, there is so much more than can be done, if we received adequate funding to do so. We do our best and make the funding dollar stretch as far as possible. Yet, we know many of our peers are unable to receive our support because they either don’t know it’s available (i.e. Phone Connections) or the service is only for a specific locale (i.e. Hospital to Home).

Terms of Reference Two: 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):

CAN (Mental Health) Inc. would like to make the following general comments only:

- When people are denied a service as outlined in Terms of Reference one the accuracy of reporting suicide and attempted suicides in Australia is very seriously flawed. Deny the service, get rid of the problem and subsequently then don't have to report. Discharge the person who is still suicidal in the inpatient unit so the person doesn't become part of the statistics for the unit, if they attempt or complete suicide during their hospital stay. In other words – it is very convenient indeed for public mental health services to refuse to accept any responsibility or liability for the non provision of services to the individual.
- In private mental health services, most private hospitals are not gazetted beds, therefore any person attempting suicide or self harm during their hospital admission are immediately discharged. CAN (Mental Health) Inc have been informed on different occasions where the private mental health consumer has been immediately discharged for self harm or attempted suicide. Their families have been contacted to pick up the consumer and deal with the crisis.
- Anecdotal evidence also highlights the under reporting of suicide and this can be for many reasons. Either the person has taken their life in such a way it was not reported as a suicide or potentially is reported as an accident i.e. car accidents is a classic example.

Terms of Reference Three: 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:

The role of emergency departments and the concerns our organisation has in regards to people who are suicidal is outlined in Terms of Reference One.

Police now find themselves the defacto mental health crisis team as either the public mental health service crisis teams have been closed down, operate minimal hours therefore not able to be accessed at the time of the crisis, or as in many cases if available inform the consumer and/or the family to ring the police. This inadvertently makes suicide a "law and order" issue rather than a health issue.

The involvement of the police is clearly inappropriate to respond to suicidal attempts and criminalizes the illness. The Ambulance service can and do at times refuse to deal with such issues thereby passing the buck to the police. In the first instance it is the Ambulance Service who is required to be the first point of contact to transport the person to hospital. This being that many mental health crisis services refuse to transport consumers to hospital stating it is an OH&S issue.

Everybody is too busy passing the buck and saying "it's not our problem; it's not our core business" thereby leaving the individual, the family and friends trying to cope by themselves.

Suicide is "society's problem". Mental Illness is everybody's business. There is no health without mental health.

People should not be treated as having a committed a crime because the only way they find they can seek the help they're desperately need is to attempt suicide.

The Hospital to Home service has on occasions experienced trying to obtain clinical support for a consumer who they visit is highly suicidal and the mental health services have refused to respond. The crisis team has refused to visit the consumer and undertake a suicide risk assessment. They even more often than not refuse to even talk to the consumer over the phone, or if they do agree to do this, they rate the consumer as too low a risk to require support or simply inform the consumer to go to the emergency department. In other words they're too damn lazy and insensitive to get off their butts and deliver the service they're established to provide – support mental health consumers when in crisis.

In many respects, the public mental health crisis services view is: since the Hospital to Home service is involved, our service will by default provide the crisis support. Even though the Hospital to Home service is clearly not established to provide, nor can the service provide the much needed clinical support the consumer requires.

Consumers constantly complain and we've had occasions where the consumer has refused to go or be transported by our Hospital to Home staff to the emergency department as they have to wait in the emergency department for anything up to eight hours or more to be seen and then informed they have to now go home. Or, alternatively they're held overnight in the emergency department only to be discharged still feeling highly suicidal the next day.

Terms of Reference Four: Information, encouraging help-seeking and enhancing public discussion of suicide:

CAN (Mental Health) Inc. would like to advocate for public mental health campaigns and the enhancement of public discussion and debate of suicide. Our organisation is only too willing to participate in such campaigns and public discussion and debate as our peers are dying at a rate of knots under the current circumstances.

In saying, this, the organisation believes the discussion and debate should centre on prevention and promotion – that people can and do recover and live quality lifestyles of their choice. Mental Illness does not in fact have to be a death sentence.

Whilst media does occasionally present to the community media articles and stories, there are too few stories of people successfully getting on with their lives. To give an example: the Sydney Morning Herald published an article on the reporting of suicide in NSW and Qld was potentially under-reported by at least 30%. The article called for support for people on discharge from hospital – the very thing that CAN (Mental Health) Inc. is funded to provide via our Hospital to Home service. The Development Manager wrote a letter to editor requesting support to promote this service and to inform readers it is possible and in one area of Sydney is actually happening. The newspaper didn't bother to respond, nor did they contact to undertake a follow up and find out more information about such a positive service being provided.

Media is too quick to give society all the bad news and reinforce stereotypical messages of people living with mental illness, however very slow and loathe to present the community with positive news stories and positive messages that people living with mental illness can and do recover.

When at times the television media do run mental health stories the only services they promote are Life Line and Beyond Blue. No other community organisation can get a look in.

Funding needs to be allocated to organisation's such as CAN (Mental Health) to develop with relevant skilled professionals media adverts and the like to promote positive mental health messages to the community and that our peer support services are available. In many respects, governments whether Federal or State do not consider providing extra funding so organisations can undertake a range of highly visible community promotional activities to inform viewers and/or listeners and/or readers on what is available. Thereby, potentially denying many people the hope there is help available to them.

Terms of Reference Five: The efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk:

Training, training and more training - However, until the culture as outlined in terms of reference one is addressed, all the training in the world will ultimately mean absolutely nothing, waste of money, time and resources because the person can and often is denied a clinical service.

Mental health clinicians need to change their views on suicide, the person who is suicidal and actually listen to what the consumer is actually saying.

Terms of Reference Six: The role of targeted programs and services that address the particular circumstances of high-risk groups:

CAN (Mental Health) Inc. agree the role of targeted programmes and services that address the particular circumstances of high risk groups are very important. The Community Connections project is one such project targeting people living with mental illness.

The difficulty for our organisation is the funding whilst very much appreciated is simply not enough to provide both Phone Connections and Hospital to Home to the degree the organisation would like to undertake. We know our services work. Why, because the consumers who access both services regularly inform us.

One of the major difficulties re funding, is the funder usually wants fully researched results and outcomes in a short period of time, whereas to measure the full impact of any intervention or support requires more than five years of follow up. Even if an external evaluation component is part of the

funding agreement, our experience is, such external evaluation is far more costly than the allocated amount, therefore the external evaluation does have to be limited in scope due to funding parameters.

In many respects, it was an absolute miracle our organisation was funded for a further 23 months to provide the peer support services. The organisation is very proud the Department of Health & Ageing, Suicide Prevention Branch continue to believe in consumer operated services and the peer support services provided and that we can and do make a difference to people lives.

However, in saying this, the government took six months to make a decision which left our organisation and the staff in limbo and with the uncertainty of whether the services would continue for the first six months of 2009. It was only the commitment and dedication of the organisation's staff to continue to provide the best service possible under the circumstances that kept the services operating in such a high climate of uncertainty. Not only this, such a delay also meant the consumers, especially accessing Phone Connections and some had accessed this service since its inception, were uncertain on whether they would continue to receive support.

Yes, put the money in community services and support organisations such as CAN (Mental Health) to support people living with mental illness and make a difference to their lives. Increase the funding for prevention and promotion programmes and in the long term people will get on their lives thereby contributing to the community, rather than accessing services and potentially increasing the long term costs.

Terms of Reference Seven: 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

CAN (Mental Health) Inc. would like to make the following general comments:

- Research bodies constantly advocate they should receive a very large pocket of the suicide prevention funding, whereas the research is already available. Thereby, denying community services and programmes the much needed funding to deliver services to people on the ground.
- However, in saying this, services such as our organisation provides does require much needed research and evaluation funding to prove the efficacy of the peer support services is indeed a complimentary pathway for mental health consumers to receive support, prevent crisis from taking place and/or support to get over a crisis when this takes place.
- Research needs to be person centered and reflect the personal stories and experiences of individuals rather than simply a data collection exercise.

In other words, researchers and research bodies appear to want to analyse suicide to death at the expense of the provision of much needed services to the individual. Research and evaluation funding should be now directed towards services to fully and over the long term ascertain and disseminate how its service meet the needs of individuals and make a difference to their lives.

This then would provide governments with increased relevant information and data for policy development which reflect the needs of individuals.

Term of Reference Eight: The effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress

CAN (Mental Health) Inc. would like to make the following general comments:

- The strategy requires the ongoing commitment of the federal government to provide increased funding and resources to community organisations to meet the needs of people living with mental illness.
- The strategy will always fall short if public mental health services continue to maintain the culture it has towards people who are suicidal and/or continue to deny consumers a much needed service because they put them in the "too hard" basket.
- Australia is the land of policies, however, few policies, if any, are actually implemented to their full intent at the grassroots level. This being bureaucrats and senior mangers decide it too costly or takes too much time to fully implement, thereby decreasing the potential positive outcomes that people who are suicidal could actually achieve to have lifestyle of their choice.
- A major barrier that our organisation sees is too little funding to provide services by organisations such as ours on the ground. There appears to be a tacit thinking that non-government and community organisations should get out there and obtain "extra funding" to be able to provide best practice services. For example: approach philanthropic organisations to fund. Such organisations have provided feedback to our organisation mental illness is a health issue therefore is a government responsibility to fund. This subsequently leaves small organisations such as CAN (Mental Health) being caught in the gap.
- NSW Health when approached refused outright to even contemplate providing additional funding support to our organisation to extend and/or continue the peer support services as they consider it would require recurrent funding which they refuse to allocate.

In conclusion:

Once again thank you for the opportunity to write this submission. Please don't hesitate to contact us on the numbers listed below if you wish to have further clarification of the points or recommendations provided.