Submission to:	**Senate Community Affairs References Committee**
	Inquiry into suicide in Australia

From:	**Integrated Primary Mental Health Service** of **North East Victoria**

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To the Senate Community Affairs References Committee,

Thank you for the opportunity to present a submission to this important inquiry. I have prepared this submission from information provided by staff from the **Integrated Primary Mental Health Service (IPMHS)** in Northeast Victoria.

Service Profile:

IPMHS is a service delivery partnership between the **North East Victorian Division of General Practice** and **Northeast Health Wangaratta**. In addition to providing direct clinical mental health services across the region's general practices, the **IPMHS Community Development team** provides a range of mental health education, health promotion and active outreach to 'at risk' community members. Funding for our services is obtained through State primary mental health and Commonwealth ATAPS, rural and remote and bushfire / suicide prevention funding streams. We are thus closely linked with regional suicide prevention and postvention activities.

We routinely provide counselling and support to community members following suicide and, in conjunction with the regional Adult Mental Health Service, are currently establishing a '*Bereaved by suicide*' group'. We work always in partnership, in particular with the **Northeast Victorian Division of General Practice**, regional shires, **Department of Primary Industry**, **Country Fire Authority** and **Anglicare**. The mental health service development component of the IPMHS includes the provision of a range of activities aimed at supporting dependent children of parents living with mental illness, delivered under the auspice of the Families where a Parent has a Mental Illness (FaPMI) Strategy. Additionally, we provide dual diagnosis capacity building and education, and direct clinical servides to women and families experiencing perinatal mental health problems.

Thus, we provide a range of mental health promotion, early mental health intervention and treatment services and mental health development within the wider regional health and welfare system and context.

In summary we are a rural / remote primary mental health service that:

- provides direct clinical services for 'at risk' clients in general practice
- has direct liaison with the region's suicide intervention services
- formulates and delivers targeted rural and remote community development and resilience building activities in partnership with other health /welfare / emergency services
- supports front line drought / bushfire workers

Key points:

Firstly, we would like to congratulate the **National Suicide Prevention Strategy** (NSPS) on its work around raising awareness of the issues around suicide, provision of excellent resources, and funding of targeted suicide prevention projects.

Since 2003, we have been engaging community 'guide dogs' to assist us in identifying and facilitating programs which directly and indirectly address suicide prevention and postvention. This is long term work. We cannot stress strongly enough the need for ongoing funding for these workers. Grant funding does not allow for community engagement, and is viewed cynically by the community. Our workers have uncertain funding, making forward planning difficult. Our area is plagued by long term drought, economic hardship and bushfires, and we must continue to provide the excellent community based programs we offer.

As a service, we are often frustrated with a lack of clarity around accurate regional suicide statistics, and how to access them. This lack of accurate epidemiological data makes it difficult to counter the anecdotal ' 1 in 4 farmers is committing suicide in our region' stories which cause stress and uncertainty within our communities. Improved dissemination of these statistics would be immensely helpful in supporting our delivery of evidenced-based mental healthcare.

Cross-jurisdictional activities involving the engagement of emergency services and mental health services assisting people who are at risk of suicide are frequently problematic. We would support the introduction of a federally funded program aimed at supporting the coordinated delivery of a dedicated national suicide intervention service and practice model.

We support a tiered approach to suicide intervention training from community awareness and upskilling programs to graduate programs for front line workers, Peer support programs, such as we are managing in this area, are also essential to maintaining the wellbeing of front line staff.

We also support the NSPS in using targeted approach to community programs, as there is no 'one size fits all' for communities. Our own communities face immense challenges, and services must use community 'guide dogs' to ascertain relevant responses and programs. Since 2003, IPMHS has been building these networks, but are continually frustrated with lack of resources and funding to achieve our community driven goals.

The NSPS has, we believe been successful in raising awareness of suicide, and providing a forum for engaging a wide range of stakeholders. It has been an excellent example of inclusive planning, and supports government policy. Its efficacy could be improved by the incorporation of improved dissemination of local/state/national data and improved sector understanding of and support with funding processes and mechanisms.

Responses to the Terms of Reference

a) The personal, social and financial costs of suicide in Australia.

We commend the National Suicide Prevention Strategy (NSPS) on it's recognition of the devastating effects of suicide, and its comprehensive strategies and funding of community development projects. As a primary mental health service, we are keenly aware of the costs to families and friends measured in psychosocial terms, including disconnection, family breakdown, complicated grief and despair. These can all themselves lead to mental health crises and suicide.

We cannot stress enough the need for long term funding for mental health skilled community workers. Grant funding is inappropriate. Short term projects are regarded cynically, '*How long are you lot going to be around?*'. We have learnt that workers need months to years to successfully be accepted and valued by a community, and that they need to provide targeted mental health literacy, mental health promotion/early intervention programs and active outreach to 'at risk' clients and families.

Workers also need strong links to crisis services and other health and welfare services. Our workers have uncertain funding, making forward planning difficult. Our area is plagued by long term drought, economic hardship and bushfires, and we need to continue to provide the excellent community based programs we offer. These programs include:

- Saleyards health screening and support,
- provision of *Mental Health First Aid* and *Youth Mental Health First Aid* to rural and remote communities,
- Pitstop Men's health screening,
- women's 'Coffee and Conversation' and
- Sustainable Farming Families programs.

We also manage a peer support program for front line staff. Our funding is uncertain and a forced withdrawal of these services due to funding constraints has the potential to be devastating to communities who rely on our support.

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).

As a service, we are often frustrated with a lack of clarity about suicide statistics, and how to access them for our region. There are frequently 'stories' about alleged suicides, particularly among the farming community. The 'ripple effect' of these stories spreads distress and anxiety among communities, and are often exaggerated. It would be extremely helpful to have ready access to statistics for our region, while understanding the sensitivity required in their dissemination.

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;

Difficulties routinely arise in cross-jurisdictional activities involving emergency services and mental health service and assisting people who are at risk of, or exhibiting, suicidal behaviour(s). A Federal funding program aimed at supporting the delivery of a dedicated national suicide intervention model with proper coordination and leadership across jurisdictions would help to overcome this problem.

Regional and remote services also experience the tyranny of distance, with police and ambulance services often unavailable for long periods in these communities. While this continues to be a problem, it is critical that we can continue to provide community up-skilling programs, which foster a community's ability to recognise and respond to suicidal behaviour.

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

This is difficult to comment ton without there being a consolidated body of knowledge from evaluative research to use as a frame of reference. Without there being particular standards to assess efficacy against, how can we assess whether suicide prevention training and support for front-line health and community workers providing services to people at risk meets a suitable standard or not.

We believe that a tiered approach to training is required – from community programs like ASIST up to graduate programs for front line workers, and programs suitable for community drought /bushfire and Centrelink workers. Peer support programs, such as we are managing in this area are essential to maintaining the wellbeing of front line staff.

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

Within a public mental health service context, there is no discrete program funding aimed specifically at suicide prevention. In the context of scarce resources, the chief focus of specialist services is direct service. From reading the NSP literature, it is evident that there a number of targeted programs which are innovative, culturally and geographically appropriate, and probably effective. We commend this approach – there is no 'one size fits all' for communities.

Our own communities face immense challenges, and services must use community 'guide dogs' to ascertain relevant responses and programs. Since 2003, IPMHS has been building these networks, but are continually frustrated with lack of resources and funding to achieve our community driven goals.

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

There is limited funding for clinical research programs to enable studies to be undertaken as a means to develop or generate hypotheses about suicide in rural suicides, through the eyes of the mental health workforce. Statistical information is not routinely made available for clinical staff within their own geographical environment and contexts. There is limited statistical information made available to clinical staff concerning the epidemiology of suicide, particularly with stratification outlining those with diagnosed mental illness. Research results should be routinely streamed through all mental health services.

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

The NSPS has, we believe been successful in raising awareness of suicide, and providing a forum for engaging a wide range of stakeholders. It has been an excellent example of inclusive planning, and supported government policy. It's efficacy could be improved by the incorporation of improved dissemination of local/state/national data and improved sector understanding of and support with funding processes and mechanisms. Our time poor staff requires= ease of access and straight forward funding applications to encourage them to seek new opportunities for programs.

Again, thank you for the opportunity to present this submission. We would welcome an opportunity to speak in support of it.

Yours sincerely,

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