Wesley LifeForce

Wesley Mission Feedback To the "Mental Health: Productivity Commission Draft Report Overview And Recommendations"

January 2020

Wesley Mission Feedback
for the
"*Mental Health: Productivity Commission Draft Report Overview and Recommendations*" Draft

A. Introduction

Wesley LifeForce is the suicide prevention arm of Wesley Mission. This submission is in addition to Wesley Mission's original submission and is written in response to the Mental Health: Productivity Commission Draft Report Overview and Recommendations released October 2019 (referred to hereinafter as the 'Draft Report').

Wesley LifeForce has a national coverage and is active in four suicide prevention areas. These national suicide prevention areas which come under the "Wesley LifeForce" banner include:

- Training: Provision of industry standard suicide prevention training workshops for the community and other individuals and service providers in the community
- Networks: Supporting the development of community-based suicide prevention networks and responses to the threat of suicide at the local level
- Memorials: Holding memorial services which also supports the grieving of a key high-risk group – people who have lost someone close to suicide
- Research: Employed to support and validate policy and funding submissions and to support evaluation of services and programs to review and improve our suicide prevention practice.

Lifeline was started by Wesley Mission in 1963. Wesley LifeForce takes a comprehensive approach to preventing suicide and enhancing community wellbeing and empowerment through work across the areas of prevention, intervention, postvention in additional to project and events. The program was established in 1995 as a direct response to the growing number of suicides in Australia.

Wesley LifeForce delivers the following programs and initiatives within the community:

Prevention	Intervention	Postvention	Projects
• Wesley Lifeforce Networks • Wesley LifeForce Training	• Lifeline Sydney & Sutherland • Counselling support to Older Australians	• Suicide Memorial Services • Grief and Loss support programs	• Research Initiatives • Conferences & Forums

Wesley LifeForce Training and Networks are funded through the Australian Department of Health and through a number of Primary Health Networks throughout Australia.

B. Overview

Please find following Wesley LifeForce responses

- The Key Themes of Our Response to The Productivity Commission Draft Report
- The Responses to Key Reforms and Recommendations Covering
    - In Reform Area 1: Suicide Prevention and Engagement with Schools and, Existing Challenges with Primary Health Networks

  - In Reform Area 2: Evaluation of General Practitioner Training, Low Intensity Mental Health Care and Suicide Prevention in Rural, Regional and Remote Australia, Quality and Evaluation, Data Development, Network and Training Evaluation Outcomes and the Suicide Prevention Trial
  - Reform Area 3
  - Reform Area 4
  - In Reform Area 5: Governance Reform and Implications and Issues with Implementing Regional Commissioning Authorities
- The Conclusions summarise Wesley LifeForce views based upon our experience and research information about:
  - Prosocial focus and a cultural shift
  - Prevention and higher level care
  - Social and environmental factors
  - The funding vehicle
  - The nature of community service provision.

Throughout our feedback we have sought to provide evidence of our position based upon evidence drawn from past and current experiences and from recent or current research.

Wesley Mission is putting forward these responses to "do all the good we can, by all the means we can, in all the ways we can, in all the places we can, at all the times we can, to all the people we can as long as ever we can" in accordance with our mission statement.

C. Key Themes in the Wesley LifeForce Response to the Draft Report

Through its suicide prevention arm Wesley LifeForce, Wesley Mission, conducts pro-active social and educational strategies within geographic communities across Australia, that seek to prevent suicide by influencing people in person and in communities at the local level.

Prevention and Higher-level Clinical Care

As Wesley Mission directly supports local suicide prevention, the concern is that the Draft Report appears (with some exceptions) to be less about prevention and alignment with a "Stepped Care Approach" and more about post-hoc higher-level clinical interventions higher up the Steps of the ladder of care.

Wesley LifeForce directly emphasises the importance of prevention, seeking to be proactive and community focused rather than reactive. This is congruent with the purpose of the inquiry "to enhance the well-being of individuals family and community and for the participation and contribution of people affected by mental health to the workforce, their community and for an effective social life" (Page 4, Draft Report).

With Wesley Mission's demonstrated commitment to government policy that recognises "the need for suicide prevention to be every Australian's business", individuals in the community are now playing a key role in both raising awareness of suicide and doing what they can in the community to help prevent suicide. By undertaking our Wesley LifeForce suicide prevention training, community members are in a better position to help a person considering suicide, by recognising the signs and using the skills learnt to effect a referral to appropriate help.

This could be described as helping people onto the first rungs of the mental health "Stepped Care Approach" process, enabling the prevention of suicide by supporting people to engage with the appropriate level of care.

Key Psychosocial Factors

The Draft Report also omits reference to the key psychosocial progenitors of mental illness and suicide in our society and in the community. As such, it does not take sufficient account of the impact of social structural issues which could underpin, guide and provide the where-with-all to enable the development of strategies to improve mental health and reduce suicidality in our communities. The psychosocial contexts and social progenitors of mental ill health and suicide need to be more prominent. These issues can include access to services and isolation

in rural and remote communities, discrimination, lack of social cohesion, economic circumstances, workplace issues, cultural factors and, for instance can include the existence of suicide in communities.

Given the pro-social focus of our services, with the recognition that "implementing person-centred care consistently across the mental health system will be a significant cultural shift," it is not clear how that this cultural shift will be facilitated by some of the key recommendations (Page 23, Draft Report). Rather, the Draft Report appears to emphasise overcoming clinical deficits by redistributing resources through Regional Commissioning Authorities (RCAs) towards higher levels of clinical care rather than prevention. The creation of RCAs appears to seek to impose efficiencies at the regional level with the singular purpose of saving the health care dollar. As such Wesley LifeForce is concerned that such a strategy will weaken both State, Federal and local Government capacities and also weaken the capacities of the third sector, to improve the lot of people with mental illness and to prevent suicide.

As the result of the Wesley Mission's policy commitment to person-centred care, we believe the community is entitled to expect the Productivity Commission to seek to understand and employ prosocial factors to support the recovery, participation and contribution of people with mental illness and that support people experiencing suicidal ideation to help prevent suicide.

Some of the key reform elements of the Draft Report, focus more upon reactive and clinical responses to mental health issues in our community, rather than looking to examine how to address the origins of mental ill health and suicide in our society and its economic and workplace implications.

D. Responses to Key Reforms and Recommendations

Reform Area 1: Prevention and Early Intervention for Mental Illness and Suicide Attempts

Gaining access to schools to support suicide prevention can be difficult due to the existing risk-averse culture with community suicide prevention networks experiencing difficulties building partnerships, a barrier to collaborative initiatives for young people in suicide prevention.

Implementing systematic approaches to suicide prevention can be problematic, such as. For example, implementation of the 'LifeSpan Model' through Primary Health Networks, community networks have experienced difficulties in engaging in decision making and planning processes for regional suicide prevention plans, especially, as it depends on community engagement and facilitation expertise of PHNs. Barriers include PHN staff:

- not using inclusive language to discuss suicide prevention issues,
- using sector specific jargon (i.e. such as Gatekeeper) having high turnover affecting relationships with the community

General practitioners can also be unaware that PHN suicide prevention training trials exist and do not know who they are.

Highlighted below are existing challenges that the suicide prevention network members have faced when engaging with schools, as well as the experience that members have had with the PHN representation in their communities.

- ***Suicide Prevention and Engagement with Schools***

Wesley Lifeforce has developed ways to engage students by promoting a youth-focused approach in its community suicide prevention networks and in doing so, has supported communities to organize events to build resilience and leadership skills in young people. Some Wesley Lifeforce suicide prevention networks have engaged with schools by inviting motivational speakers to share their lived experiences with students and have been successful in funding school-appropriate mental health workshops. Networks have also received funding to deliver 'Safe Talks', a strategic and structured plan of intervention that allows schools to better embrace the

idea of suicides awareness and prevention. Schools have historically been guarded over the terminology and potential triggers associated with suicide prevention training. Keeping this in mind, networks have entered the school realm by prioritizing building trust in order for the school, teachers, parents and students to fully embrace and become involved in the training.

Suicide prevention networks have also offered bi-monthly subsidized courses in Youth Mental health and First Aid Training for teachers interested in attending. Teachers who are also members of a network, have received suicide prevention training and are more likely to advocate for training internally within schools.

Furthermore, some networks have approached apprenticeship, trainee and trade schools with the recommendation to include suicide prevention training as a module alongside existing occupational health and safety modules. This will help form an army of skilled and informed individuals before they enter the workforce.

According to a suicide prevention network member of a remote, Aboriginal network in the Northern Territory, in a small community with only one local council, one health centre and one school, the school is heavily involved in suicide prevention programs for teachers and students. Given that the community is confronted with risk-factors such as cultural stigmatization, domestic violence, and drug and alcohol abuse, the school leads the way in implementing the programs and activities to empower the young people.

Wesley LifeForce is indirectly engaged with schools through its networks program. The following issues arose from the research conducted for this submission, through phone and in-person interviews with Wesley LifeForce staff and members[1]:

- Some schools were keen to include teacher training but are under resourced: they do not have the financial capability to replace teachers if teachers are sent for suicide prevention and mental health training. Also, some schools would rather spend their resources internally than on training

  This is especially an issue for schools in small towns in rural, regional and remote areas compared with metropolitan areas

- Headspace is a leader in building awareness in mental health and has collaborated with young people and Wesley LifeForce networks in implementing mental health initiatives

  As an example, Headspace operates in schools in Katherine for school-based training which allows training for teachers and principals that are located within the networks. Yet, there is a dearth of available funding and resources for teachers to attend training

- Access into schools can be complicated and complex. While some schools are open to training, others are not, due to their risk-adverse nature. Community suicide prevention networks have had difficulties building partnerships with schools because of this culture, creating a barrier to collaborative initiatives for young people in suicide prevention

- There is a growing need for youth-focused support and resources in suicide prevention.

While progress is being made, it is still challenging to get access into schools. A reactive more than a proactive approach is taken regarding mental health and wellbeing within schools. There have been new government-mandated educational programs to support topics on sexuality, gender differences, and encouraging respectful relationships, with a limited number of training workshops on building resilience workshops and suicide prevention training. Such programs are imperative to educating and empowering individuals with the capacity to face challenges and support those most at risk of taking their own life.

[1] Wesley Lifeforce conducted phone and in person interviews with four community development coordinators, one senior community development coordinator and four active members of the suicide prevention network regarding their perspective on engagement with schools for suicide prevention

Furthermore, there are many individuals playing a key role in the arena of implementing suicide prevention training and launching networks in schools. Establishing a crucial link between parents and community programs ensures that parents are well-informed and approve of this process. Similarly, close liaison with school principals is necessary to determine if the resourcing for teacher and student networks and training is within their capacity. Doing so can uncover funding gaps that need to be addressed in order to promote suicide prevention in schools.

- ***Working within Schools***

There is a need to develop a specific training package to upskilling teachers and educational staff in mental health, as well as improving the knowledge of support services.

Wesley LifeForce recommends implementing suicide prevention training through a joint program approach that involves collaborating with directors of education, parents, principals, teachers, other school staff and suicide prevention trainers in schools.[2]

- An age-appropriate, school-based program led by an experienced and qualified trainer or full-time senior teacher would include suicide prevention training in a program that builds resilience and promotes mental health and wellbeing
- In addition to conducting training for students, teachers should attend training workshops at school on pupil-free professional development days to reduce their resource implications for schools. Doing so will enable teachers to identify and respond to suicide-related risk factors and offer practical tools to support students and staff
- It would be most beneficial to implement the program in the early years of primary school learning, to equip students with the capacity to confront obstacles related to bullying and peer pressure that may arise in secondary school. This supports the finding in the Draft Report that "early identification of risks in children offers the greatest potential for improving health, social and economic outcomes" (Page 11, Draft Report).

Wesley LifeForce may be able to assist in preparing schools to become useful gateways for students to access help, as suggested in the Draft Report (Page 18). For instance, in areas where there are operating networks, Wesley LifeForce could assist Beyond Blue in working with schools.

- ***Existing Challenges with Primary Health Networks***

Wesley Lifeforce works closely with the Primary Health Networks (PHNs) assisting them to deliver our suicide prevention programs. The following issues with PHNs and primary care provision were evident from recent research conducted by Wesley LifeForce for our response to the Draft Report, through phone and in-person interviews with Wesley LifeForce staff and network members[3]:

- It is difficult to communicate with the medical general practitioners (GPs). Some GPs do not have time to go to training and would prefer to earn their Continuing Professional Development points in another field. This is despite the fact that general practitioners are responsible for between 65-70% of prescriptions for mental health related medications

[2] Anecdotes from discussion with a school principal

[3] Wesley Lifeforce conducted phone and in person interviews with four community development coordinators, one senior community development coordinator and four active members of the suicide prevention network regarding their perspective and experience with the PHNs for suicide prevention training

- GPs are often unaware that PHN suicide prevention training trials exist and about the research that they are conducting[4]
- Remote and rural communities are difficult to access. Some doctors are only on site for two days a week. At times mental health workers must be flown in from metropolitan areas
- There have been many instances of suicide prevention networks that have had trouble engaging with PHNs after attempts to reach out to them
- At times there are little to no services and collaboration provided by the PHN in some communities. This may be due to a lack of interest, time-constraints, limited staffing, funding problems and geographic location exposing a need for improved lines of communication. For example, according to the Wesley LifeForce Drought Affected Communities Report, while 47% of respondents were aware of the role of their Primary Health Network, 50% of respondents were either unsure or unaware. This reflects a significant gap in community awareness of the PHNs[i5].
- Working groups have been established in some networks based on consultation projects as per the suggestion of some PHNs. However, network members have complained that in addition to PHN representatives not being present at meetings throughout the year, huge gaps still exist in providing referrals in mental and suicide prevention services, and concrete results are not being seen.

  In those communities, suicide is frequent and there is a lack of significant change or facilitated support to immediately help individuals and their families in crisis.

Implementing systematic approaches to suicide prevention can be problematic. For example, through PHN's implementation of the 'LifeSpan Model', networks have experienced difficulties in engaging in decision making and planning processes for regional suicide prevention plans. This is dependent on community engagement and, facilitation expertise of suicide prevention staff from the Primary Health Network. The use of inclusive language can be lacking in discussing suicide prevention issues. Sector specific jargon be used, such as 'gatekeeper', creating a barrier to stakeholders' participation in dialogue and to their understanding of key decisions being made about suicide prevention. Communities' engagement in systematic suicide prevention planning has been further complicated as a result of the high turnover in some PHNs, who have difficulties retaining staff. This can impact both the trust and relationships between the PHN and the community[6].

PHNs vary in their approach, delivery and interaction with the suicide prevention networks. Often this depends on whether being community based is a priority for the PHN. While some PHNs are supportive and proactive with the networks, and do attend network meetings, Wesley Lifeforce has been integral to connecting and forming linkages between the PHN and networks, through their community development coordinators. This is demonstrated by Wesley Lifeforce helping facilitate key stakeholder meetings and assisting in strengthening the relationship between service providers and PHN representatives.

Having a member of a network who is a member of the PHN has shown positive outcomes. Members will work actively to plan workshops and meetings, develop leadership groups and inform members about new changes and developments. This has led to some suicide prevention networks being more informed and engaged.

Reform Area 2: Close Critical gaps in Healthcare Services

[4] Wesley Lifeforce is involved in innovative suicide prevention trials that employ a systems-based approach in established networks as well as in new networks being developed. Trials have rendered successful suicide collaboratives and vary in their delivery with some trials being more service and clinical oriented and others that are purely community-led

[5] Particularly as they relate to drought relief (Wesley LifeForce Drought Affected Communities Report, 2019)

[6] Anecdotal Evidence from Community Development Coordinators and Networks

Wesley Lifeforce Training has a significant role in raising awareness and helping educate community members and medical practitioners with similar positive outcomes[7].

- ***Evaluation of Wesley LifeForce General Practitioner Training***[ii]

Wesley Lifeforce has initiated workplace suicide prevention training programs for healthcare workers who may be the first point of contact for those at risk of suicide. Healthcare professionals such as general practitioners, nurses, general proactive office staff, relationship counsellors, aged care nurses and aged care workers are equipped with the knowledge to engage with and apply intervention strategies with suicidal patients.

Wesley Lifeforce engaged with the University of Sydney to perform an external evaluation of the Wesley LifeForce Suicide Prevention Training Program for (General Practitioners and Practice Nurses). The principle investigator conducted research with GP and Practice Nurse respondents from 2017 and 2018 through an initial questionnaire, a phone call and subsequent in-person interview. A qualitative and quantitative analysis was then performed on the results. The final response sample size was comprised of 35 possible respondents.

The evaluation for the effectiveness of the Wesley LifeForce Suicide Prevention Training demonstrates that on virtually all measures, 85-90% of the participants over a 2-year period benefitted from the training, given that they were able to deliver, and confidently, use the good skills learned.

In terms of logic and content, the SALT principle- a framework that allows the clinicians and allied health team to support a person with suicidal ideation- was well received as majority of the respondents believed it to be an easy and appropriate tool to apply to their existing clinical knowledge. In addition, 77% percent of the respondents stated that they have used the acquired techniques they learned in the last 3 months.

From the perspective of the patients, clinicians felt that the skills gained assisted with their consultations with the patients and helped determine patient planning and overall outcomes. This is significant in that there is a potential for a greater number of patients benefitting from the outcomes of the Suicide Prevention Training program.

Given that the survey group contained respondents and clinicians that had been in practice for various lengths of time, the findings suggests the versatility and value of the program to clinicians in different phases of their occupational journey. What is particularly useful from the findings is its applicability to be offered to all general practitioners at all levels including general practice registrars.

The findings state that with slight variations, this training may be expanded to the training needs of peer workers and workers within the 'Stepped Care Model' with the Primary Health Network mental health programs nationally. Other recommendations include the possibility of actively promoting the program to GP training organizations around Australia to be included in training syllabuses of GP registrars.

- ***Low Intensive Mental Health Care and Suicide Prevention in Rural, Regional and Remote Australia***

The Draft Report refers to the 'difficulties in finding and accessing suitable support, sometimes because the relevant services do not exist in the regions when the people who need them live' (Page 6, Draft Report).

Wesley Mission provided a submission to Australian Senate Community Affairs References Commission for Inquiry and Report upon the accessibility and quality of mental health services in rural and remote Australia in 2018, for which we conducted research in the sector. Elements of both the Wesley Mission Senate Submission and the research conducted for are relevant to the current Productivity Commission Inquiry and are discussed briefly.

[7] Wesley Life Force April 2019, inquiry into the economic impacts of Mental ill-health: The Social and Economic Benefits of Improving Mental Health, Wesley Mission Submission to the Productivity Commission, page 5.

The research concluded 76% of respondents agreed "*a lack of access to mental health services impacts upon local people at risk of suicide"*. Other quantitative research supports the proposition that rural and remote areas have higher suicide rates than urban areas. The gap in suicide rates is widest between metropolitan and remote areas, with rates highest among rural males.[iii]

Poor support services and stigma are cited as key factors driving poor outcomes in the Australian mental health system.

The underlying causes of limited accessibility and quality of mental health services in rural and remote Australia were identified in the research as a lack of services generally, and where a service does exist, inconsistent mental health service provision, in which a key factor is the part-time, unreliable and relatively under-skilled nature of the mental health workforce.

Research with rural and remote suicide prevention networks identified *"...It is about empowering all the community groups, with the understanding that they provide social connectivity to people where people can actually talk with each other."*

The lack of capacity to access mental health services also provides a clear barrier to an individual in contemplation accessing help to avert suicide[8].

Key underlying causes of in these mental health service inadequacies[9] are:

- the nature of the mental health workforce including staffing issues with the workforce part-time, inconsistently available, unreliable and not often locally based
- funding including brief funding cycles for mental health roles and services

More local mental health workers, put succinctly, would *"Give us more people on the ground instead of in Hospitals".* More support staff in the community would free up the limited time of mental health workers. It would enable better connections for local mental health workers with their clinical supports and with other workers and community members in the local community.

From the Senate Inquiry Submission, Wesley Mission supports:

- better linking of rural and remote mental health workers to clinical leaders
- more collaboration with other local connections
- mental health workers more adequately to do enable them to do their jobs with distance and onsite education, with support workers to enable staff to survive working as a sole worker and with clinical guidance remotely using video technology.

Wesley Mission also supports affording and enabling increased use of information and communication technology which also involves being an active part of local communities. Each rural and remote area will require a technology solution on a case by case basis.

Wesley Mission supports Draft Recommendations 5.7 and 7.1 which provide for psychiatric consultations by video conference and 11.7 which supports "greater use of videoconferencing, subject to the availability of communications infrastructure, for health workers to remotely participate in professional development activities and meetings and conferences with peers" (Page 65, Draft Report).

[8] Since "referral to professional help" is the last stage in the SALT intervention strategy to avert suicide taught by Wesley LifeForce Trainers, not being able to access the professional help required could mean nowhere to go for the person at risk. In this context specific and more specialised training in suicide prevention for local mental health workers and with local community members or workers in other services could provide one solution.

[9] Referent to the Productivity Commission Inquiry

It is important to have a diagnosis and/or individual mental health plans in place, so local mental health personnel and families are in the "loop" and are informed about how to support the person with lived experience.

Wesley Mission emphasises and amplifies the role of Suicide Prevention Networks as a community-based response to local suicide events which provide support, awareness raising and supports community education for local people.

Networks in rural and remote Australia need additional staff resources to do be able to expand their effective engagement and collaboration with the community and local services.

The lack of consistent and regular accessibility and quality of mental health services impacted upon people's awareness of mental health issues in the community and upon their potential for help seeking behaviour. In rural and remote areas, a greater concern is the barrier it creates to individuals accessing local mental health services at all.

Although the recommendations in Wesley Mission Submission to the Senate Inquiry and the discussion above are broadly in line with those in the Draft Report [iv], some are additional to those to be found in the Draft Report.

Some key recommendations from the Wesley Submission to the Senate inquiry include:

A) For additional resources to support the employment of staff and community engagement in Suicide Prevention Networks in rural and remote areas.
B) Funding for mental health services in rural and remote Australia be moved to five-year funding cycles
C) A collaborative approach to increase local suicide prevention training based on including participation from local clinicians and service staff, community members and people with lived experience.

- **Quality and Evaluation**

As a matter of practicality, Wesley Lifeforce recognises the need to improve the service quality and effectiveness by developing information and information resources to achieve improvements in the sufficiency, relevance and quality of quantitative information available and to support the improvement of data.

The improvement of the quality and quantity of information collection along with evaluation practice forms part of a virtuous circle that enable the joint development of best practice in the evaluation of services and practices and best information for use to improve services.

Wesley LifeForce are achieving this both through the employment of an onsite Researcher and through the employment of independent evaluators. We are eliciting information to evaluate, assess and improve performances and to contribute substantively from our practice to inform and support feedback from our activities into government and government policy, such as through this submission.

Independent evaluations, include:

- Evaluation of Wesley Life Force Suicide Prevention Training (Community) from 2016 to 2018 by the Australian Institute of Suicide Research, Lead researcher Jacinta Hawgood, Griffith University
- Wesley Life Force Suicide Prevention Training Evaluation (General Practitioners and Practice Nurses) 2019 by Professor Morton Rawlin, University of Sydney.
- Evaluation of the Wesley LifeForce Suicide Prevention Networks currently being conducted by The Centre for Mental Health at the University of Melbourne
- Evaluation of the Wesley Mission Memorial Services Program, to be conducted with Western Sydney University in 2020.

- ***Data Development***

While Wesley Lifeforce is doing its best to improve program and practice data and performances in suicide prevention, as per above, there is a dearth of suicide data. As a result of this dearth and gaps in the research, with our original submission[v] recommending:

5. The development and access to real time suicide data
6. "Need for resources to develop and support effective cross-sectoral, multidisciplinary and whole of sector suicide prevention benchmarking to inform and develop practice and improve performances in the suicide prevention across Australia"

The availability of real time and consistent suicide data across Australian would enable the development of a more contemporaneous and as a result a swifter and more effective response to prevention and the avoidance of contagion. It would also enable a better understanding of the circumstances for local prevention and individual support strategies.

Additional resources are required to push suicide prevention practice in the community to a new level. An effective benchmarking program or process would enable the develop of ever more practical and demonstrable ways to increase preventative outcomes and to develop and link with improved information with which to measure and evaluate performances.[10]

Given the current cost of mental ill-health and suicide to the Australian economy, we need to consider what the economic and environmental benchmarks are/should be? Simply continuing to pour in funds to tackle increasing needs is not a long-term solution to the problem. With good information, if we set benchmarks/targets, we can evaluate impacts and outcomes, helping to realize whether we have achieved success after program implementation. We need to develop national and program level benchmarks to monitor and evaluate on-going programs and to assess impacts.

- ***Network Evaluation Outcomes***

The Draft Report states the need for reforms that can be implemented quickly, especially by tapping into existing resources and evidence-based interventions that can deliver services to a small group in the population or community-wide, in a cost-effective manner. Additionally, the Draft Report prioritises the need for reforms to be supported by further evidence and evaluation, stating that evaluations of programs need to be rooted into the program design, 'not only to ensure that public funds are spent efficiently but also that programs achieve their intended goals, and contribute positively to mental health and wellbeing' (page 7&48, Draft Report). In order to measure the impact and progress that Wesley Lifeforce has had on community members, it is part of the objective to conduct evaluations to monitor the efficiency and success of our programs.

The services provided by a Wesley LifeForce Suicide Prevention Network may include community consciousness raising, development and advocacy of strategies to reduce suicide and provision of information about services available. The practical strategies employed by Networks can range from patrolling the community to identify suicide risk, to providing information to link people at risk with services, to designing out or building out physical suicide risks, to eliciting and supporting suicide prevention training locally, the support of people bereaved by suicide, to advocacy on suicide related issues, such as, for better mental health services. The Wesley Lifeforce Suicide Prevention Networks are designed to bring together people and organizations to promote locally driven suicide prevention strategies.

Community Suicide Prevention Network Evidence:

In 2019, with Melbourne University, Wesley Lifeforce initiated a study to explore the effectiveness of the suicide prevention networks, including a total of 41 networks in the analysis. Close to one-third of these networks were based in New South Wales (29%), 22% in Victoria, 22% in Queensland, and the remainder in Western Australia

[10] Such benchmarking social processes have been well documented in Mental Health Benchmarking, for instance in NSW Specialist Mental Health for Older People Benchmarking Project.

(10%), Tasmania (7%), Northern Territory (7%), and South Australia (2%). The network members were asked to complete surveys pertaining to the perceived outcomes of internal network processes and operations.

According to the preliminary results from the Wesley Lifeforce Networks Survey, network members demonstrated a better understanding of key suicide prevention issues in the community, gaps in suicide prevention efforts, and help-seeking barriers and facilitators. Furthermore, network members now have increased confidence and capacity to plan initiatives to encourage help-seeking, address knowledge gaps and strengthen community responses. In terms of external community-focused network activities, the service providers also have an improved awareness of suicide preventions services/strategies, an increased confidence in assisting people at risk of suicide and an increased capacity to respond and help someone at risk of suicide

- ***Training Evaluation Outcomes***

The aim of a Wesley LifeForce Suicide Prevention Training Program is to educate, empower and resource Australian communities in a sustainable and ethical way seeking to train people from all walks of life to know what to do in a time of suicidal crisis, appropriately and confidently.

Community Suicide Prevention Training Evidence[vi]:

Research was conducted by Wesley LifeForce from questionnaires completed by from people attending 467 workshops over the period February 2013 to March 2017 inclusive. From the 837 respondents who completed a survey three months after attending the workshops we found 16.7% of participants had used the "SALT strategy" with at least one person at risk of suicide. Of this group 84% were able to link a suicidal person to appropriate professional help.

For every 100 attending this training who were surveyed it is calculated between 23 and 32 people identified at immediate risk of suicide were effectively referred to professional help within three months of receiving the training.

The Phase 2, Evaluation of Wesley Life Force Suicide Prevention Training, Hawgood et al. (2018), found 3 months after receiving training that:

• Trainees' "Ability to ask an at-risk person if they had considered or were considering suicide" was 'moderately capable' to 'highly capable' at 88.4% compared with 41.8% prior to training. (page 22):

• Trainees' "Ability to identify suicidal behaviours' was 'moderately capable' to 'highly capable' at 86.6% compared with 37.1% prior to training (Page 21).

A key finding of the Phase 2 Evaluation research was there was little or no difference in learning outcomes between professional and non-professional groups attending suicide prevention training workshops. The fact all achieved between 75% and 80% adherences effective across the different groups, suggests that the suicide prevention training is relatively equally accessible and effective for all groups in the community (pages 75 80).

Hawgood et al (2018) on page 88, concluded,

"Finally, at the grass roots level, the results [...] highlighted the strength of Wesley LifeForce Training in setting and meeting international best practice standards for suicide gatekeeper training."

- ***Suicide Prevention Trials***

The draft report states the importance of suicide prevention trials in reflecting the needs of communities, avoiding a 'fragmented and uncoordinated approach' to preventing suicide (Page 15, Draft Report). Wesley Lifeforce, in partnership with the PHNs, is involved in innovative suicide prevention trials that employ a systems based, coordinated approach in established networks as well as in new networks being developed. Trials have rendered successful suicide collaboratives and vary in their delivery with some trials being more service and clinical oriented and others that are purely community-led. In addition, in some networks the PHN's have approached Wesley Lifeforce for guidance on building sustainable programs by using a similar framework. The

trials will be analysed and evaluated in June 2020 to determine their impact, practicality and applicability to other localities in Australia.

In the Northern Territory PHN and Darwin Youth Suicide Prevention Network, the formation of a suicide prevention and mental health youth working group launched in December 2019, titled 'Strengthening Our Spirits' is one example of a Wesley Lifeforce Suicide Prevention Trial. The model, which has received grants for training, is designed by members of the Greater Darwin region's Aboriginal and Torres Strait Islander community as part of the National Suicide Prevention Trial. It is a systems-based approach to suicide prevention, therefore considering the many people, systems and processes which need to work together to help prevent suicide.

Reform Area 3: Investment in Services Beyond Health

Wesley Mission already has an investment in the following services beyond health including Opportunity Pathways, with assisted support into employment with appropriate training, case managed coaching, strength-based assessment and through relationships developed by Wesley Mission with suitable employers.

Wesley also has a partnership network which would also enable the delivery of social programs such as:

- Community Housing Tenancies
- Specialist Homeless Services
- Permanency Support Program
- Mums and Kids Matter
- Financial Capability including financial counselling and literacy workshops
- Emergency Relief
- Disability Services including residential and flexible NDIS services
- Community Aged Care services.

Wesley Mission supports most suggestions aimed at "Improving peoples' experience with services beyond the health system" contained in the table on page 36 of the Draft Report. However, it is not clear how all regionally commissioned PHNs would be able to support this outcome given their general lack of experience with working with a wide range of services beyond the health system (see ***Reform Area 5*** for more details).

Reform Area 4: Assistance for people with mental illness to get into work and enable early treatment of work-related mental illness

In addition to the wrap around services mentioned in ***Reform Area 3*** above, Wesley Mission has a presence in the helping people with mental health with:

- A Mental Health and Resilience Program addressing mental health in independent retirement living
- Two mental hospitals at Kogarah and Ashfield
- The Mum and Kids Matter program offers mental health care, parenting skills training and practical support to mothers in NSW

And Wesley Mission is in partnership with St. Vincent's Hospital providing accommodation for homeless people in Edward Eager Lodge, Surry Hills, addressing homelessness and mental illness.

Reform Area 5: Fundamental Reform to care coordination, governance and funding arrangements

Wesley Mission has some experience with care co-ordination and local community governance and funding processes, acquiring an understanding of the relationships across and within the community with other community-based services and with Federal, State and Local Government services and funding sources.

It includes work within communities, such as to construct the online service finder resource supporting access and navigation to services, and research conducted to inform current service improvement.

Information has been collected from a survey into the mental health of older Australians residing in independent living units conducted with help from Western Sydney University. Wesley Mission will be able to relate the mental health well-being needs of people to the construction of a new project that will seek to improve mental health and to reduce suicide risk for retired people living independently.

From Lifeforce's recent experience it is unclear that PHNs can easily or successfully "tasked with the promotion and monitoring of GP assessment and referral practices in line with a stepped care model of mental health (Page 20, Draft Report) as many GPs do not relate to PHNs directly and are unaware, even of their current functions.

Given the primacy of clinical support aims for GPs within PHNs it is not clear that it would be completely appropriate to vest the responsibility in PHNs for "the behind-the-scenes arrangements and incentives to ensure services for people in need are as seamless and timely as possible" (Draft Report, page 14).

Although the role of the Australian Mental Health Commission as the effective promoter of evaluative oversight in the area of mental health programs or practices may be appropriate, it is not clear that the PHNs would be the most appropriate bodies to work with the evaluation of services because they would be put in the position of evaluating themselves and of services they have no history of managing. Many State Departments of Health have conducted a sophisticated form of evaluation with their public sector clinical and allied mental health services, mental health benchmarking. The proposed reform would also run the risk of losing the organisational memory which has been built over the last 20 years or so among mental health clinicians through systematic benchmarking, dispersing the learning from this experience willy-nilly, not necessarily finding a place in the PHNs.

As current best practice, the Victorian Suicide Prevention Framework[vii] provides what some might call an ideal standard for leading the way in the co-commissioning model and provides a clear distinction between of the role of PHNs and the role of states.

The lack of a role for local government and a role for local community services that directly or indirectly support people living with mental illness in the community is also a concern in the proposed reforms as is the lack of existing relationships between these entities and many PHNs. It is also not immediately clear what the difference between a state authority and that of the RCA/PHNs will be.

- ***Governance Reform and Implications***

The Draft Report considers the need for "helping people to maintain their mental health and reduce the need for future clinical intervention, including by tackling early mental health problems and suicide risks" (Page 7).

Wesley Lifeforce encourages reform that focuses on community-based social capital. Through its networks and training programs, Wesley Lifeforce reinforces bonding within communities, and bridging across communities to help provide services to promote suicide prevention.

The Draft Report suggests a 'structural cultural shift' to a stepped care model to enable person-centred care in the mental-health system, with a focus on monitoring and improving outcomes for consumers, through workplace training and a more holistic approach to families and carers (page 17, Draft Report). Given that the general health system does not follow a stepped care model, this is a significant shift.

With suicide prevention, the stepped care model is utilized[11] to prioritize the first step, self-management. Through community-based training and establishing networks, Wesley Lifeforce believes that community-based service interventions focussed on suicide prevention and mental health at this level have a greater potential to

[11] Refer to Figure 3: Stepped Model of Care, page 18, Draft Report

cater to the needs of the individual within a stepped-care model and to achieve, the next step, an effective referral for appropriate care.

- ***Issues with Implementing the Regional Commissioning Authorities (RCA)***

The Reform that identifies the RCA working in co-ordination with relevant PHNs, fails to take account of the current level of community engagement with the existing local suicide prevention networks and of the need to maintain networks and to support their development. With support from the Australian Department of Health, over the past 13 years, Wesley LifeForce has facilitated the creation of 110 community-based networks to support local suicide prevention and awareness raising where suicide was recognised as an issue. More networks will be developed to bring the number up to the current target of 126.

It is Wesley Mission's contention that the proposed RCA reform does not take account of the need for specialised staff to support the development and maintenance of community suicide prevention networks. And given the focus it is not clear how, or even if, the networks would continue, if dependent upon a PHN for support, with a net loss of preventative social capital ensuing.

It is not clear how the development of Regional Commissioning Authorities working with Primary Health Networks will be able to represent local people and their suicide prevention needs and mental health needs. If the RCAs were responsible for direct funding for mental health and suicide prevention and the PHNs were responsible for provision, it's not clear that the support of these Networks and their development could be continued on a national basis.

The culture of PHNs varies greatly across the country as does the range of services they currently provide, adding to the difficulties and therefore the resource requirements of producing the vaunted 'structural cultural shift' to a stepped care model.

The claims that "mental health interventions delivered in schools and other types of community services are funded through a very wide range of programs, which is leading to duplication, inefficiency and unnecessary red tape" (page 44), misunderstands the roles of different levels of government and the third sector in mental health and suicide prevention. For example, in the case of access to schools, specific roles and permissions are required in the mental health and suicide prevention area to protect the child in the school in loco parentis requiring a range of different approaches based upon the child at their stage of life. The provision of prevention, as available through state education departments such as appropriate drug education or the like at the school level, clearly would lie outside the responsibility of primary health care generally.

Rather, the wide range of programs also reflects the fact that mental health and suicide can affect people in all sorts of different places and stages of life. This is in fact recognised by Part IV, which seeks "Better use of childhood services to identify and enable early intervention for social and emotional development risks" and its accompanying Recommendations, such as 17.3 looking at social and emotional learning programs in the education system. The Draft Report also ignores the fact that such a regional funding organisation, linked so closely with a general practitioner run primary health network would be likely to exhibit cultural, professional biases in favour of clinical services and against social and preventative "community health" services such as suicide prevention and local community support for recovery for people with mental health issues.

A key dynamic of the Australian health care industry has been the capacity for doctors in procedural occupations to earn reliable incomes from conducting procedures, as the result of a 'bias towards services for which it is easy to collect payment'.[12] As the Primary Health Networks are subject to significant influence from the key clinical service provider in the primary health care field, the general medical practitioner, the promotion of the PHNs to the role of direct provider of mental health and suicide prevention services as suggested by the "*fundamental reform to care coordination, governance and funding arrangements*" would introduce such a bias. This follows

[12] Joan Robinson, 1933, 1969, The Economics of Imperfect Competition

as most direct clinical services are funded on a 'fee for service' basis directly with subsidised payments under Medicare. Wesley Lifeforce is concerned such a bias would also work against the provision of preventative services and social and support services which are not able to be funded in this way, such as suicide prevention training and network development services. Nor are these preventative, prosocial services for which it is easy to obtain payment.

It is also not clear that PHNs and general practitioners are all that accessible to the uptake of suicide prevention training for general practitioners. Currently with PHNs responsible for organising specialised suicide prevention training provided for GPs provided by Wesley LifeForce, it is still difficult to attract local doctors to participate in the training available for them as they either are not aware of it or do not have the time available, even to satisfy their need for Continuing Professional Development (CPD) points or even because the training has not been promoted effectively by the PHNs.

Wesley Mission requests the Productivity Commission continue to focus on community led responses to suicide prevention, such as suicide prevention networks or suicide prevention training which have the capacity to support help seeking for individuals at risk of suicide to prevent suicide.

A concern of this reform is that in the zest for eliminating purported "duplication, inefficiency and red tape", there is the potential to overlook community-based prevention and inadvertently externalise the economic and emotional costs of suicide to individuals and communities. Such a reform could also undermine the role played by prevention services to enable access to the first steps of the 'Stepped Care Model'.

In addition to the emotional costs and economic and financial losses associated with losing a breadwinner, parent or child and the need for additional health and well-fare services, there is an additional impact of suicide upon community and individual well-being. An increased risk of suicide and worse mental health outcomes could be the result of this reform.

In its current form, "reforming the funding and commissioning of services and supports" creating regional funding and provision bodies, has the potential to undermine efficiency of health care provision, and confuse the delineation of relatively clear roles between federal government and state government. It also fails to take account of the current roles of local government, local community services and local social capital that presently support mental health and wellbeing. Wesley LifeForce, through its networks, is aware of the value of local community for suicide prevention and is concerned about the potential impact of these reforms upon the community.

E. Conclusions

Pro-social Focus and a Cultural Shift

Given the pro-social focus of Wesley Missions suicide prevention services, with the Draft Report's recognition that "implementing person-centred care consistently across the mental health system will be a significant cultural shift", it is not clear how that this cultural shift will be facilitated by some of the key recommendations (Page 23, Draft Report), particularly in relation to the proposal for an expanded role for provision by PHNs in conjunction with the proposal to set up Regional Commissioning Authorities.

As the result of the Draft Report's commitment to person-centred care, Wesley Mission believes we are entitled to expect the Productivity Commission to seek to understand and employ prosocial factors to support the recovery, participation and contribution of people with mental illness and people experiencing suicidal ideation in the community, in the workforce and in a social life.

Prevention and Higher-Level Clinical Care

By contrast the key reform elements of the Report, tend to focus more upon primarily reactive and clinical responses to mental health issues in our community and suicide, rather than looking to examine on addressing the origins of mental ill health in our society and its economic and workplace practises.

The Report supports "the importance of non-health services and organisations in both preventing mental illness from developing and in facilitating a person's recovery are magnified, with key roles evident for — and a need for coordination between – psychosocial supports, housing services, the justice system, workplaces and social security" (Page 8 for one example, Draft Report).

Social and Environmental Factors

Support for the importance of social and environmental factors in mental health and suicidal ideation also comes from new research conducted by Wesley LifeForce in Wesley Mission retirement villages which found, unsurprisingly, that more active social participation is associated with less loneliness, depression and suicidality.

While proactive community based and coordinated psychosocial strategies, such as those referred to above are supported in numerous places in the Draft Report, with some exceptions, it is not clear where or how they are facilitated in the community within the Draft Report.

The Funding Vehicle

In addition, Wesley Mission has some queries about the funding vehicle suggested for mental health and suicide prevention the Regional Commissioning Authority (RCA), including the role of the PHNs in service provision, and the omission of the level of government closest to the people – local government and the less than inclusive role of the community in contributing to the direction of funding for local social and community mental health and for suicide prevention. It is not clear that efficiencies will increase with the proposed regional structure, generally and in connection, with community mental health.

Amongst other issues with the Draft Report, many of our queries reflect the concern raised above about the need to address key psychosocial progenitors of mental illness and suicide in our society and in the community and does not take sufficient account of the impact of social structural issues upon mental health and suicidal ideation and the community support required to support individuals recovering in the community from mental health or the suicide of someone close to them.

Nature of Community Service Provision

The Draft Report's claim that the provision "mental health interventions delivered in schools and other types of community services are funded through a very wide range of programs, which [lead] to duplication, inefficiency and unnecessary red tape" misrepresents the nature of community service provision. It also fails to take account of the multifarious nature of community service provision and strategies to be employed generally and particularly in the mental health and suicide prevention.

While Wesley Mission supports most suggestions aimed at "Improving peoples' experience with services beyond the health system"[13], it is not clear how all regionally commissioned PHNs would be able to support this outcome given their general lack of experience with working with the full range of services beyond the health system.

[13] Contained in the table on page 36 of the Draft Report

Appendix 1: Recommendations from the Wesley Mission Submission

Wesley Mission recommends funding to:

1. Continue evaluated and evidence-based gate keeper training initiatives, inclusive of programs which are able to both target and upskill un-qualified and qualified community stakeholders

2. Support the ongoing establishment of community suicide prevention networks/ initiatives, which enable community members to build confidence in their ability to prevention suicide, enhance inter-community relationships and increase participation in suicide prevention activity

3. provide additional resources to support the maintenance of local community Networks and suicide prevention activities and initiatives, especially in those areas where participation is waning or where there are limited if any human resources available locally to support a Network

4. to provide the additional resources to fund and evaluate innovative community suicide prevention training, Network and/or community-initiated activities to promote the prevention of suicide and improve mental health and other issues which bear upon suicide and mental health well-being in the community

Key gaps in the research:

Wesley Mission also points to gaps in the availability and quality of data and linkages needed across the suicide prevention generally which are recommended, including:

5. Development and access to real time suicide data

6. Need for resources to develop and support effective cross-sectoral, multidisciplinary and whole of sector suicide prevention benchmarking to inform and develop practice and improve performances in the suicide prevention across Australia.

7. Enhanced funding for Lifeforce networks to link with Primary Health Networks (PHNs)

8. Greatly enhanced coordination for Commonwealth funded programs with an emphasis on whole of government approaches.

References

[i] Wesley LifeForce. *Drought Affected Communities Report*. October 2019

[ii] Rawlin, Morton. *Wesley LifeForce Suicide Prevention Training Evaluation (General Practitioners) 2019*. University of Sydney.

[ii]Hawgood et al. (2018) '*Wesley LifeForce Suicide Prevention Training-Overview of findings from the Australian Institute for Suicide Research and Prevention report'.* Griffith University.

[iii] The key research has shown that the relative rate of male suicide in rural Queensland was 1.99 compared to rates in metropolitan locations:

Hirsch, J. K. (2006) A review of the literature on rural suicide: Risk and protective factors, incidence, and prevention. Crisis, 27, 189-199

Kõlves, K., Milner, A., De Leo, D. (2009) Suicide risk in different subpopulations in Australia (Queensland). A Report to the Commonwealth Department of Health and Ageing. Brisbane, Australian Institute for Suicide Research and Prevention.

References quoted in Kairi Kõlves, Allison Milner, Kathy McKay & Diego De Leo (eds) (2012): Suicide in rural and remote areas of Australia. Australian Institute for Suicide Research and Prevention, Brisbane. Copyright Australian Institute for Suicide Research and Prevention, 2012.

[iv] *Inquiry and report upon the accessibility and quality of mental health services in rural and remote Australia Submission by* Wesley Mission to the Australian Senate Community Affairs References Committee, May 2018, page 12 and 13.

[v] *Inquiry into the economic impacts of mental ill-health: The Social and Economic Benefits of Improving Mental Health* Wesley Mission Submission to The Productivity Commission April 2019, page 12.

[vi] Victorian Suicide Prevention Framework 2016–25, Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne. © State of Victoria, Department of Health and Human Services, July 2016. Available at www.mentalhealthplan.vic.gov.au