Rotary Community Corps
of Western Australia
(RCCWA)

PO Box 1343
Canning Bridge, WA 6153

AfterShock

ENTERPRISING WORLD INTERNATIONAL LIMITED
T/A AfterShock and the ROTARY COMMUNITY CORPS OF WESTERN AUSTRALIA
ABN 37 113 543 285

Introducing afterShock

Giving a Voice to Post Traumatic Shock, Chronic and Acute Stress and Suicide Survivors; and

Parents of Children and Adolescents Suffering from Asynchronous Development

KEY RECOMMENDATIONS

- **Commonwealth Government to provide, as a social investment, $10 million for new community care infrastructure (*that is co-funding the pilot development of one regional Aboriginal Community afterShock Centre plus one other in metropolitan Western Australia, as two specialist forms of Super Clinic*) so as to prevent traumatic shock, chronic stress and suicide occurring in Western Australia.**

- **Commonwealth Government to match Western Australia's investment, as a social investment, in the development and delivery of HELP-ME FOUNDATION'S 1800-HELP ME telephone counseling service for the suicide bereaved.**

20th November 2009

"In almost every case, suicide is caused by pain, a certain kind of pain -- psychological pain, which I call *psychache."*

Edwin Shneidman

Among those who are suicidal, pain is ***the*** problem. Much of what has been learned about dealing with physical pain applies to ***psychache*****.**

Psychological pain is under assessed and under treated. More attention is paid to the causes than to the pain itself. Suicidal individuals are left to contend with pain alone.

Severe pain has the same impact on humans, both physically and psychologically.

Anxiety, sleeplessness, fatigue, depression, and anger set in. These modify and aggravate the pain. They elicit changes that increase stress which further drives pain. Severe pain is destructive.

Pain overwhelms coping and leaves helplessness in its wake.

Pain travels in the company of suffering, which has been defined by Cassell as "*a state of severe distress induced by the loss of intactness of person or by a threat that the person believes will result in the loss of... intactness.*"

Suffering is where pain and suicide meet and hopelessness begins.

Suicidal individuals and those with chronic pain share the same experience. Recurrent stress and intense pain decreases endorphin *(natural substances that relieve pain)* levels in the brain.

This increases their vulnerability.

This must be offset.

This is the function of pain management.

Worsening pain attacks self-control and self-esteem. It generates fear and powerlessness. It creates a sense of profound isolation. **"Any person has the potential to become suicidal when confronted with a situation that produces emotional pain and is believed to be inescapable, interminable, and intolerable."**

J. A. Chiles and K. Strosahl (1995) *The Suicidal Patient: Principles of Assessment, Treatment, and Case Management*

Time is critical with suicidal individuals.

They are in jeopardy and may be within hours or days of succumbing to their condition.

Immediately impacting their pain is the only way to save their lives.

afterShock – A Model for Developing Community Trauma and Wellbeing Centres

"Helping each other to distress less, because life will always delivers bumps in the road"

Executive Summary

afterShock is currently still in formation. Over the last five years the concept has been cooperatively developed by a Western Australian community consortium, as a community based support centre and a cooperatively branded one-stop shop for Western Australians affected by post traumatic shock, emotional trauma, chronic stress, acute stress or suicidal ideation and bereavement.

Utilising the definition of health adopted and endorsed by the World Health Organisation (WHO), afterShock will build Western Australian awareness and understanding in a community about:

(a) Suicidal ideation bereavement, emotional trauma and chronic and acute stress and provide early intervention services so as to help prevent such suffering;
(b) Resilience and Emotional Intelligence, including how to rebuild and restore both when eroded through emotional trauma and chronic stress;
(c) Value of developing emotional intelligence and social development skills.

It is planned, once fully developed, that afterShock should have capacity to become a national information and service distributor, as well as a specialist primary care provider for those suffering from trauma and/or a range of stress disorders.

At that stage it is planned to transfer community ownership of the afterShock network in Western Australia from the Rotary Network to Lifeline WA.

During its early development, afterShock proposes to work with State property developers as well as public and private healthcare property management service providers, to co-locate highly valued support services, already being offered by known and trusted NGOs or community care providers within the community, identified as essential for recovery by those who are, or have been in the past, suffering from emotional trauma, chronic stress, post-traumatic shock, suicidal ideation and/or bereavement.

This early intervention service development is expected to take considerable pressure off emergency departments at hospitals, as well as community crisis services, such as Lifeline telephone counseling services and other help-line providers *(as consumers will be empowered to self manage their condition more easily through greater awareness of their symptomology, and will be diagnosed as suffering from trauma at a much earlier stage than might currently be the case)*.

afterShock will not only supplement and complement these services, but it will also complement service development activity currently being undertaken by the Help-Me Foundation (developing a "HELP ME IF YOU CAN" promotional campaign that will promote and provide a 1800-HELP ME telephone counseling and information service for the suicide bereaved).

In a staged development, specialist primary care *(independent general practitioners specializing in post traumatic shock-emotional trauma, and/or chronic, acute and post traumatic stress)* will be co-located with other independent but necessary allied health stress management professionals/services, including grief and

trauma counseling, physiotherapeutic (including clinical pilates) services; naturopathic services (including therapeutic massage, yoga and meditation services), diabetic educators and social workers.

Early education and child care services will also be co-located within the same facility so as to provide consumer access to emotional development, occasional child care and parenting information services, at the same time as they undergo early stage treatment.

Together these integrated services will support those in our community suffering from emotional trauma and chronic stress disorders at a much earlier stage – thereby providing an effective mechanism for preventing suicidal ideation and bereavement in vulnerable communities.

Other complimentary services planned for the first stage include a range of shared services (office and documents management; personal development and training; student intern placement as well as supervision); as well as vocational rehabilitation placement service for those suffering psychiatric disability, that will include access to tagged in-house postings in order to assist sufferers to rebuild their confidence and better manage their return to the workforce.

Finally, mental health legal advisory, Alternative Dispute Resolution (ADR), victim support, family mediation and factual investigation services will also be made available, in the final stage of development.

Background

The concept began to emerge in 2000, as a joint Rotarian initiative of the Rotary Clubs of Western Endeavour and Claremont-Cottesloe.

Its initial aim was to provide community mental health and wellbeing forums, resourced through Rotarian Club sponsorship, with additional funding and social marketing support provided by the Australian Rotary Health Fund.

These forums not only targeted the local community's educational needs, but also provided effective recovery-oriented information to both carers and consumers, especially parents of young people diagnosed as suffering from drug addiction, depression and/or suicidal ideation.

The information provided was academic research-supported, practical and reflective of lived experiences, and was delivered by clinicians, advocate-counsellors, carers and survivors.

The inaugural forum, held at the University Club located in the grounds of the University of Western Australia, attracted more than 200 people from the wider community, which included the local minister *(then Hon. Colin Barnett, MLA)*; with some driving to Crawley from as far away as Northam.

The primary aims of this forum were:

- To engage and collaborate with Western Australian consumers and carers, and explore the communities' perception of drug abuse, depression and suicide and contributing factors within a Western Australian context.
- To determine the community's knowledge and awareness of existing Australian culture, various ethnic heritage values, laws, preventive and intervention services.

- To provide recommendations based on community and individual diversity for the development of appropriate and applicable strategies so as to support families, parents, men, women, young people and children.
- To provide a basis for research in the area of depression and suicide within the community.
- To strengthen relationships within vulnerable communities and families and between government and service providers. It was hoped an improved network of relationships could to some extent overcome the disconnection of the family system that commonly occurs with this cohort.

The Forum provided an opportunity to examine, with a diverse group of people from the wider Western Australian community, their understanding of family and drug abuse, depression and suicidal ideation and what they saw as possible ways of addressing this issue in their communities. It was hoped that the Forum would establish how the community and the Rotary network in Western Australia could cooperate with government and service providers so as to reduce the incidence of drug abuse, depression, trauma and suicide in Western Australia.

After its successful launch it was first proposed to grow the initiative into becoming, over time, a Western Australian Centre for Suicide Prevention, to be located at UWA.

However what occurred was the initiative instead morphed structurally into becoming the Rotary Community Corps of Western Australia (RCCWA), which in turn evolved from a bringing together of a consortium of community interests that met on a monthly basis at Curtin University.

The result was a broadening of the program's objective towards supporting the vulnerable *(that is indigenous, young people and those suffering from mental ill-health and suicidal ideation)* to become more enterprising of spirit, by assisting them with support services through to recovery, and by providing them with access and the opportunity to participate in mainstream personal development and growth opportunities, provided not only by Rotarians, but by others, culturally like them but more advantaged, drawn from their own community.

Its founder representatives included individuals drawn from senior managers working for Lifeline WA, Mission Australia, CentreCare, Curtin University, Holyoake, Beacon Foundation, University of Western Australia, Churchill Clinic, Community Vision, Outreach and the School Volunteers Program (SVP).

The current elected President of RCCWA is Ms Tracy Pollett.

Of Indigenous (Maori-Australian) heritage, not only has Tracy personally experienced suicide bereavement, but she is also a strong human rights advocate in the social justice and wider communities, having been formerly the Deputy Director of the Edmund Rice Centre for Social Justice.

Today the RCCWA continues to provide community development training, community consortium development and facilitation services.

It also provides a support group and electronic library and information services - not only for around fifty suicide survivors[1], but also to the parents of children and youth experiencing asynchronous[2] development – identified

[1] Refers not only to those bereaved by suicide, but also to those who recover, after suffering suicidal ideation, and to their significant others who helped care for them whilst suffering (carers).

by some from within the support group as being a high risk group, in terms of increased vulnerability to teenage suicidal ideation, mental ill-health, homelessness and either anti-social behaviour or else social phobia/social isolation.

The purpose of afterShock as a Community Trauma and Wellbeing Centre will be to inform and equip people with additional knowledge and skills as well as access to relevant and integrated early intervention services, so as to prevent suicide, emotional trauma and stress disorders occurring within a local community.

The activities of afterShock and the Rotary Community Corps of Western Australia (RCCWA)[3] are currently sponsored by three Western Australian Rotary Clubs.[4]

The programs are currently governed by a Rotarian Community advisory board as well as a RCCWA membership elected Board of Directors.

Current boards comprise company officers who bring to the table a variety of professional expertise and personal experience.

This includes four elected members who have experienced either suicide death or suicidal ideation to recovery, of a child, sibling or spouse.

One was the family carer of a teenage suicide survivor now fully recovered, but who consequently suffered mental illness and experienced suicidal ideation herself.

One of its officers is of Maori-Australian heritage – two others are migrants from Irish or Seychelles heritage, with one currently living and working as a PTSD family counselor in regional Western Australia.

Other advisors have experienced the suicide death of a work colleague, student, parent or a close friend.

The professional background of the various Board Directors, advisory and company officers, including the sponsoring Rotarians, represent business advisory services and corporate governance, social justice and the law, journalism, vocational training, international development, computer software and graphics, education at high school and university levels, and the not-for-profit community sector.

Although structured as a not for profit non government organization (NGO), as per the governance requirements of Rotary International, the Rotary Community Corps of Western Australia has not been structured as a charitable institution, so as to not be seen as another competitive structure for critical resources and volunteers.

RCCWA relies solely upon its cooperative consortium arrangements in order to carry out its programs.

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[2] A circumstance where a child's physical, emotional and intellectual development does not occur in the normal fashion (that is, at the same time and pace) - either because of cultural, genetic or excitability/sensitivity differences; gifted abilities and/or because of emotional trauma and shock.

[3] The NGO is a structured not for profit company, nationally registered as Enterprising World International Limited T/A Rotary Community Corps of Western Australia and afterShock

[4] Rotary Club of Western Endeavour Inc; Rotary Club of Hillarys Inc; Rotary District 9450 (Perth and North Western Australia) Inc

Specific memorial donations or general contributions to its work are made by donating to its community affiliates in the consortium, who are all registered health promotion or other community charities operating in Western Australia.

NGO parties who have currently expressed preliminary interest in joining the consortium in order to deliver Western Australia's Suicide Prevention Strategy and aftershock Community Mental Health and Wellbeing Forums include Lifeline WA; Australian Rotary Health; GP Network; Rotary District 9450 (*District 9450 ARH Committee*); Injury Control Council of Western Australia; Balga and Mirrabooka Senior High Schools, and Outreach (WA).

Scope of the Problem in Western Australia

Mental health problems are a significant burden on the health care system in Australia, accounting for $3.7 billion in health care expenditure in Australia in 2000-20014 and an estimated 13% of the burden of disease in Australia in 2003[5].

Given the impact of mental health issues on Australia's health system, and on vulnerable communities and society in general, mental health and (*emotional and social*) well being is considered a priority health issue by both Healthway and Australian Rotary Health.

Much of the premature mortality and morbidity associated with chronic diseases is preventable through well targeted and sustained early intervention strategies (health promotion and early treatment) so as to address key risk factors for these diseases.

Healthway advises[6] that in 2005/06 less than 2% of total health expenditure was allocated to preventive services or health promotion, whilst over 30% of the disease burden could be attributed to these risk factors[7].

Suicide Prevention Australia estimates today that all Australian governments invest less than $1 per Australian for purposes of suicide prevention, whilst the disease burden itself is costing in excess of $300 per Australian to service.

The four key behavioural risk factors of smoking (7.8%), unhealthy eating (2.1%), physical inactivity (6.6%) and risky alcohol consumption (3.2%) each make a significant contribution to the burden of disease in Australia[8]. However such behaviour is also common in those practicing very poor stress[9] management techniques or else those suffering from post traumatic shock.

RCCWA's support group also considers such conditions to exist in both high or low achievers (for purposes of self medication) - using socially accepted and affordable means for the purpose of self managing a mental ill-health, overwork, underwork or an emotional trauma condition, or for managing physiological conditions of hyper-

[5] Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD. 2007. The burden of disease and injury in Australia 2003. PHE82. Canberra: AIHW

[6] Healthway Annual Report, 2008-2009

[7] Australian Institute of Health and Welfare. 2008. Australia's Health 2008. Cat. no. AUS 99.

[8] Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD. 2007. The burden of disease and injury in Australia 2003. PHE82. Canberra: AIHW

[9] Psychological or physiological stress, or both.

arousal, chronic pain or chronic fatigue *(that is making use of nicotine and caffeine as stimulants and/or alcohol as a sedative/pain medication).*

Stress is a widely used concept in our society. Its formal definition is very much context dependent and potentially confusing. The concept of stress has been used interchangeably for events, perceptions or clinical outcomes, and clearly involves legal, managerial and medical perspectives[10].

There is an extraordinarily large literature on the origin, characteristics and sequelae of stress. Many early studies approached the issue from a strictly biological perspective. The field of interest has broadened to cover psychology, organizational behaviour, sociology[11] and recently epidemiology[12].

Definitions of stress relate to the stressor (factor or situation); the human processes of emotional focusing (motivation) and/or physiological arousal (energisation); or the stress response (the individuals reaction to the stressor).

Stress in moderation can actually have positive influence on productivity and improved performance ("eurstress"), but the tolerance of the amount of stress a person can handle depends on the individual.

Everyone needs some pressure to feel challenged and energized.

However everyone also has a burnout point or a switch when stress starts to become counterproductive, erodes resilience and takes physical, psychological and behavioral tolls on a person.

The Forbes Continuum highlights the emotional focus/point of productivity that exists directly in the middle of a perceived under load of work, and a perceived overload of work.

At the middle of the Continuum optimal performance will occur (also known as hyper-mania or high energisation), whilst on either end of the spectrum no productivity will take place.

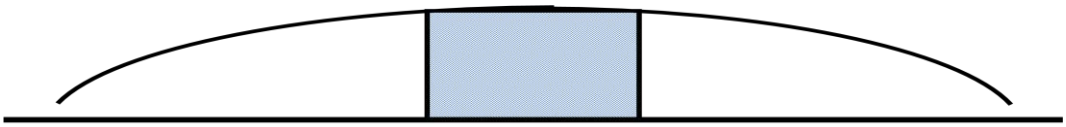


Figure 1 - Forbes Continuum

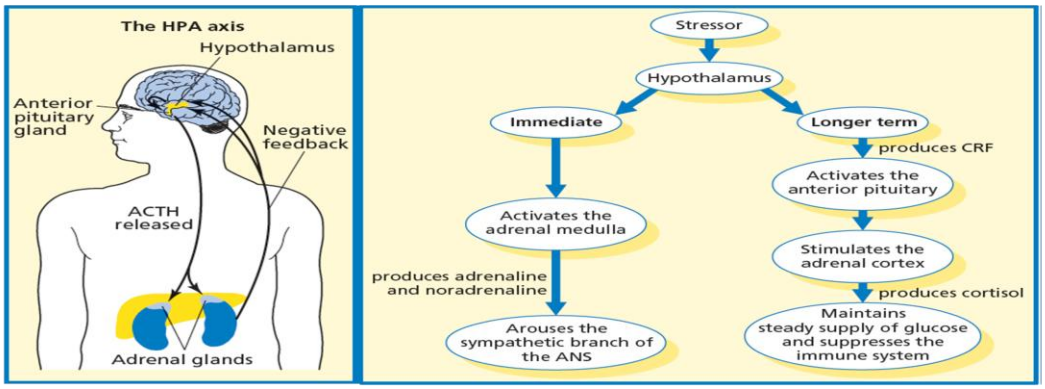
Qualities such as boredom, irritability and over qualification for work takes place at the under load end while strained relationships, irritability and poor judgments occur at the over load end.

In the shaded region productivity occurs with qualities such as mental alertness, high energy, the capacity to emotionally focus "into the zone" on a single task, and realistic analysis of problems.

Selye[13] defined stress as: *'The nonspecific response of the body to any demand made upon it. The demand can be a threat, a challenge or any kind of change which requires the body to adapt.'*

[10] 21. Moodie R Borthwick C. Emotions at work. Medical Journal of Australia 1999; 170: 296-297.
[11] 22 Peterson CL. Work factors and stress : a critical review. International Journal of Health Services 1994; 24 (3): 495-519.
[12] 23 Kivimaki M Vahtera J Pentti J Ferrie JE. Factors underlying the effect of organisational downsizing on health of employees: longitudinal cohort study. British Medical Journal 2000; 320: 971-975.

General Adaptation Syndrome



3 stages (Selye 1936, 1950)

More recent models of stress have incorporated an understanding of the relationship between a person and their environment.

The outcome of a stressor depends very much on whether the individual perceives the situation as stressful[14], and whether he or she can cope with the situation.[15]

McGrath refines the issue by including the concept that problems are more likely with a 'substantial imbalance between demand and response capability, under conditions where failure to meet demand has important [perceived] consequences.'[16]

In a biological sense, the stress response is thought to be mediated by a series of neuroendocrine mediators including adrenaline, noradrenaline and cortisol.[17]

Chronic physiological stress conditions, involving trauma, adrenal illness and cortisol overload have been closely associated with malnutrition, obesity, hypertension and diabetes; whilst psychological stress conditions, such as depression, anxiety and post traumatic shock are more closely associated with malnutrition, eating disorders, Crohn's Disease, Fibromyalgia and Irritable Bowel Syndrome.

Numerous associations have been made between stress and negative physical, mental and social outcomes.[18].

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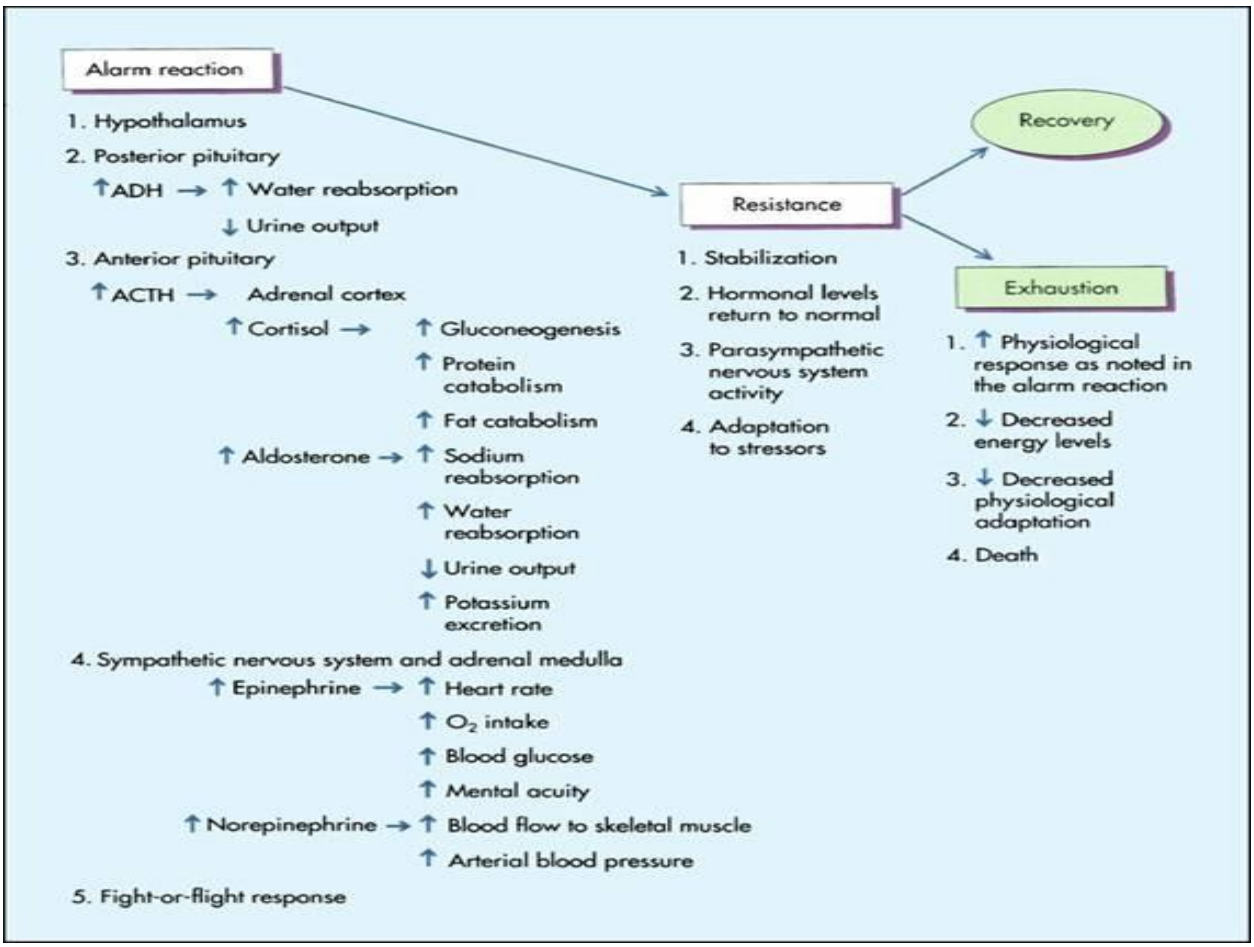
[13] 24 Selye in Posen DB. Stress management for patient and physician. Canadian Journal of Continuing Medical Education 1995.

[14] 25 Williamson AM. Managing stress in the workplace : Part II - The scientific basis (knowledge base) for the guide. International Journal of Industrial Ergonomics 1994;14: 171-196.

[15] 26 Cox in Kent G Dalgleish M. Psychology and Medical Care. Berkshire: Van Nostrand Reinhold (UK) Co Ltd; 1983.

[16] 27 McGrath in DeCarteret JC. Occupational stress claims - effects on workers' compensation. AAOHN 1994; 42 (10): 494.

[17] 28 Spillane R. Stress at work : A review of Australian research. International Journal of Health Services 1984;14 (4): 589-604.



The role of stress in precipitating psychiatric illness has been controversial in the past, but the American Psychiatric Association (APA) legitimised the concept by including the diagnoses of 'adjustment disorder' and 'post traumatic stress disorder' in the D*iagnostic and Statistical Manual, 3rd Edition (DSM III).*[19]*…."*
Today our understanding of stress has evolved to where we now have a fair grip on where it comes from, how it affects us, how to measure it, and, most importantly what to do about it.

Originally a term used by physicists, it was measured in pounds per square inch. In the 1940s and 50s, the term was expanded to describe the influence of excessive demands and pressures on physical and mental health.

Because it affects everyone, stress and its ramifications have become topics of popular discussion in the media and draw much attention from print and electronic media. An internet search on stress, for example, comes up with over 17 million hits from various disciplines investigating stress in one arena or another.

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[18] 29 Williamson AM. Managing stress in the workplace : Part I - Guidelines for the practitioner. International Journal of Industrial Ergonomics 1994;14:161-169

[19] American Psychiatric Association. Diagnostic and Statistical Manual of mental disorders. 3rd ed. Rev ed. Washington DC: American Psychiatric Association; 1987.

Work related stress is an intriguing subject. In a little over two decades it has come to represent a large proportion of expenses for workers' compensation schemes. In a broader sense its assessment involves concepts of medical diagnosis and the nature of disease and illness. Its management touches on communication, an understanding of the legal system and raises questions about the tasks of primary health care.

Western nations have identified a range of options to control the epidemic of occupational stress. Strategies range from workplace and organisational modification to methods aiming to optimise the care of the individual worker. Although most methods seem well considered, their effects have been minimal at best.

Despite WorkCover advising stress related conditions to now comprise a significant proportion of Western Australian workers compensation claims, **The Royal Australian College of General Practitioners (WA Research Unit)** advises workers' compensation claims to make up approximately 10% of the average GPs caseload, although for many the number is a lot lower. However work related stress claims are a minute proportion of that figure, with a lot of GPs seeing only one case per year.

Results from their administered questionnaire indicated that even when presented with a reasonably definite scenario of work related stress, over half of the GP sample chose not to open a workers' compensation claim. Those opening a claim favoured DSM IV or ICD 10 diagnostic criteria, and overwhelmingly advised a week or less off work.

Although respondents with training or experience in occupational health were significantly less likely to certify the patient as totally unfit for work, training and experience in occupational medicine had no effect on any other parameter.

Finally the report found that although the scenario was, by its nature artificial, there was at that time a strong suggestion that most GPs were following previously published guidelines in the early management of the condition.

Indeed contrary to WorkCover's perception that most GPs did not adopt holistic approaches in dealing with stress issues, the qualitative data suggested that most GPs were more than aware of the complexities of causation.

Indeed a number of GPs raised the possibility that it was the biomedical aspects of disease needed to be considered in work related stress claims. Furthermore, most seemed to have a reasonably good understanding of potential workplace issues, in particular those relating to conflict at the workplace.

The barriers to full assessment seemed more related to those traditional GP limitations of insufficient time and inadequate remuneration…."[20]

Recent research has clearly shown an increase in stress hormone activity effects neurotransmitters in the brain. Dopamine (DA) and serotonin have been implicated in the regulation of aggressive behavior, but it has remained

[20] ***"Stress, compensation and the general practitioner: A report prepared for the Workers' Compensation and Rehabilitation Commission by The Royal Australian College of General Practitioners WA Research Unit"***, WorkCover WA, March 2001, p6

challenging for medical researchers to assess the dynamic changes in these neurotransmitters while aggressive behavior is in progress.[21]

No simple one-to-one causal relationship has been found between serotonin and aggression. The influence of serotonin is best analyzed within a broader framework that includes consideration of its role in the inhibition of impulses, the regulation of emotions and social functioning, domains that are closely linked to aggression. Impulsivity and strong emotional states often accompany violent acts.

Aggressive individuals are likely to experience general difficulties with impulse control and emotional regulation, and they show impaired social cognition and affiliation. Serotonergic dysfunction will influence aggression differently, depending on the individual's impulse control, emotional regulation, and social abilities.

Yet, aggressive acts occur in a broader social context. As such, serotonergic function has an effect not only on the individual but also on the group dynamics, and it is in turn influenced by these dynamics. Whether aggression will occur when serotonin dysfunction is present will depend on individual differences as well as the overall social context[22].

So What Might Really Be the Scope of this Community Problem?

> *"The complexity of the interaction between risk factors, and the capacity for health care and social interaction to influence individuals' choices, suggests that government and society have a responsibility to act.*
>
> *Kuitert (1995) argues this obligation on the basis of the moral principle of 'beneficence', which implies that whenever possible there is an obligation to prevent harm to others, providing that the means used are effective and are in themselves ethical. For the individual service provider, Kuitert suggests, an ethical response involves taking seriously the person considering suicide and paying attention to the emotional and social experience that underlies the suicidal behaviour.*
>
> *For the community, an ethical response involves providing normal human companionship and support. For government, it means remedying as far as possible the social circumstances (such as child abuse and social disadvantage) associated with suicide risk.*
>
> *The attitudes of young people reinforce this obligation. Australian young people who have attempted suicide have sought responsive, practical and supportive action from the health and welfare system. They have attributed their self-harming behaviour to complex life circumstances and sometimes to mental health problems. While keen to resolve their own*

[21] "van Erp AM, Miczek KA, Department of Psychology, Tufts University, Medford, Massachusetts 02155, and Departments of Psychiatry, Pharmacology, and Neuroscience, Tufts University, Boston, Massachusetts 02111. "Aggressive Behavior, Increased Accumbal Dopamine, and Decreased Cortical Serotonin in Rats", *J Neuroscience* 2000 Dec 15; 20(24):9320-9325.

[22] **Menahem Krakowski, M.D., Ph.D. , "Violence and Serotonin: Influence of Impulse Control, Affect Regulation, and Social Functioning", Journal of Neuropsychiatry and Clinical Neurosciences, May 2002**

problems, they have also sought protection from their own self-harming behaviours (Keys Young 1997). Society has a responsibility to address these needs as effectively as possible".[23]

Accuracy of suicide reporting in Australia

Data relevant to suicide risk and outcomes are collected systematically by police, health services, the census, and child and family services. These include data on drug overdoses, accidents, domestic violence, child abuse, family breakdown and minor crimes.

Population data on suicide risk are collected in a standardised way by other agencies *(for example, population age, location, country of birth, school leaving age, unemployment rates, certain figures around poverty and social disadvantage, percentage of population living in rural areas, ratings for particular media programs).*

Some information has been collected on a one-off basis or through research studies *(for example, numbers of prison inmates, percentage of population from particular migrant groups, sexuality and gender identity data)*.

Some of these data are accurate and reliable, but some are influenced by reporting bias (for example, the community's perception of the likely effect of the reporting), or only small-scale one-off data collections are available, and differing terms may make it difficult to compare studies or regions.

Data collection related to suicide can rarely be objective. All the data collected is influenced in its definition by our society's cultural diversity, and its associated ethical and moral frameworks.

Personal, social and financial costs of suicide in Western Australia

A Loss of Self Identity

It has been reported that the overall suicide rate in Australia has been relatively stable since the 1920s[24], lying mainly in the range of 10-14 per 100,000. Fluctuations have coincided with the two world wars and the 1930s economic depression. The increase in female suicides during the 1960s is thought to be associated with changes in the availability of barbiturates and other new drugs, and the rate fell again when prescribing patterns were changed by regulation and practitioner education[25].

However, while the overall rate has remained relatively stable and is comparatively favourable in an international context, a different picture emerges when trends for specific age groups are examined.

These have varied across age groups and while rates have decreased for older people over recent decades, rates have risen dramatically among younger people. Rates for males aged 15 to 24 have more than tripled over the past 40 years.

Since 1973, this rise in rates has been paralleled by a similar rise in rates for men aged 25-35, with the burden in potential years of life lost greatest for this latter age group in 1997.

[23] Commonwealth Department of Health and Aged Care, 2000, " LIFE: A Framework for Prevention of Suicide and Self Harm in Australia", Publications approval number 2762 (rescinded)
[24] Australian Bureau of Statistics, 2000
[25] Oliver and Hetzel 1972

Comparable rates for females, however, have shown no significant changes (De Leo et al 1999). However self harm rates and suicidal ideation (attempted suicide) hospitalization rates for females remains much higher than that for men.[26]

Suicidal behaviours

Hospitals record the numbers of people presenting to accident and emergency departments, and the numbers discharged from in-patient care after non-fatal deliberate self-harm. The figures are compiled and analysed by the Australian Institute of Health and Welfare (Cantor et al 1998).

However, there are inconsistencies between hospitals in the way data are collected and coded.

Several population surveys have asked about self-harm, suicide attempts or suicidal thinking (for example, Patton et al 1997; Headspace 2008), whilst surveys of service providers or their clients have investigated how often suicidal people are seen in their practice (for example, McElvey et al 1998).

Problems in these studies include recall bias and the difficulty in defining particular types of suicidal behaviour, making it difficult to compare study outcomes (Beautrais 1998, Cantor et al 1998).

However such data can give a preliminary indication as to the scope of the problem and the number of Western Australians that may form part of a vulnerable community.

Suicide, Trauma, Stress and Involuntary Admissions

Based on the latest information readily available from the Mental Health Review Board, during the year to 30 June 2005, 2988 persons commenced periods as involuntary patients as a result of orders that they be detained in an authorised hospital (2638 persons) or community treatment orders ("CTOs") (350 persons). These represented an overall increase of 8% over the previous year's corresponding figures, with increases of 6% for detained patients and 25% for CTO patients.

Although it is always a careful balance to protect and care for individuals versus safeguarding community safety, involuntary admission does involve a number of known traumatic risk factors, such as a lack of informed choice and deprivation of liberty.

For every traumatized victim, there is also a significant potential for vicarious trauma to extend to close family members (such as parents, siblings and grandparents) who care for that victim.

Thus for every person involuntarily committed, it is estimated that there can be up to seven times more people emotionally traumatised or chronically stressed from that event - strongly affected by the vicarious trauma and/or the chronic stress of being their carer.

For this vulnerable community, the statistics might be equivalent to almost 210,000 persons, or 1 in 10 of all Western Australians.

[26] LIFE, "Australian Self Harm Statistics, Key Findings", Ausinet - April 2006

Suicide, Trauma, Stress and Police and Corrective Services

Last year Police Services reported there to be almost 57,000 against the person, drug or breach of restraint offences in Western Australia, with most being violent offences.

Such offences commonly traumatize the victim as they are unexpected, not chosen, lack their informed consent and often entail a deprivation of the individual's liberty.

This number includes an unknown prosecution number from the 31,000 cases of domestic violence also reported in that year.

> *"…**That's reported**. Given that many victims are too frightened or too ashamed to talk, the hidden statistics almost don't bear thinking about.*
>
> *Except we must. Future generations depend upon it. A National Crime Prevention survey of 5000 children aged between 12 and 20 found that one in four was aware of domestic violence against their mother or stepmother from their father or step father.*
>
> *Research shows that the effect of witnessing violence against a loved one is often as severe, in terms of psychological damage, as being the direct victim.*
>
> *Forget the financial cost, estimated at $13 billion annually by the National Council to Reduce Violence Against Women and their Children, the appalling number of victims should be enough to wake us from our sleep…."*[27]

There were also 115 witnesses and victims assisted by the Victim Support Service last year – being 81 children and 34 adults.

Also, counseling and other services such as assistance with violence restraining orders were provided to adults who were not involved with court proceedings as witnesses.

A review conducted by the Department of Attorney General advised for the two year period between 2004 – 2006 that the police issued 12,296 police orders (that is, violence restraining orders).

In total this would suggest that every year at least 64,000 Western Australians are either emotionally or physically traumatized (or both) from being victims of crime.

For every traumatized victim, there is potential for seven more persons to become affected by vicarious trauma – being close family members (such as parents, siblings and grandparents) or friends, who care for that victim.

This is equivalent to a vulnerable community of almost 450,000 persons in Western Australia, or 1 in 4 of all Western Australians.

[27] Hosking J, November 10th 2009, **"Time to lift veil on hidden abuse",** The West Australian, p 21

Self Harm Admissions

Responsibility.org reports that in 2003-04 more Australian females than males were admitted to hospital due to self-harm injuries, with females accounting for 62% of hospitalised self-harm cases in that year (i.e. 14,228 female and 8,722 male cases).

This would suggest that 2300 Western Australians per year might be emotionally or physically traumatized (or both) or experiencing chronic stress, in order to be hospitalized for self harm.

Thus for every episode of self harm there can be up to seven times more emotionally traumatised or chronically stressed Western Australians - strongly affected by the vicarious trauma and/or the chronic stress from being a carer.

This is equivalent to a vulnerable self harm community of over 16,000 persons, or 1 in 15 of all Western Australians.

The total number of patient days in hospital due to self-harm was reported as 61,220 days in 2003-04, with each case of self-harm resulting in an average 2.7 days in hospital.

Mental Health Admissions

The Department of Health reports that in the June 2009 quarter, there was an increase of 217 (or 10.3%) public mental health admissions compared with the same quarter in the previous year, with 2,327 people being admitted for mental health services.

Given the average hospital stay for mental health admissions is 28 days, public mental health admissions were equivalent to more than 65,000 hospital bed nights.

On the last day of June 2009 the Department of Health reports there were 4,395 average number of available overnight (occupied and unoccupied) beds, with 78.0% overnight bed occupancy. This suggests that each month there is available an average 102,850 bed nights for all admissions.

There were also 153,419 attendances at mental health outpatient clinics - 10,538 more attendances at mental health outpatient clinics for the quarter, or a 7.4% increase.

For the same period, metropolitan public hospital mental health admissions increased by 180 (or 9.6%). For country public hospitals there were 37 (or 16.0%) more mental health admissions for the June 2009 quarter compared with the June 2008 quarter[28].

These statistics suggests self harm and mental health hospital admission is equivalent to more than 10% of all hospital overnight bed occupancy, and that the number is growing rapidly.

Family Violence

Each year in Western Australia, at least 6 women and 2 children die as a result of family violence[29].

[28] Figures include mental health admissions at all authorised hospitals as well as designated mental health inpatient units at public hospitals and the authorised mental health inpatient unit at Joondalup Health Campus. However Peel Health Campus is excluded as it is not a designated mental health facility, and some private psychiatric accommodation and health services are also not included.

Domestic violence occurs irrespective of social class, ethnicity and culture.

Research has identified violence to be a common behaviour when a person is serotonin deficient. The research clearly shows that an increase in stress hormone activity effects the neurotransmitters in the brain.

Dopamine (DA) and serotonin are implicated in the regulation of aggressive behavior, but it has remained challenging for medical researchers to assess the dynamic changes in these neurotransmitters while aggressive behavior is in progress.[30]

To date no simple one-to-one causal relationship has been found between serotonin and aggression. The influence of serotonin is best analyzed within a broader framework that includes consideration of its role in the inhibition of impulses and the regulation of emotions and social functioning - domains that are closely linked to aggression. Western Australia's justice system clearly highlights that impulsivity and strong emotional states will often accompany violent acts.

Aggressive individuals are likely to experience general difficulties with impulse control and emotional regulation, and they show impaired social cognition and affiliation.

However serotonergic dysfunction will influence aggression differently, depending on the individual's impulse control, emotional regulation, and social abilities.

Yet, aggressive acts occur in a broader social context. As such, serotonergic function has an effect not only on the individual but also on the group dynamics, and it is in turn influenced by these dynamics. Whether aggression will occur when serotonin dysfunction is present will depend on individual differences as well as the overall social context[31].

However, this is not to say that the risks of becoming a victim of domestic violence are evenly spread. There is now considerable research evidence suggesting that the risks are considerably greater for Aboriginal women (and children) and for those from socially marginalised backgrounds.[32] Most likely this is because such communities experience multiple stressors (such as relationship breakdowns, financial and/or legal pressures, homelessness, poverty, ill-health, unemployment etc.)

Therefore vulnerable communities include population sub-groups such as homeless young people[33], men and women with experience of involvement in the criminal justice system (particularly prison)[34], people with

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[29] Source: www.angelhands.org.au; extracted 16/10/2009

[30] "van Erp AM, Miczek KA, Department of Psychology, Tufts University, Medford, Massachusetts 02155, and Departments of Psychiatry, Pharmacology, and Neuroscience, Tufts University, Boston, Massachusetts 02111. "Aggressive Behavior, Increased Accumbal Dopamine, and Decreased Cortical Serotonin in Rats", *J Neuroscience* 2000 Dec 15; 20(24):9320-9325.

[31] Menahem Krakowski, M.D., Ph.D. , "Violence and Serotonin: Influence of Impulse Control, Affect Regulation, and Social Functioning", Journal of Neuropsychiatry and Clinical Neurosciences, May 2002

[32] Ferrante et al, *Measuring the Extent of Domestic Violence* (1996); D. Indermaur, L. Atkinson and H. Blagg, (Crime Research Centre) *Workingwith Adolescents to Prevent Domestic Violence* (1998).

[33] Western Australia Crime Research Centre and Donovan Research, *Young people and domestic violence: National research on young people's attitudes and experiences of domestic violence* (2001).

[34] Kilroy, D., (Sisters Inside Inc., Qld) 'When Will You See The Real Us?: Women in Prison' (Paper presented at the Women in Corrections: Staff and Clients Conference convened by the Australian Institute of Criminology in conjunction with the Department for Correctional Services SA, Adelaide, 31 October-1 November 2000).

disabilities[35] or a mental illness, adults who suffered asynchronous childhood development, groups involved in high risk behaviours (drug and alcohol use, the sex industry) and young people in 'enmeshed' dating relationships[36] , as they all remain at high risk.

Submissions to Western Australia's Department of Attorney General's Review of Part 2 Division 3A of the Restraining Orders Act highlighted the need for the vulnerabilities and special needs of the above sub-groups to be acknowledged and properly addressed in the provision of services and protection[37].

Suicide, Emotional Trauma, Stress and the Elderly

In 2008/09 the Public Trustee experienced a 14 per cent increase in the number of Trust clients and a 29 per cent increase in the number of Protective Management clients (elderly abuse and neglect).

Similar rises are occurring in the client base of the Public Advocate who is responsible for guardianship, advocacy and administration services.

The number of investigations increased by 17 per cent in 2008/09, whilst the number of new appointments as guardian of last resort increased by 23 per cent.

The increasing number of people with dementia is one of the major causes of increasing appointments, and it is also another vulnerable community.

The Public Trustee expects the dementia trend to likely continue, with more new appointments occurring as a result of the increased prevalence of dementia.

Working Towards the Development of a Preliminary Business Plan

Establishing a Network of afterShock Centres in Vulnerable Communities (towards a Western Australian Community Network for Suicide Prevention)

Expenses

* Voluntary Position Only	#	2009	#	2010	#	2012	
Staff		6		10		15	
Executive Officer/Director	0.2*	0	1	90000	1	110000	
State Manager/Secretariat	0.2*	0	0.5	50000	1	110000	
Community Engagement Mgr	0.2*	0	0.2*	11000	1	55000	
Community Coordinator	0.2*	0	5	275000	50	2750000	
Corporate liaison Officer			0.5	27500	1	55000	Offset through income g
Promotions Officer			0.5	27500	1	55000	activity & onsortium aff

[35] [35] Women with disabilities are assaulted, raped and abused at a rate of between 2 and 12 times greater than women without disabilities: L. Mulder, Reclaiming Our Rights: Access to existing police, legal and support services for women with disabilities or who are deaf or hearing impaired who are subject to violence (1995); M. Sceriha, 'Let Down the Drawbridge – Women with Disabilities and Domestic Violence' (Paper presented at the National Domestic Violence Summit, Parliament House Canberra, September 1996).

[36] Nancarrow, H., 'In search of justice for domestic and family violence: Indigenous and non-indigenous Australian women's perspectives' (2006) 10(1) *Theoretical Criminology* 87.

[37] Submissions from: the Minister for Disability Services; Citizenship and Multicultural Interests; Minister Assisting the Minister for Planning and Infrastructure; Director of Public Prosecutions for Western Australia.

Office Administrator			1	45000	1	45000	
Officer junior			0.2*	0	4	136000	Seek Recurrent Co Volunteering
Finance Manager	0.2*	0	0.2*	0	1	110000	
Grants Officer			0.2*	0	1	55000	Rotarian affiliated Volu
Finance Officer			1	40000	1	40000	Ditto
Trainer	0.2*	0	1	45000	1	55000	
IT Manager			1	55000	1	55000	
IT Officer			1	40000	1	40000	
Student (Prof) Supervision					1	60000	
Voc. Rehab Supervision					1	60000	
Total	**0**	**0**	**10**	**706000**	**68**	**3791000**	
Operational expenses							
RCCWA_NGO Board Expenses		800		15000		25000	
MCSP Advisory Board Expenses		0		108800		108800	
Community Action Plans / Forums		0		150000		600000	
IT/Communications		17500		17500		55000	Offset by Com'ty/Corp G
Administration		15000		15000		30000	Accounting/Audit Costs
Marketing and Promotion		15000		15000		38000	Offset by Comm/Corp G
Staff/Volunteer Travel		8000		25000		50000	Offset by Grants/Schola
Accommodation (Lifeline)		0		5000		65000	Seek 2 year rent free co
Infrastructure		800		15000		50000	
		57100		**366300**		**1021800**	
Total Non Staff Expenses		**57100**		**1072300**		**4812800**	
Total Income/In Kind Value		**57100**		**1316500**		**5318500**	
Deficit / Surplus		**0**		**244200**		**505700**	

Income

Note:

	#	**2009**		**2010**		**2012**
Membership Fees	34	2100		8000		18000
Internship Placements			2	10000	5	25000
Rehabilitation Placements			2	5000	10	25000
DOH Service Agreement				500000		500000
Local Government				100000		200000
State Government				275000		3250000
Federal Government						200000
Project Admin Tax						40000
Corporate Sponsorship				120000		450000
Rotary Community Sponsorship				10000		250000
Total	**34**	**2100**	**4**	**1028000**	**15**	**4958000**

Income (Pro Bono-Volunteering)	#	2009		2010		2012
Membership Fees	10	-300	50	-1500	150	-4500
Internship Placements		0	2	-10000	5	-25000
Rehabilitation Placements		0	1	0	4	-10000
Community Volunteering		40300		50000		150000
Corporate Volunteering/Pro Bono	1	15000	2	250000	4	250000
Total	**11**	**55000**	**55**	**288500**	**163**	**360500**

Total Income/In Kind Value	**12**	**57100**	**59**	**1316500**	**178**	**5318500**

* Audit, Legal and Comp

PROPOSAL – BUILDING AN ABORIGINAL MENTAL HEALTH AND WELL BEING NETWORK AND SERVICES DEVELOPMENT

(WA Suicide Prevention Strategy) / aftershock)

RATIONALE:

There are existing services to address Aboriginal Mental Health and Well Being, however, none have yet effectively and wholly addressed the issue of suicide and mental illness in the community. The reasons for this are as diverse as the issues surrounding these matters.

A possible solution, which of course will likely be one of many, is to establish one point of reference. Research undertaken with those with the lived experience at the coalface, so to speak coupled with academic reference will provide a very solid foundation to launch appropriate strategies that will in the long term have a meaningful and positive impact on Aboriginal community.

The difference with this proposal is that I intend bringing together people that can make a significant impact. I know five (5) people – all indigenous – with the skills to yarn one on one, in groups and with services across the sector, but also have strong administrative and analytical skills. In fact all have also experienced suicide in their families with one having lost over 8 family members in the last 18 months, and of course myself, with my son being the 9th suicide in my family during my lifetime.

I believe we can add value to existing information, but also delve beneath the layers of what is usually shared. Further to that, in lifting the layers, all personnel also have counseling skills and will therefore be able to assist the people that share their stories. There is much to learn about causal factors, indicators and impact and this proposal will endeavour to bridge the gap between what we know, what we think we know and what we haven't thought of at all.

There has been much 'speak' about ensuring we have culturally appropriate services, hence the proposal includes the development of Service Audit tools specific to Aboriginal suicide or self harm that services, medical

services and government departments – or perhaps – even families could undertake. Furthermore the development of a long term holistic strategy will also be a positive outcome.

There are a number of stepping stones to achieving these outcomes that in and of themselves will assist community, whether that be on the ground or in services. The collation of a database is one example.

I submit this proposal for your perusal and invite further discussion should you be interested in exploring this further. I do ask that timeliness is considered as I am aware that the six people referred to as staff in this proposal, while employed are willing to make the move at this time should the opportunity be made available.

OBJECTIVES:

- Establish an Aboriginal advisory and support group.
- Appoint staff.
- Research the extent of suicide and self harm in Aboriginal communities.
- Research indicators, significant behaviours and intervention services/opportunities of and for Aboriginal people with suicidal ideation.
- Research contributing factors that may cause an Aboriginal person to self harm or to suicide.
- Record stories.
- Develop a Risk Assessment tool based on research findings.
- Develop strategies and relevant frameworks to address self harming or suicidal behaviours for families, community workers and professional service providers.
- Raise awareness of the extent of suicide in Aboriginal community.
- Develop information and promotional materials using different formats and medium.
- Develop a database of culturally appropriate services.
- Provide cultural training internally and externally (fee based) to assist with service delivery and best practice for working with Aboriginal community.
- Develop tools to audit and assess service appropriateness for Aboriginal community.
- Develop training schedules and modules for Aboriginal community to identify and address suicide and self harming behaviours.
- Develop training schedules and modules for Aboriginal community to undertake training in mental health and wellbeing to explore other possible mental illness conditions that may be being experienced by Aboriginal community.
- Develop an appropriate framework to deliver holistic services in Aboriginal community.
- To provide appropriate support for Aboriginal families who have experienced suicide.
- Offer access to counseling.
- Establish, collect and/or develop a selection and range of resources specific to Aboriginal suicide and self harm.
- Establish an Aboriginal support network for families that have or are experiencing a family member/s that are self harming or have attempted suicide.
- Work with related organisations in the field of counseling, eg. Drugs, substance and alcohol misuse, sexual abuse/rape, stolen generation to ensure availability.
- Develop sustainability strategies, and seek further funding.

PROPOSAL – ABORIGINAL HEALTH AND WELL BEING NETWORK AND SERVICES DEVELOPMENT

ACTIONS/TASKS – EXPECTED TIMEFRAME

OBJECTIVE	ACTION / TASK	MY ROLE	TIMEFRAME
Establish role of Aboriginal Health and Well Being Network and Services Development Manager.	Prepare JDF. Appoint AHWNSD Manager.	Assist with JDF. Finalise project development strategy. Finalise budget.	Immediately
Appoint staff. (It is envisioned that an initial complement of six (6) staff is required: 1 x FT Administration, 3 x Counsellors/Assistant researchers - .6 FTE Counselling, .4 FTE Researching preferably 2 female and 1 male; and 2 x .8 FTE Youth Workers).	Develop JDF's based on identified staff needs at point of project commencement. Appoint required staff. One week retreat to develop working protocols, establish goals and objectives; identify roles and responsibilities, establish expected work ethic, learn 22organizations22 policy and procedure and team support mechanisms.	Write JDF and selection criteria. Advertise, shortlist and interview position applicants. Develop Induction Package. Appoint staff. Organise and facilitate retreat.	Completed within six (6) weeks of commencement.
Set up office.	Set up office. Minimum requirement at this stage is 1 x desktop computer, 4 x laptop computers – all with LAN and wireless capacity, 6 x Blackberry phones, stationery and general office furniture and resource. Purchase 4 vehicles	Purchase required items. Develop asset register. Ensure all staff are aware of equipment use policy and procedure.	Completed within six (6) weeks of commencement.

Develop sustainability strategies, and seek further funding. (Part one)		Develop networks with corporate, government and philanthropic bodies.	From month three (3).
Establish three (3) Aboriginal advisory and support group.	Meet with Aboriginal elders and community members from Perth, Kimberley and Pilbara to seek commitment to being a member of an Advisory and support group. Develop protocols, meeting procedures and meeting schedule.	Arrange meeting in Perth with elders and community members. Write up meeting determined protocols, meeting procedures and meeting schedule. Compile member list and contact details. Distribute minutes and annual meeting schedule.	Completed within three (3) months of commencement.
Develop a database of culturally appropriate services.	Explore known databases, contact organisations and service providers for further contacts.	Encourage staff to draw on their networks and known sources of information about services being provided.	Completed within three (3) months of commencement.
Research extent of suicide and self harming in Aboriginal communities. Research indicators, significant behaviours and intervention services/opportunities of and for Aboriginal people with suicidal ideation. Research contributing factors that may cause an Aboriginal person to self harm or to suicide. Research contributing factors that may cause an	Establish a schedule for the following: Organise forums, discussions groups, meetings, gatherings, consultations, yarning groups and one on one meetings across Perth, Kimberley and Pilbara. Collate existing research. Conduct internet research for existing material. Document sources.	Facilitate meeting with staff and Advisory Committee to develop research methodology and subsequently document pathways to be taken. Direct research activities and content. Compile and review received information. Conduct weekly staff meetings to discuss steps while researching.	Completed within nine (9) months of commencement.

Aboriginal person to self harm or to suicide. Record stories.	Produce a comprehensive document of all information to include an analysis of trends, future projections and recommended actions of prevention, intervention and support.	Manage staff work load. Ensure all tasks are carried out. Provide written reports to key stakeholders.	
Raise awareness of the extent of suicide in Aboriginal community. Develop information and promotional materials using different formats and medium.	Develop easy to read pamphlets, brochures and one pagers. Arrange feedback gatherings, workshops, forums and one on one's to present research.	Facilitate team discussions about resource development. Oversee staff schedules to ensure ample opportunities are provided for feedback to community.	From month six (6). Full presentation in month 10. Ongoing
Develop a Risk Assessment tool based on research findings. Develop strategies and relevant frameworks to address self harming or suicidal behaviours for families, community workers and professional service providers.	Develop an easy to understand and use tool for application in a variety of forums. Develop a range of strategies that are preventative, interventive and supportive for use by service providers and families drawn from recommendations included in the research document.	Support staff to develop Risk Assessment tools. Support staff to develop a range of strategies that are preventative, interventive and supportive for use by service providers and families.	Month 10 - 13
Develop tools to audit and assess service appropriateness for Aboriginal community.	Develop an easy to understand and use tool for application by services to determine level of appropriateness for service delivery and provision to Aboriginal community.	Oversee and assist staff to develop tools to audit and assess service appropriateness for Aboriginal community. Promote availability of audit and assessment tool for services.	Month 12 - 15
Provide cultural training internally and externally (fee based) to assist with	Develop cultural training package. Facilitate regular internal	Oversee and assist staff to develop cultural training package.	From month 14 – ongoing.

service delivery and best practice for working with Aboriginal community.	training. Promote opportunity for training to external organisations.	Promote availability of cultural training.	
To provide appropriate support for Aboriginal families who have experienced suicide. Offer access to counseling.	Staff to counsel families and / or individuals during the research phase. Staff to identify if ongoing counseling and support is required by the families, and if so to either commit to further support or refer as deemed appropriate.	Ensure staff maintain safe and best practice when working with families during research phase. Develop support service network and develop referral processes if necessary.	From commencement of research. Ongoing.
Establish, collect and/or develop a selection and range of resources specific to Aboriginal suicide and self harm.	Staff to collect or develop resources in accordance with information received. Staff to distribute resources as is relevant to needs or as they become available. Staff to develop database of resource availability. Staff to commence discussion about website development. Staff to identify other forums or media for information availability.	Assist with resource collection and compilation. Follow up to completion resource development. Ensure distribution of information and resource. Promote availability of resource and information to other services / organisations. Commence discussions with relevant parties about website development.	
Establish an Aboriginal support network for families that have or are experiencing a family member/s that are self harming or have attempted suicide.	Staff to support and / or facilitate the establishment and structures for support groups. Staff to assist with participation if able.	Oversee the development of support groups. Attend occasional support group gatherings to support participants and staff.	

Work with related organisations in the field of counseling, eg. Drugs, substance and alcohol misuse, sexual abuse/rape, stolen generation to ensure service availability.	Develop referral process with relevant support and counseling services.	Oversee network development and referral process. Attend meetings and form links with service CEO's. Arrange meetings with private practioners and develop network, if possible, of those willing to work pro bono.	
Develop sustainability strategies, and seek further funding. (Part Two)		Lodge funding submissions. Develop package for promotional purposes.	From month three (3). From month 12.

Staff Support

Given that much of the work undertaken by staff is stressful, confronting, intense and personal, I suggest that two consecutive paid days per month is allocated to staff retreat and recovery. Over the two days group sessions and meditative activities will be undertaken to reduce the possibility of psychological unwellness.

PROPOSAL BUDGET

(One year)

Manager	90,000		
Superannuation x 10%	9,000		
Leave loading x 10%	9,000		
3 Counsellors / Researchers – 3 x 76,000	228,000		
Superannuation x 10%	22,800		
Leave loading x 10%	22,800		
2 Youth Workers – 2 x 60,000 pro rata	96,000		
Superannuation x 10%	9,600		
Leave loading x 10%	9,600		
Administrator	52,000		
Superannuation x 10%	5,200		
Leave loading x 10%	5,200		
		559,200	

Purchase 4 Vehicles	80,000		
Insurance	4,000		
Maintenance / Service	2,000		
RAC Membership	600		
Running Costs Per month 200ea	9,600		
Running Costs – Rural, Regional and Remote	12,000		
		108,200	
			667,400
Desktop Computer	1,500		
6 Laptop Computers x 1,400ea	8,400		
Printer	500		
Colour Printer	750		
Scanner	500		
Programmes/Licences	4,250		
Photocopier / Fax	2,500		
7 Desks and office Chairs x 500	3,500		
Office Furniture – General	2,500		
		24,400	
			691,800
Stationery	2,500		
Office Resource	2,500		
Staff consumables	1,500		
Telephone purchase	3,500		
Telephone	2,400		
Mobile Telephones (Blackberry) – Purchase	6,000		
Mobile Telephones (Rental) $150.00 ea per month	10,800		
Audit	2,500		
Promotional materials	5,000		
Research Document	6,000		
Binding	1,000		
Presentation expenses	3,500		
Meeting expenses	1,500		
Catering	1,500		
Advertising	1,500		
Postage	1,500		
Business cards	1,000		
Insurance incl. liability, directors etc	2,500		
General	1,500		
		57,700	
			750,000

Introducing afterShock – a Network of Community Care

Introducing A New Concept for Preventing Western Australian Suicidal Ideation and Bereavement

Whilst

Overcoming community fragmentation by growing a Strong Consumer and Carer Network for Those Suffering from Asynchronous Development; Emotional Trauma; Traumatic Shock; Post-Traumatic, Chronic and Acute Stress; and Suicidal Ideation and Bereavement

Working together for a healthier WA

A CONSORITUM DISCUSSION PAPER[38]

November 2009

Submissions Close 20 November 2009

Prepared & distributed by

Rotary Community Corps of Western Australia Ltd

In conjunction with its potential

Suicidal Ideation and Bereavement Prevention EOI Consortium Affiliates[39]

Background to the Proposal

The social fabric of our communities and the health and community safety system in WA are undergoing more intense periods of change than ever before. This is due to a number of factors, including change driven from a global perspective, change driven from within government, and change driven by society, community and industry itself. The challenge is to manage the change and meet the requirements of the new environment in a planned and cooperative way so as to ensure suicide in WA becomes everybody's business.

The Senate Community Affairs References Committee Inquiry into Suicide in Australia provides additional opportunities to have a fresh look at suicide prevention nationally, just as did the development of the Suicide Prevention Strategy (2009-2013) by the Ministerial Council for Suicide Prevention, ably assisted through its engagement of two experienced community group facilitators (Tim Muirhead and Kim Bridge), which provided a unique opportunity to look at suicide prevention in Western Australia and to provide leadership and direction for the future of this great State.

[38] Noting that some aspects contain commerce-in-confidence information

[39] Lifeline WA, GP Network; Swan District Behavioural Management Unit; Swan Education District; Help Me Foundation; Vietnam Veterans; Community Vision Inc; Australian Rotary Health; Injury Control Council of WA and Outcare WA

The inquiry should focus on identifying new concepts and emerging research for the next iteration of its planning – not on validating and evaluating performance against historic plans.

Nor should the focus be solely on allocating roles and responsibilities between governments and community or on listening solely to expert medical service providers.

It must also choose to listen to the wisdom and voices of those who have experienced suicidal ideation and to those who have suffered a bereavement.

Western Australia's final report and its expression of interest documentation for Implementation, as well as the industry briefing conducted by the Office of Mental Health on 30th September 2009, contained key recommendations as well as specific requirements so as to prevent suicide in WA that are likely to prove relevant and assist improvements in the national circumstance.

These include:

- Appointing a non government organisation to operate as the **peak consumer body**, structured as a non-government organisation, tasked with responsibility for engaging the community in the implementation of the Western Australian Suicide Prevention Strategy (2009-2013), aligned with the National Suicide Prevention Strategy, in conjunction with the Minister for Health and the Ministerial Council for Suicide Prevention;

- **Providing a secretariat service for the Ministerial Council for Suicide Prevention** (a non incorporated advisory body), supporting them with a range of executive services, including ministerial liaison services and risk management services (e.g. DAO insurance; MCSP Conflict of Interest Policy; Advisory Board Governance Policies; Resolutions Register)

- **Having a socially responsible business plan** for future access to support and resources, so as to both ensure community service continuity, and fiscal sustainability for the non government organisation appointed;

  "….Securing dedicated support and funds from the corporate sector and from other government departments (state and federal) in the longer term is an important function…"

- Providing the Minister with community mental health and wellbeing service needs advice, including development of a MCSP-NGO board selection process for prioritisation of contractual services capable of readily demonstrating procedural fairness, that **considers each community independently in assessing its service and resourcing needs, especially those most vulnerable,** rather than applying generic state-wide policies and plans for early intervention support.

- The non government organisation should **recognise the different vulnerable communities and community priorities** and, importantly, consider support of regional "assessment panels" designed to plan and prioritise at each community level, their particular development needs.

(Placing particular emphasis on people in prisons, young people, young men, Aboriginal people and people who live in rural and regional Western Australia).

In response to the Strategy's Implementation needs, and to respond to community, carer and consumer issues raised with the Rotary Community Corps of Western Australia, whilst it undertook ongoing consultation with representatives drawn from the Consortium and its membership, including advisory boards and employees, a new concept for suicide prevention has been developed.

This new concept, to become known as afterShock, is characterised by life course experiences, community self help and management, survivor empowerment, and reduced medico-legal risk and opportunity for survivor re-traumatisation.

Not only will it provide a coordinated approach to community suicide prevention activity into the future – but the provision of co-located, shared service, consumer self management, community based mental health and wellbeing services, with access to emotional and social development skills as well as a wide range of community education tools at a much earlier stage of the intervention, will ensure a sustainable approach as well.

Proposed to be piloted in Western Australia, initially these Community Trauma and Wellbeing Centres (CWCs) could operate like "Super Clinics", combining the 24/7 health and allied health services that survivors have advised are necessary to support emotional trauma, post traumatic shock, chronic stress and suicide survivors (such as Trauma and Stress Specialist GPs; Grief and Trauma Counsellors; Social Workers - Counsellor/Advocates; ADR and Family Mediation Officers; Naturopaths, Physiotherapists, Sports Psychologists, and Pilates Clinicians).

Operating as community cooperatives, but structured as unit trusts, suicide survivors, post traumatic shock, emotional trauma and chronic stress consumers would all become members of their own local cooperative society – thereby also guaranteeing that they would always have access to a specialist trained doctor.

Risk and return will need to be allocated between government and non government service providers (public, private and third sector), dependent upon who is best capable of bearing the risk and/or getting the financial and social returns.

Over time it is expected community CTWCs would be progressively (re)built so as to co-locate and replace existing community infrastructure, services and resources, wherever and whenever possible (such as co-locating child care centres, early education centres, infant healthcare centres, family mediation/ADR services and community legal services within the trauma and wellbeing super clinic, with common areas/shared services provided for administrative functions and records management).

Each centre will also provide for professional student internship and supervision opportunities for health, allied health and legal professionals and para-professionals, as well as provide rehabilitation work opportunities for people suffering a psychiatric disability caused by trauma.

Although initially the focus will be on co-locating and aligning health and allied health services, eventually it is planned that the model be expanded to include and encompass, in full, the "health-justice" element.

Other jurisdictions (such as NSW) are already embracing this type of co-managed model for persons in correctional institutions or for those hospitalised or on a CTO, under an involuntary order.

Such a model

(a) potentially maximises the individual sufferer's human rights, freedom of choice and informed consent, whilst minimising trauma they may experience from an enforced deprivation of liberty or a re-traumatisation (*such as having to retell their story to multiple service providers*); and
(b) better balances the inherent community conflicts of interest related to assisting a trauma sufferer to recovery, whilst still ensuring the wider community can remain as safe as possible.

Every afterShock Community Trauma and Wellbeing Centre would have a community non government organisation (RCC) with responsibilities and adequate resources to implement their own community's Suicide Prevention Strategy.

This concept, which includes a new way of delivering health promotion and early intervention as well as community and industry representation in all regions and vulnerable communities of Western Australia, builds on the current commitment, dedication and professionalism of the many volunteers and professionals working in and for community care and service, and is designed to provide better support for their initiatives and hard work.

Your input is important

The new concept has been developed based on feedback provided to the RCCWA through its afterShock survivors support group, from its awareness of research findings funded by Australian Rotary Health, and others, and from the community, media, higher education and industry in general.

This discussion paper outlines key issues identified to date, which we think will generate the most interest and debate within the community and with other stakeholders involved in suicide prevention – thereby providing a proposition for discussion.

The Rotary Network in Western Australia

RCCWA Vision – "From vulnerability to service above self"

afterShock Vision – "Helping each other to distress less – because throughout life there are always bumps in the road".

Finding a Cure for Suicidal Ideation by Supporting and Listening To Post Traumatic Shock and Acute and Chronic Stress, Fatigue and Pain Survivors

Supporting healthier minds, bodies and communities through research, awareness and education

A fair share for those in need, with service delivery according to need

Improving service access based on need; whilst securing a just share of resources by being socially responsible, community connected and accountable for their use

Closing the gap to improve Aboriginal health and wellbeing as well as the overall health and wellbeing of the mentally ill

Improving the health of Aboriginal people and those suffering from mental ill-health

Encouraging workforce stability and excellence (*in both paid employment and voluntary service*)

Building occupationally healthy, safe and skilled workforces within supportive workplaces that recognise the value of workplace carers, adopt stress management practices, and reward emotional intelligence.

Recognition of Personality Diversity, and Implications for Youth Suicidal Ideation from Asynchronous Child and Adolescent Development

Ensure that as much early education, child and adolescent health, community education and workforce development emphasis and effort is placed on emotional intelligence building and social skill development, as there is on "normal" or "average" intellectual cognitive intelligence and psychomotor skills and development.

Our values

Community Care

Encouraging community learning, service and positivism, where there is openness, generosity and cooperation. Building healthy and empowered communities and teams, being inclusive, working together, valuing each other as well as the value of diversity, and recognizing the difference a single community can make when it works together.

Emotional Intelligence

Listening and ensuring the voice and wisdom of survivors is heard. Committed to caring for others – by demonstrating compassion, empathy, kindness and respect. Satisfying the community by being emotionally intelligent.

Quality

Striving to provide the best possible care and service through listening to and responding to the needs of those most affected; always questioning and reviewing and adopting as high a standard as is feasible; focusing on innovation, creativity, learning and improving.

Integrity

Building trust based on openness, honesty and social responsibility, and valuing and respecting others opinions and points of view. Building positive relationships and being mindful of the legacy we hand on to our future communities.

In Pursuit of Justice

Pursuing ethically based achievements. Valuing, embracing and mitigating for diversity and difference whilst holding people accountable for the consequences of their preventable actions. Respecting confidentiality, privacy and responsibility, but speaking up when there is injustice.

Our key actions

1) To give a voice to post traumatic shock and chronic stress survivors, especially those who have experienced suicidal ideation and bereavement, and to empower them to access a provision of meaningful and necessary services, available to them at their community level

2) To remove the stigma associated with suicide and mood (affective) disorders in the community, by normalising it through community education to the wider community of Western Australia, so it can be understood to be:
   - a sane decision made by the individual about ongoing pain[40] management, their lack of wellbeing and the level of burden they perceive they are placing on their loved ones or society in general; and
   - a normal human response *(metabolic-digestive, stress hormonal and brain-CNS disorder)* to trauma and chronic stressors. In contrast, common community stigmas, related to suicide, see it as:
     i) abnormal human behaviour within the context of their socio-cultural environmental *(that is a behavioural response to normal human events and life stages that is different to that of the "normal" person, as others have judged the "normal" person is resilient enough, or "normal" enough, to always be able to tolerate the emotional pain that comes with stressful life events);* or
     ii) an ethical or moral issue.

3) To link Western Australian health, allied health, community and justice services into a cohesive and effective community and industry sector, and to strengthen prevention and health promotion, so as to enhance the community's social and emotional wellbeing.

4) Ensuring any suicide prevention strategy implemented:
   - Has been based on meaningful consultation
   - Has respect for diverse cultural beliefs, including a recognition of ethnographic (*heritage*) values and attitudes held around suicide and mental health, and provides holistic culturally secure responses; and
   - Ensures ownership and involvement by local community members.

[40] Whether physical or emotional pain, or both

Governance Structures

Enterprising World International Limited was established, in 2005, by a consortium of Rotary Clubs and Rotarians as a not for profit public corporation, to operate as a youth development and vocational skills social program incubator, and to assist the disadvantaged and vulnerable to access mainstream Rotarian scholarship opportunities *(or sponsorship for personal development and vocational skills training provided by others).*

It currently oversees the management of two programs – the Rotary Community Corps of Western Australia and afterShock.

Rotary Community Corps (RCC) is one of Rotary International's nine structured programs designed to help Rotary clubs and districts achieve their service goals in their own communities and in communities abroad, fostering fellowship and goodwill in the process. For more information please visit http://www.rotary.org/en/serviceandfellowship/startaproject/Resources/Pages/ridefault.aspx.

The Rotary Community Corps of Western Australia operates under the Rotary Community Corp governance structure, as adopted and approved by the Board of Rotary International and the Board of Rotary District 9450 (Perth and North Western Australia) Inc. Its membership is limited to non Rotarians.

The Board of Rotary International developed Rotary Community Corps Guidelines and Bylaws, which are adopted by each RCC after being adapted in order to cater for local conditions.

This structure enables Rotarians, individual or consortiums of Clubs and multi-Districts to support, with community sponsorship and volunteering, disadvantaged and vulnerable individuals and groups, currently living or working in their own community, or any project with which they may be associated,.

As partners in service, RCC members and Rotarians have the opportunity to

- Develop communication and leadership skills.
- Enhance community pride.
- Share the responsibility to take charge of their community's future.

It is registered as a public not for profit corporation, operating under Corporation Law.

Requiring sponsorship from at least one Rotary Club, as well as from its associated District, at formation *(RCCWA was formed in April 2008)* - membership of the Rotary Community Corps of Western Australia is restricted to non-Rotarians, although Rotary Club and District representatives may sit on its advisory boards and sub-committees so as to provide its leadership with guidance and governance skills.

As a community organisation and a cooperative society, the RCCWA provides automatic reciprocal membership rights to any non Rotarian member drawn from any other community based organisation, for a RCCWA joining fee of only $20 (plus GST), which is a value equivalent to each member's limited guarantee under Corporations Law.

Financial annual membership entitles members to be elected to either the community or technical advisory boards of the RCCWA and of afterShock, and to attend the Annual General Meeting and vote the election of Directors who control the activities of Enterprising World International Limited.

The elected president and vice president of the RCCWA are automatically elected by the membership to the board of Enterprising World International Limited.

Financial annual membership fees are $50 per annum (plus GST) for individuals, and $250 (plus GST) for corporate members.

Its legal advisor is Freehills, its bankers are Westpac and its company secretary/auditor is MGI Perth.

APPLICATIONS FOR GRANTS

A comprehensive multi-Club sponsorship and volunteering application and evaluation process has been developed, replicating the best practice exemplar already existing for Rotary Australia World Community Service (RAWCS).

Proposed Role of RCCWA-NGO

Under the Executive Officer leadership of President, Tracy Pollett, it has been proposed to the Western Australian government that the RCCWA operate as the NGO in support of the Ministerial Council for Suicide Prevention.

The RCCWA offers a Rotary International endorsed structure that readily enables the wider community (3000+ members) through the Rotary network to engage with vulnerable individuals, communities and service providers.

Development of Council governance, planning and resource prioritisation processes, as well as an early expression of interest to develop an Indigenous Engagement Strategy and progress the establishment of Community Coordinators and Action Plans in vulnerable Aboriginal Communities and finalisation of the afterShock feasibility study are planned as its key activities for 2009-2010.

AUSTRALIAN ROTARY HEALTH

Vision

To encourage and stimulate the promotion of good health in Australia

Governance Structure

Australian Rotary Health is approved by the Board of Rotary International as a multi-district project and is registered under Corporation Law. It operates through a Constitution which provides for membership to be restricted to Rotarians and for control by a Board of Directors elected by and drawn from the Members.

Membership entitles members to attend the Annual General Meeting and to vote at the election of Directors who control the activities of Australian Rotary Health.

Membership fees are $50 on joining and $10 per annum (plus GST). Applications for membership should be directed to *The CEO, Australian Rotary Health, PO Box 3455, Parramatta, NSW 2124.*

Experience has shown the health and wellbeing needs of Australians are great, and Rotarians can make a significant impact.

Australian Rotary Health, through its efforts to date, has earned a significant reputation for itself in supporting vital health promotion *(such as "Driving the campaign against depression across Australia"; a strategic alliance with BeyondBlue and the Commonwealth Department of Health and Aging, see attachment 1)*; and research, which is conducted *by Australians for Australians.*

The administration of Australian Rotary Health is conducted from Parramatta. Costs are minimal due to the extent of honorary service rendered by members of the Board and supporters at district level. Australian Rotary Health is a health promotion charity, exempt from Income Tax. Australian Rotary Health seeks donations from:-

- The Australian public in general
- Rotary clubs
- Individual Rotarians
- Commercial organisations
- Charitable trusts
- Bequests

Last year donations from Rotarians totaled almost $2.3 million. One of the key benefits of Rotarians donating to ARH is that they can designate what they want the money direct to go towards. Relevant ARH Funding for 2009 is:

- Evaluation of Mental Health Service Provision $543,403
- Evaluation of Rural Health Services— $79,707
- Research Grants – All Health Areas — $1,658,304 allocated

2008 EXPENDITURE

- Indigenous Scholarships $325,000
- KidsMatter $250,000
- Rural Medical Scholarships $130,000
- Mental Health Public Forums $100,000
- Media Training for PhD Students $10,000
- Research Grants & Scholarships $3,416,928
    - *Evaluation of Mental Health Service Provision – approx $550,000 in 2009*
    - *Evaluation of Rural Health Services – approx $80,000 in 2009*
    - *Health Research Projects in 2009 – approx $1,650,000 in 2009*

TOTAL PROJECTS SPENDING (2008) $4,231,928

APPLICATIONS FOR GRANTS

Since 2000, Australian Rotary Health has focused research on Mental Illness. Funding is given to research project grants, to PhD scholarships and to post-doctoral fellowships.

The Board has determined a standard procedure for the application for grants. Advertisements are placed in The Australian newspaper, in the Australian Medical Journal and in RDU calling on applications. The research offices of all universities are also notified as well as advertising on the Australian Rotary Health web site. Application forms can be downloaded from the web site.

Once applications have closed, the Research Committee meets to evaluate and recommend to the Board those considered suitable for funding.

Projects funded are carefully monitored with regular reports requested.

All projects are approved for one year only and must reapply for subsequent years. Projects that are funded for more than one year go through an intensive review process with their progress for the first year a major consideration on renewal for additional years.

At the end of the grant period, a final report is requested.

Proposed Role of Australian Rotary Health

If successful in its expression of interest related to implementing the WA Suicide Prevention Strategy, the RCCWA will contract ARH to:

(a) financially administer the $13,000,000 whilst the RCC-NGO grows its internal capacity so as to transfer roles and responsibility of the afterShock initiative to Lifeline WA; and
(b) Coordinate the Research and Evaluation functions.

Rotary Clubs of Western Australia

Rotary in Western Australia is made of up of approximately 120 independently incorporated clubs, who operate under harmonious governance arrangements existing within a hierarchy of local, divisional, state, national and international Constitutions and law.

Established in Western Australia in 1927, there are Rotary clubs in most metropolitan suburbs and country towns. Every Rotarian, as an individual, is a member of both their local Club and of Rotary International. Some 3300 men and women are currently involved in Rotary in Western Australia, living or working in towns as far North as Kununurra and as far South as Esperance. Each year they hold an Annual General Meeting and elect their incoming leadership. There is also a succession plan in place because a President Elect is also selected. The President Elect acts as the President's Nominee throughout that year thereby gaining personal development experience before having to become an official office holder.

Every Rotary Club is also a member of their District organisation, as an association which is led by a District Governor. Originally divided into three districts (9450, 9460 and 9470), from 2010 Rotary in Western Australia will be divided into only two districts (north and south). Rotary District organisations also have individual members, as every past president is also an individual member in their own right.

The Rotary network (Rotary International® Clubs, Rotarians and devolved Rotary health promotion charities) is very experienced in the implementation of community based health promotion and prevention programs, for a wide range of health and wellbeing initiatives.

Not long after Australian Rotary Health (ARH) embraced Mental Illness as the theme of research, it became the second largest funder of mental health research in Australia – second only to governments. Last year, ARH on behalf of the wider Australian Rotarian community, invested

The Commonwealth Government became interested in Rotary's ability to inform and educate the general public on various aspects of Mental Illness. The Rotary Club of Mosman, NSW became the first Rotary Club in Australia to sponsor an awareness meeting by inviting members of the community to come along and learn more about mental health. Over 300 people attended this first forum and heard high calibre speakers – a carer, a consumer and a clinician – talking about their experience with mental illness.

A new ARH campaign, begun in 2007, focuses on providing information relevant to specific mental illnesses in specific populations, rather than providing general information about "mental Illness" to the broader population, as occurred in the previous forum program. This campaign will also provide a greater "dose" of intervention to individuals who attend forums to increase the likelihood that they achieve relevant behavioural change.

In implementing its programs, ARH works closely with the Rotary and Probus Clubs of Australia, as well as the Commonwealth Department of Health and Aging and BeyondBlue.

Together these organisations have developed a range of educational tools for communities to use in order to stage Community Mental Health and Wellbeing forums – which were vital for driving a national campaign against depression into communities all across Australia – especially into rural and remote communities.

ARH also supports the school based program, KidsMatter, as well as providing indigenous health and rural medical scholarships.

Other successful major Rotarian initiated health and wellbeing initiatives supporting Western Australian communities include funding the building of the first School of Medicine at the University of Western Australia; active support of Foodbank Western Australia as well as Wheelchairs for Kids, and working with the Australian Red Cross Western Australia to develop Western Australia's Rotary Cord Blood Bank.

Smaller less impactful programs (although no less important) include working with Curtin University on the Rotary Waist Management project, the staging of a wide array of youth development initiatives with a particular emphasis on trying to attract participants from vulnerable groups, and development of a

Rotary Community Corps of Western Australia (RCCWA) - established to become a self-help support group of vulnerable individuals and communities.

Sponsored at foundation by the Rotary Club of Western Endeavour Inc, the RCCWA assists vulnerable Western Australians and communities to engage with each other in an honest and open dialogue about common issues that undermine their wellbeing.

Through contractual service, MOU, pro bono and affiliated reciprocal arrangements, the RCCWA facilitates support for them, through to a life stage that will see them able to access mainstream development opportunities, offered by Rotarians, and from others in their own communities more advantaged, so they can learn how to place their "service to others above themselves" – a key Rotarian community learning and service value.

Founding members were drawn from individual experts invited specifically to help with its formation and early development. They included experienced senior practitioners working in organizations such as Curtin and UWA, Lifeline WA, Holyoake, Beacon Foundation, Mission Australia, Centrecare, Outcare, SVP, Edmund Rice Centre and Churchill Clinic.

Rotary Community Corps are an approved and accredited Rotary International community and economic development program and governance structure, enabling non Rotarians to gain community sponsorship (financial and volunteer resourcing and access to transitional self-governance arrangements), not only from the Rotary Club(s) of a single community, town, state or country, but also from the wider Rotary International membership itself.

They operate to the governance standards set by Rotary International.

RI restricts Rotary Community Corps from being structured as charitable institutions, so as to avoid community conflict with other charitable organizations. Instead they operate as not for profit, non government social enterprises or community cooperative societies.

In establishment at least one sponsoring Rotary District needs to endorse the Rotary Community Corps application through to Rotary International.

District Governor Eli Quartermaine and the governing board of District 9450 (Perth and North Western Australia) endorsed the establishment of the Rotary Community Corps of Western Australia in April 2008.

Through the work of individual Rotary clubs, and through the programmes of Rotary International, The Rotary Foundation and a wide array of Australian Rotary health promotion charities, Rotary is making the world a better place.

Conclusion

This New Concept for WA Suicide Prevention is presented by the RCCWA as we believe further investigation and implementation of this concept will have very tangible benefits for preventing suicidal ideation and bereavement in WA including clearer lines of responsibility, simplified contracts, less

bureaucracy, greater efficiency, improved health promotion and greater freedom for vulnerable Western Australian communities to chart their own future.

To get a change of this magnitude right, considerable input from communities and industry is needed and this expression of interest paper is an important part of that process. We would welcome your input through the expression of interest process.

SUBMITTED BY

Tracy Pollett	Glenda Bye MAICD, MBA, BA
PRESIDENT	PP, ROTARY CLUB OF WESTERN ENDEAVOUR
ROTARY COMMUNITY CORPS OF WA	Project Coordinator afterShock
(Maori-Australian Survivor)	(Anglo-Australian Survivor)
(Mental Health Carer)	Mental Health Carer and Consumer

Not on My Watch

"Thriving in a World of 'Normal' - When You're Not©"

Ways parents can help prevent teenage self harm and suicide

Glenda Bye
Founder
Enterprising World International Limited
T/A afterShock and Rotary Community Corps of Western Australia

Preface - Glenda's story

Before that evening, being 5.10pm on the 30th October 1998 – a time and date now fused onto my brain forever - the concept of suicide had never entered my consciousness.

Sitting in my office at work, I had answered a call from my husband.

His voice breaking with the emotion, he'd advised me that the school counselor from the western suburbs private school where our 14 year old daughter was attending had phoned him at our home.

She'd told him that our bright, talented and sensitive daughter had tried to throw herself from the second story banister surrounding the library into the car park below.

She also told us that our daughter had come to see her several times over the past few months, seeking her counsel and help, but she had thought there was nothing really to worry about as she was doing so well in school.

She advised we needed to arrange for our daughter to see a psychiatrist urgently, and suggested taking her to a child and adolescent mental health centre *(but told us it might take some time to get a first appointment)*, or else to the emergency department of a hospital.

As I drove myself home from the office the tears were literally streaming from my eyes – making me a danger on the road, not only to myself but to others as well.

Thus began my primary carer journey of helping to prevent her suicidal ideation and our family's bereavement (grief and loss as well as the vicarious trauma, compassion fatigue and carer burnout that goes with it) – a journey lasting more than eleven years and which, after ten years, took me into the very same space myself.

Fortunately, and requiring an inordinate strength of mind as well as increased tolerance for pain (both sensory and emotional), our family has all come out on the other side of an emotional trauma initiated by asynchronous childhood (*physical*) development and teenage bulimia – although not without its normal legacy of physiological damage and intensified emotional sensitivity.

I experienced three extreme "ah-ha" moments in that journey of immense struggle involving fourteen *(known)* suicide attempts by my daughter.

The first was whilst sitting and waiting for my daughter's return from counseling in the South Metropolitan Child and Adolescent Health Centre (CAMHS).

By this time our daughter had been admitted to hospital, in both a voluntarily and involuntarily capacity, many times.

At the time our family was having great difficulty maintaining an emotional connection with my eldest daughter – she'd rebelled, rejecting all our behavioural boundaries and was engaged in a variety of anti-social behaviour.

She'd also repudiated all approaches from her nine year old younger sister – claiming she hated us all.

By now she'd learnt panadol wouldn't alleviate her pain no matter how many she took, but that it was a very cheap overdose drug, capable of assisting her to end it all.

From her hospital ward (*lock-up*) peers she'd also learnt how to tie shoe laces so as to hang herself - either in a wardrobe or a toilet booth – and as a result we'd actually found her in that state, on several occasions.

After all, as an adolescent, both methods were incredibly simple to access, and very cheap and easy to buy.

We'd also now experienced the system of involuntary admission – and been traumatised ourselves when informed we couldn't take our daughter home instead, or even take her in our own car to a top cover private hospital for which we were self insured, or even drive her, ourselves, to the adult lock up ward of the nearby public hospital, which is where we were told she was to be sent.

Instead we'd had to wait for hours, so the police could arrive, and then watch helplessly as our 15 year old daughter pled with us for our help, whilst being restrained, sedated and placed in the back of the policy paddy wagon, as was required under the Mental Health Act at that time.

Then again, once we'd all arrived and felt the ambiance of the ward and its lock-up security provisions - as her parents we felt totally horrified, helpless and powerless, as our fifteen year old daughter again pleaded with us to take her home, and we found, legally, that we could do nothing.

This trauma was further compounded once we found out that despite being driven under police supervision to an adult lock up ward in a public hospital[41], once there she was locked in the ward, but within an unlocked room she had to share with others, where she was subsequently physically assaulted and sexually propositioned by adult in-patients.

Then, when she finally had the strength to tell us about her ordeal, her care-givers instead claimed it was more likely than not that she was lying.

So apparently this was all deemed psychiatrically necessary, so as to keep her safe from harming herself or from taking her own life.

Certainly what it did do was to traumatize her sufficiently that she would ensure, to the best of her ability, that she never again slept in a bedroom that she could not lock or control its light - for the next seven years!

So by now she'd been well and truly subsumed into the psychological model of transference, empowerment and confidentiality, which ensured she became well advised of all her legal rights and welfare entitlements, but made certain we lost most of our parental influence.

Unfortunately no one spoke to her at the same time about the obligations and responsibilities that should have gone with those rights and entitlements.

[41] As there were no private hospital beds available, nor any specialist adolescent wards built at the time

Another legacy was that she became a heavy user of tobacco and other drugs, including various benzoid based medications and anti-depressants, although she denied feeling depressed, and was subsequently found to become suicidal on her antidepressant medication.

However she often complained of chronic fatigue, or else of being unable to relax - staying in bed alone in her bedroom for most of the day.

So how she coped with these symptoms was to self medicate in a way that was socially acceptable to other teenagers – abusing alcohol and illicit drugs so as to sedate her level of arousal, numb her emotions, remove her social inhibition and enable her to escape realism into her preferred space of fantasy.

But by now she'd also attempted suicide almost half a dozen times so the family was steadily becoming more desensitized to the act and as such, more insensitive to and uncaring about her need for help.

My first "ah-ha"

So on that day in Fremantle CAMHS I was reading the story of Christopher Reeve's accident ("Superman") and its aftermath, written by his wife Dana.

In the story she written how she'd told him that she understood why he might choose to commit suicide given both the emotional and physical pain he was experiencing, but that he needed to understand that she would do everything in her power to prevent him doing so.

My mind raced and my heart stopped.

Despite all my life, always using lifelong learning as my primary emotional coping tool, so as to seek understanding and enable forgiveness.

Despite my being a Masters trained organisational behavioural and social scientist.

Never before had I been able to make that connection between suicide and euthanasia, nor had I realized that emotional pain might cause people as much suffering as physical pain.

I decided to tell my daughter the same thing that Dana Reeves had told her husband.

The reconnection with her was almost instantaneous – I was starting to understand her world and was no longer judging her behaviour based on the reality, consciousness, observations and experiences of my own.

My second "ah-ha"

About two years later I was staying in a hotel in central Sydney on business after flying in from Perth that same afternoon. It was very late but I was unable to sleep due to the time zone difference.

My mobile phone rang about 2am and my heart dropped like a stone.

What had happened to my elder daughter now?

However when I picked the phone up I heard the voice of my best friend, telling me that she could no longer live with the pain of living.

I couldn't believe what I was hearing.

After all, I had known her for over twenty years and she was a professional community development officer and a loving single mother, as well as a trained counselor and experienced welfare worker – highly competent, incredibly resilient (**stoic even**), very practical and an excellent communicator.

However she'd also lost her youngest daughter – one of four children, in exceptionally traumatic circumstances only two years prior. Her daughter had been gang raped by foreign sailors at only 17, whilst walking home from the bus-stop through their local park.

At 20 her daughter had unexpectedly died from a drug overdose.

It was only when her daughter died that she found herself unable to cope. These circumstances also imploded the remainder of her family (*her two sons and another daughter who were all raised in Australia*).

In contrast she'd been born and raised in Catholic Ireland, where the culture and its practices, especially as it relates to expressing grief and bereavement, were significantly different from those practiced in Australia.

So this became my second ah-ha moment.

Suddenly it made sense.

If there is extreme trauma, especially if close family members are involved; and their carer(s) remain(s) emotionally sensitized[42] rather than desensitized into insensitivity[43];

…then even the most resilient can become deeply depressed and suicidal over time

…not withstanding they might have been professionally trained to take care of their health and wellbeing.

I pondered my friend's situation further, and realized with some shock that perhaps my book worm poet of a daughter had not been **"putting it on"** with some of the things she'd told me after she'd first been traumatised.

She'd said it had become impossible to write poetry and very difficult to read.

She was no longer able to recognise or spell words I knew she'd previously had in her vocabulary, and she started to substitute words that had the same sound but different meanings *(such as using blew instead of blue).*

[42] connected
[43] disconnected

She constantly asked me to fill in her paperwork as she found it totally exhausting, claiming she couldn't concentrate long enough in order to complete it.

I thought my daughter had been putting it all on because she wanted to get out of going to school *(as the stigmatisation, bullying and social exclusion once she'd returned to school after her initial hospitalization were other parts of her trauma story).*

But now, here again, exactly the same thing was happening to my best friend - whom I'd known as a consummate wordsmith and avid bookworm for more than twenty years.

So perhaps this was a common reaction?

I pondered a range of possibilities.

Perhaps the effect of unexpected loss, emotional trauma and nervous shock is just like experiencing a lightening strike – except it is a strike of the brain rather than the body?

Perhaps instead of the body slowly melting-down from the inside out, as occurs after a lightening strike, it is instead a slow melt-down of the brain's ability to autonomously regulate and/or self regulate its central nervous system – perhaps as a result of electrical fusion of nerves within our communication systems?

Perhaps it was just like being a fridge with a blown regulator (so it is no longer able to self regulate its temperature)?

If so, than any person so affected, no longer able to self regulate their central nervous system, would have to try and manually control their capacity to emotionally focus (stress) in order to prevent distress, whilst still encouraging eurstress for performance[44] excellence.

As a consequence that person's physiological arousal might easily become hyper aroused or fatigued.

And such a person would appear to be highly energized or else flat.

In contrast if psychologically disturbed (threatened with a belief of not being able to cope), a person might feel manic, anxious, angry or depressed.

Such a person would appear to others to be tense, or alternatively, catatonic.

It was all definitely food for thought anyway – so right there and then I decided to make myself an expert in understanding their condition.

I scrawled though every piece of relevant public information that I could find, and returned to academia so as to access the latest medical, legal, allied health, behavioural and social science journals – anything that might help me progress my afterShock journey of exploration and discovery.

[44] behavioural

Together those first and second ah-ha moments had started me on a personal journey of exploration - to gain an expert interdisciplinary understanding about how the **normal** human body and brain (mind and emotions) responds to trauma (whether it's physical, cognitive and/or emotional) and stress.

I realised no matter the colour, creed, culture, social norms or personality of the human race – there is unity and a common human response that always goes with unexpected loss and trauma – and more especially so when it's unexpected loss, or even just a strong fear of unexpected loss, of someone loved.

The stress response might be physiological or psychological – or both. But it certainly wasn't limited to just being the grief cycle.

It was only then that I started to realise that normal human response to trauma, chronic stress, grief and bereavement might actually be the same for all of us – it is only in how it is expressed, both emotionally and/or biophysically[45], that we will differ.

The third "ah-ha"

My third "ah-ha" moment arrived almost six years later.

Diagnosed by doctors to now be suffering hypertension, diabetes type II and post traumatic stress and major depressive disorders (*after initially being diagnosed with a generalized anxiety disorder*), I was off work again, from a second relapse.

Although I'd never before got into daytime television, this time I had been warned to do absolutely nothing that was mentally strenuous, whilst I recovered.

As well, and for the very first time, I felt seriously down, and was suffering chronic fatigue from my total lack of energy.

The phone rarely rang anymore as people didn't seem to know how to treat me given I'd had such a public second meltdown.

In some ways this was good because socialization with other people didn't actually energise me – instead it would seriously drain me of what little energy I had left.

I was alone, but didn't feel lonely. My own family's past experiences meant they remained very supportive of me, although often they commented that they now felt like they were walking on eggshells around me.

But I was sad at the loss of some people I had thought of as friends, and I now seriously doubted that I would ever fully recover so as to be able to return to being the person I had been in the past.

I had always been an overly responsible over-achiever – someone who believed you could do anything if you just set your mind to it, and a person who viewed threats as opportunities and who would get excited, stimulated and aroused just at the thought of a challenge.

[45] Bio-medically

All my life I'd been told these were positive attributes – things I should aspire to – and they were core to my identity.

But now?

I was still a leader – but no longer a leader able to withstand the pressure that goes with leadership.

Feeling sick and tired of it all, I hated being reliant on the insurer's and doctors' assessments of my health and capacity to work; and the enforced limits my body and brain were now placing on my capacity to work, play, sleep and care, and on my enjoyment of change.

I was, however, sincerely appreciative of the financial independence I gained from having an Income Continuation Policy in place - grateful that I would never be forced to have to take any sort of work, no matter how meaningless, boring or menial it might be.

So on that day I was lying in bed, feeling helpless, hopeless and powerless and a burden on my family.

I plotted plans about how I might end it all, over and over in my head.

I kept trying to kick myself out of it – I was normally so positive by nature and had always believed you chart your own course in life.

I knew that my husband and kids were especially worried about me this time, and that made me feel both guilty and anxious.

Around 2.15pm I turned on the television to watch Oprah *(it was better than watching the old movies or daily soaps)*.

It was a "Dr Oz" community health and wellbeing segment, and a man I had never heard of before was speaking.

His name was Dr Randy Pausch, and he was talking with Dr Oz and Oprah about his "Last Lecture".

For years, schools such as Stanford and the University of Alabama have mounted "Last Lecture Series" in which top professors are asked to think deeply about what matters to them and to give hypothetical final talks.

For their audience the question to be mulled is this: **What wisdom would we impart to the world if we knew it was our last chance?**

However, for Carnegie Mellon professor Randy Pausch it wasn't a rhetorical question – he was dying of pancreatic cancer and had been given only weeks to live.

So in his *Last Lecture,* Pausch spoke on the importance of achieving childhood dreams, and of always having fun in life.

He explained to Oprah that he'd written that "Last Lecture" for his three young children as his legacy of wisdom. Still too young to understand him now, he knew in future they would be seeking guidance and want sage advice from both their parents.

Many pearls of wisdom were discussed on that day, but three stood out especially to me, and when combined together they gave me my third ah-ha moment.

The first related to the Guilt Question

"I think that we all stand on the dartboard of life. Roughly 30,000 people a year are going to catch a dart labeled pancreatic cancer, and that's unfortunate. It's not what I would have chosen. But in no way do I feel like I deserved it"

Randy Pausch

When my daughter first attempted to take her life most people wanted to know why.

But I just wanted to know what I could do to make her not want to.

Then after she was hospitalized a few times, including once as an involuntary patient in an adult lock up, one of her psychiatrists warned me that he thought I was in great danger.

Apparently she had stabbed a chair when asked about how she felt about me *(which I readily understood given that as her mother I felt very guilty about admitting her to a psychiatric ward in the first place, as well as guilty about not being able to protect her from all the subsequent harm that happened to her, following that event)*.

Part of me refused to believe it – the other part slept with a knife next to my bed for the next 12 months…

….and to this day almost all the psychologists and psychiatrists (*both hers and mine*) ask me **if I felt like I deserved it….**

Pausch's statement confirmed to me what I'd always known – life's a lottery and you can't always see that truck heading towards you from around the corner.

Oh, and also that bad things do happen to good people…

Our family was just one of the 40,000 people a year in Western Australia who catch the dart of suicidal ideation….

Finally, I also learnt that even though I was her mother, and it was my duty to protect my child, I couldn't make her not want to take her life – only she could do that.

My lesson in life was to show her the reason her life was worth living, and to learn to let her go – to be there to help if needed, but to take my hand off the control and have the faith to just leave it to her and the universe.

That was a really tough lesson, but it was also the only way she could eventually recover, and that I could get over the panic attacks…..

The second related to recognition of just how dysfunctional western attitudes to death and informed choice have become – especially if you're unable to control your own circumstances

"…He shed a light for me on a part of my existence that, like many Americans, I shy away from thinking about…those deep corners of your existence.

Places where you don't go naturally. That's often where the greatest beauty lies….. Randy Pausch taught me to do that in the most trying of times."

Dr Oz – Randy Pausch Memorium

In that first interview with Oprah and Dr Oz, whilst he was still alive, Dr Pausch commented that he couldn't change the cards he's been dealt, but that he ***could*** control how he plays them.

> *"If you are hopeful, if you are optimistic, other people want to help you.*
>
> *And if you are down in the dumps, other people may still help you, but I've noticed that they're walking, not running, over to you.*
>
> *In the lecture, I talk about how you've got to decide pretty early in life whether you're going to be a Tigger or an Eeyore.*
>
> *What I found is if you're an upbeat person, people will flock to help you, and suddenly everything gets easier."*

It was only then that I realised that there is no health without mental health – every natural person that experiences lack of informed consent, or perceives they have no freedom of choice, or finds themselves deprived of personal liberty is likely to find their mental health will go into decline.

Pausch also described how he saw life as being 10 percent white, 10 percent black and 80 percent gray.

> *"You can go through life and say, 'Gee, that 80 percent gray part, that's black, and life is a bad thing.*
>
> *Or you can say that 80 percent gray part's part of the white and it's the goodness and the light. I want to view life that way. It becomes a self-fulfilling prophesy. That 80 percent in the middle really can go either way, and if you decide you want to make it go good, not bad, you have a lot more power to make that happen than you might think."*

Because of my interdisciplinary education, I considered myself one of the "grayest" people I knew - so this really spoke to me and made sense.

As a contrast to this viewpoint, whilst obviously wanting to heal their patients, said Dr. Oz, in many cases, the physician's role is simply to help bring a sense of calm to the family.

> *"We do not do death well in America. Americans like to win and we see death as losing. Death is an integral part of this amazing life that we have the ability to live.*

> *"The fascinating thing about the medical profession is the ancient healing rite was not to save lives. We couldn't do that that well until this century. It wasn't about doing a lot more than just bringing order to the situation.*
>
> *I unfortunately deal with this a fair amount as a heart surgeon. A lot of times, you're just making it calm for everybody to break that chaos apart."*
>
> *Dr Oz*

Finally, the third pearl revealed to me related to a new definition for Hope

Dr Oz had commented in that first Oprah interview that he'd always thought hope was making sure things would turn out right – that is holding a belief that one will eventually fully recover.

However Pausch commented that **"in my family, hope is just making sense of things."**

I realised that this was just what I had done all my life – and that as the primary carer for my family, I was also the person "making it calm for everybody to break that chaos apart" and the information provider for my own family helping them :"to make sense of things".

If I remained hopeful then so would they.

Alternatively, if I lost it, then so would they….

I realised that day that maintaining hope for myself didn't necessarily relate to having the possibility of a positive outcome – that is being able to return to my "normal" self – how I had always self identified myself.

Sometimes it was just going to be about me being able to make personal sense of the circumstance….

I finally realised that even if I had known all the health and wellbeing consequences, I still would have chosen the path in life that I actually chose.

I was just like the champion sportsman who suffers breakages and fractures throughout his career and then pays for it later with joint pain, bursitis or rheumatoid arthritis – it's just in my case the stress fractures were primarily of my brain, not my bones.

Others Lessons Learnt

Statistics suggest that of those forty other children in that first psychiatric ward with my daughter, thirty two will now be dead – most probably before their 21st birthday.

Statistics also show that of the eight still remaining alive, it is only one (my daughter) who will still be connected into her immediate family and only one (my family) that remains maritally intact.

From the implementation of its Community Health and Wellbeing program, working with BeyondBlue to carry its messages about depression into the community, Rotarians learnt that the only way to engage the wider community into active self management is to personalize and normalize depression.

So too must it be for Western Australia and its Suicide Prevention Strategy, given active self-management and ongoing community involvement are both desired outcomes.

Healthy human development is prefaced on human beings having access to informed and conscious choices, and control over their own circumstance.

It requires they understand their own emotional and social development cycles and needs, and be skilled in applying that knowledge throughout their life.

Suicidal ideation is a normal human response to abnormal events, chronic stressors and the suffering of pain (*whether emotional or physical*).

That person holds the belief that such pain can't be alleviated; will only grow worse in the future; and will make them a burden, too heavy to support, on their loved ones or on society in general.

It is not an abnormal mental response to normal events and stressors.

To stress is a normal human response – absolutely vital if we want to arouse ourselves physiologically from slumber, and emotionally focus ourselves (motivate) for performance.

The stress hormones that are activated interact with other hormones in our body and brain – coordinated in orchestral melody by our central nervous system.

It is eurstress (in the longer term) and distress (in the shorter term) that will create problems, if the stress itself is not managed in an informed way.

Medical research clearly identifies that hyperactive stress hormones circulating in the body for too long eventually lead a person into somatic illness (hypertension, obesity, metabolic disorders such as diabetes and stress disorders of the central nervous system).

This is more especially the case when the person is physiologically stressed but not psychologically stressed – that is, easily aroused and excited by challenges rather than fearful of a change, generally because of their own self efficacy (*which includes them holding a strong self belief that they can cope with such a circumstance)*.

However, when these circulating hyperactive stress hormones get combined with chronic feelings of bereavement *(actual grief and unexpected loss or else grief related to loss of an expectation, plus great fear of an actual loss in the future)…*

Especially if unexpressed within your extended family or else expressed in ways not acceptable to family, friends, your own community and/or the wider community…

Then inevitably it will progress that person towards a suffering related to the psychological stress – and possibly towards feeling socially isolated as well.

The person's trust in themselves, or of others; the strength of their internal locus of control; the positivism and goal setting of their outlook – these are all negatively effected in such a circumstance.

Experiencing such a constant barrage on the walls of their castle of resilience, their immunity, coping adaptability and resistance to ill-health just has to break down.

In the longer term, if still left unmanaged, inevitably the person is likely to suffer a major depressive disorder that may lead them to committing suicide, even though they might know, and others certainly will know, that their pain is not terminal and is something that could be alleviated over time, if managed and/or treated.

However experiences of affective suffering often differ depending on one's culture or social group, even from individual personality traits - sometimes greatly so.

For example, in most of the non-Western world, people with depression complain principally of physical ailments, such as lack of energy, poor sleep, loss of appetite, and various kinds of physical pain. Indeed, even in Australia these complaints are commonplace.

But in Australia and other Western societies, depressed people and the mental health professionals who treat them tend to emphasize only the psychological problems, such as feelings of sadness, worthlessness, and despair.

They rarely focus on the biomedical aspects.

A brain without serotonin has been shown to have the tendency to act violently.

However the opposite can also be true.

The brain without serotonin can also be sad, or chronically fatigued.

Remember too, that a brain without dopamine is a brain in pain – and a brain with too much adrenaline is a brain on speed.

So please - be patient with those suffering from grief, anxiety, depression, suicidal ideation and bereavement – and just keep giving them hope, faith and a hand up.

Wait long enough, and such people will surprise and impress you.

Glenda Bye
Trauma and Suicide Survivor
Mental Health Carer and Consumer
Parental Primary Carer (Mother)

SYDNEY MORNING HERALD

Revealed: Australia's suicide epidemic

RUTH POLLARD INVESTIGATIONS EDITOR

August 21, 2009

AUSTRALIA has dangerously miscalculated its suicide statistics - by as much as 30 per cent in NSW and Queensland - leaving a silent and growing epidemic of mounting deaths.

The figures are in stark contrast to years of backslapping by state and federal governments, congratulating themselves for reducing suicide rates from a peak of 2700 in 1997.

The *Herald* can reveal the suicide toll is as high now as it was in the 1990s - if not higher - with experts predicting a further rise as the impact of rising unemployment and other economic factors bite.

Ten people each month take their lives either inside a state health facility or within a week of having contact with one.

Discharged too soon from emergency departments, left unobserved in psychiatric wards or denied admission to overcrowded inpatient facilities, their deaths reveal a pattern of repeated systemic failures that demands urgent reform.

The dangerous combination of government under-investment, shutting families out of hospital and police processes, a lack of training and a general community malaise about how to prevent suicide means so many are falling through the cracks.

In the 18 months to June 2008, at least 175 people died from suicide within seven days of contact with the health system, figures from the NSW Clinical Excellence Commission show.

A coroner's inquest into a man who shot himself within hours of being discharged from hospital concluded last week, with police and health departments questioned over their protocols for dealing with people at risk.

In another death, in which a woman set fire to herself after being denied help by a public hospital, the coroner noted: ''This death was preventable and is probably the most tragic example of NSW Health's inability and/or failure to deal with individual cases in an appropriate manner.''

John Mendoza, an adjunct associate professor at the University of Sydney faculty of medicine, said the real rate of suicide was about 2500-2700. ''With this economic downturn we can expect that to increase by around 10 per cent, so we are looking at approximately 3000 people each year,'' he said. ''None of this takes into account suicides by way of single vehicle accidents - these are the only aspect of road accident deaths rising as a percentage of total deaths.''

These figures indicate a major health problem and are much higher than the Bureau of Statistics count of 1800 suicide deaths a year, said Professor Mendoza, who is chairman of the Federal Government's National Advisory Council on Mental Health.

''It is a hidden epidemic and yet the Federal Government only invests $1 per person per year on suicide prevention.''

The director of health and vital statistics at the Australian Bureau of Statistics, Tara Pritchard, confirmed the bureau would release updated figures in March to correct the undercounting.

''What that revision of ABS data will show us is that really we have gone nowhere in terms of overall reductions from the peaks in suicide rates in the early 1990s, and we have certainly gone nowhere among reducing suicide in indigenous populations. They remain four times higher overall,'' Professor Mendoza said.

Governments had done little more than the bare minimum to prevent deaths, said Dawn O'Neil, chief executive officer of Lifeline.

''Once we got confirmation the rates were not coming down … the Government didn't want to know, politically they wanted to believe that the suicide rates were falling.''

Lifeline: 131 114

Beyondblue: 1300 224 636