SUBMISSION

TO THE SENATE INQUIRY ON

SUICIDE

By

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Setting the Scene

The rate of rural suicide in Australia is amongst the highest in the developed world as farmers battle the crippling challenges and profound stresses of years of drought, failed crops, mounting debt and rural dwellers battle to slow the decaying towns and communities.

The World Health Organisation (WHO) says Australia has a higher suicide rate than nations such as Canada, the United States and Britain.

A total of 2,101 Australians committed suicide in 2005, the latest available statistics.

In every year since 1996 more people have died through suicide than in Motor vehicle accidents.

In addition many single vehicle fatal accidents on rural roads are often unreported suicides.

The majority of people who died were men between the ages of 18 and 44.

While the overall trend for suicide in Australia has been decreasing, in rural Australia suicide rates have been steadily increasing over the last 40 years.

While the rate of depression, which leads to suicide, is equal in urban and rural Australia, rural suicide rates are at least 20% higher. Those at greatest risk of committing suicide are men living in a town with a population of less than 4,000.

In fact, the more isolated the farmer or rural dweller the greater chance he will resort to suicide, according to the Ministerial Council for Suicide Prevention.

The Land newspaper in 2005 reported that there are around 1,000 suicides a year in rural Australia, just fewer than 20 deaths a week. National farm debt has doubled in five years to A$40 billion, as farmers borrow each season to plant crops only to see them shrivel and die.

Cattle and sheep farmers have sent valuable livestock to slaughter because they can no longer afford to buy feed or water.

Some farmers have had no income for several years and many rely on off-farm work to survive.

A recent rural study has found that life on the land, once romanticised by Australia's great writers and poets as the backbone of the nation, is a virtual health hazard.

Some 300,000 rural people suffer from depression each year.

Beyondblue's Leonie Young says we need to get the message out, in these tough times, that depression is an illness, but mental health is a taboo subject in the outback, and stoic farmers see admitting to suffering stress and depression as a sign of weakness.

These are tough rural people. They are resilient. They fight mounting debt, drought, floods, stock losses and bushfires.

Instead of seeking help many rural men retreat into the farm, become unsociable and sink further into the spiral of depression and/or mental illness.

Isolation is a real problem - living hundreds of kilometres from a town, the daily responsibility of feeding and watering starving livestock means they think they cannot leave their property.

Younger generations are reluctant to take on the burden of the farm or they are being excluded from decision making by the older generation, who reject any attempts at succession planning.

Some recent strategies have included:

The Federal Government gun buyback scheme. Many experts believed that would lead to a dramatic reduction in rural suicide, but that did not eventuate. Instead the scheme had no impact on suicide rates as victims turned to other methods like hanging.

The Federal Government initiative of Medicare Bulk billing of appointments to trained counsellors also does not appear to be having a big impact on diagnosis and treatment of new cases of depression. Existing patients are simply coming more often.

Initiatives Overseas

In the United Kingdom, to cope with the catastrophic impacts of foot and mouth disease, in 2001 suicide experts instituted a program of contacting (in person) every single farmer that had been forced to destroy stock because of Foot and Mouth to determine whether they were at risk of self harm and needed more intervention.

Australia, in coping with the catastrophe of drought can learn from the UK's Foot & Mouth crisis management.

Similarly, despite real problems with isolation on Canadian farms, where people can be cut off from all human contact for months during the harsh winter, Canada has suicide prevention programs that use regular contact and teleconferencing to combat isolation.

Despite very similar issues with isolation, Canada's rural suicide rate is significantly less than Australia's.

In India, moves away from subsistence farming into monoculture cropping has caused enormous social dislocation, and the rural poor are now at greater risk of starvation if a season turns bad.

There is an intervention and prevention program underway right now under the auspices of the World Health Organisation.

The Centre for Disease Control's Centre for Suicide Prevention based in Nevada, takes a national approach to suicide prevention programs, focusing on the rural poor and small farmers struggling to cope with inevitable changes.

We can learn from each of these programs.

What are we doing in Australia?

As a journalist with many years experience reporting for ABC Radio's Country Hour, I am convinced that the media can do more, specifically by disseminating information about successful rural suicide prevention programs.

I have travelled widely throughout rural Australia and I understand the complex nature of the relevant issues having spoken to many farmers, and also to mental health professionals who are on the frontline combating rural suicide.

We have some programs in place in Australia but more can certainly be done to focus on the issues at play in cases of rural suicide, in order to develop a more targeted and coordinated approach to fighting rural suicide.

National Action Plan not Active enough

When one looks closely at the **Council of Australian Government's National Action Plan for Mental Health 2006-2011** regarding rural assistance, it reveals broken promises, inaction, delay, slashed funding dressed up as a generous handout, and lack of political will by two separate Federal Govts and numerous State Govts.

Despite a stated aim in the action plan that special attention is now required in rural and remote areas to address the issue of mental health, the latest funding reports show a severe shortfall in funds that were promised, being delivered.

Overall the money spent is a tiny fraction of what was originally allocated by COAG.

The Rural Doctors Association says that federal government estimates of the funding that will be provided to rural GP's is always much higher than the actual funding spent because of the chronic shortage of doctors in the bush.

They just cannot recruit the doctors and nurses to fill all the positions in country towns, and the RDAA says the federal government is very aware that these jobs will never be filled and the money allocated never spent!

In the COAG progress report, in the areas directly relevant to rural mental health new funding was promised for mental health nurses of 192 million but after the first of five years only 2 million had been allocated, 52 million was allocated to services in rural and remote areas but after one year only 5.3 million had been spent and 285 million for new personal helpers and mentors but in the first year only 5 million had been spent.

An even more specific example is the **$26.3 million,** 24 hour **Mental Health Access by Telephone advice, triage and referral service** promised under this Action Plan.

The NSW Govt was supposed to commence implementation in July 06. Nothing happened until June 07 when the NSW Govt pledged "**$2.6 million** in **new funds** for the **$5.3 million** state-wide 24-hour Mental Health Access Telephone Service." **This still only adds up to $7.9 million. So where did the other $14.4 MILLION go?**

Tenders were called in March 08 with the telephone service "expected to be available to rural communities in late 2008."

It is still not up and running.

The COAG progress report of 2008 shows that in many programs relating to rural mental health, little or no money has been spent.

Clarification has been sought from the State and Federal Government Health Ministers regarding these issues, but they will not provide the details of the current funding levels of a number of these programs.

There is definitely a need to implement other strategies, tailored to suit those at risk who live in rural Australia.

RECOMMENDATIONS

- Set up a network of specialist well trained community based rural mental health workers in rural towns. Positions should be funded on a part time basis (based on the UK model) and with Commonwealth government funding, perhaps with assistance from Local Councils, businesses or the relevant State Government. Local residents, community elders, retired health care workers or health care workers seeking part time work could be encouraged to apply. The Chief medical officer of the UK says that due to a shortage of doctors in the

UK they have come to rely more on community health worker type solutions and she says rural Australia could follow that model.

- Training in counselling, mental health first aid and related fields would be valuable but, as in the experience in India, an important part of the job would be the ability to recognise when people needed referral to additional medical help to prevent incidents of self harm or harm to others.

- The mental health worker could ensure face to face personalised contact with people in isolated rural areas believed to be at risk of harm or mental illness.

- The Rural Alive and Well program in Tasmania is an excellent example of an on the ground program that reaches out to people in rural areas and provides face to face contact with isolated people. The Farmlink pilot program in NSW is another similar community based model that works well along similar lines. These small scale programs should be expanded on a national level, with benchmarks set on program aims and service delivery expectations.

- Limiting access to the means of committing suicide is a big element in prevention. In Australia more could be done to limit access to guns and access to ropes that might be used in hangings. Some international experts have suggested that if there is any thought that suicide is being contemplated then ensuring that rope and guns are locked away may be just enough of a deterrent for some people at risk of self harm. This could be incorporated in future education campaigns in local communities.

- Set up a specialist Farm Crisis Help Line that runs 24 hours a day based on the Canadian model with highly trained telephone operators with knowledge and experience dealing with rural issues, such as isolation, farming, agronomy, alcohol abuse issues, family crisis issues, debt management, banking and financial issues.

- Farm Crisis Help line staff training would need to be much more comprehensive that on current help lines and targeted to the needs of people living in rural areas or towns.
- Web based programs like Beyondblue are no substitute for face to face contact. It is not effective in ensuring isolated rural people suffering from depression or mental illness get the medical attention they need. It is misguided of the Federal Government if it believes its multi million dollar funding of Beyondblue is filling a gap of services in rural areas where there are no doctors. There is no mechanism to ensure medical attention is sought when needed and there is strong anecdotal evidence to suggest that many rural people at risk access Beyondblue internet sites and do not undertake suggested follow ups with GP's or counsellors.

CHURCHILL FELLOWSHIP PROJECT DESCRIPTION

The Fellowship tour was undertaken between 23rd March and 23rd June 2009. The focus of the fellowship was to study rural suicide prevention programmes around the world that may be adaptable to an Australian rural environment.

Chennai, India

The first part of the Fellowship was based in Chennai, formerly Madras, as it is the base for the Psychiatrist Dr Laksmi Vijayakumar who is running a new World Health Organisation pilot program.

She is also the founder of SNEHA, the centre for suicide prevention in Chennai.

The funding for the WHO program was announced in the week that I arrived in March 2009.

It is designed to reduce suicide by reducing the access that farmers have to farm chemicals as this is the most common cause of death, that is, the intentional drinking of herbicides or pesticides.

This is a huge problem in South East Asia with the United Nations figures showing 250,000 people committing suicide this way every year.

In India it is accounts for between 22,000 and 30,000 deaths per year.

The idea behind the new pilot program is to set up a town “lock up” of farm chemicals so the whole community can be in charge of the store of chemicals and to try and minimise access to those people considered at risk of suicide.

It is a bold plan but it is supported by the community which will set up a sort of locked shed which is controlled by one central person who is a respected elder in the farm community.

The WHO in approving the scheme stated that it is the most effective and culturally sensitive project to limit access to farm poisons that the WHO has yet seen.
The pilot program will be based in a farming area 6 hours north of Chennai, where the climate has really seen a big shift to crops like cotton and chillies - two crops that require new chemical regimes only introduced into India since the late 1990's.

Dr Vijayakumar has published research that shows that part of the problem with suicide and financial stress among many farmers can be traced back to the emergence of these new mono cropping systems with GM cotton, in particular, forcing people to buy seed and chemicals and, if the crop fails, they have enormous unpayable debts.

She says it is a big cultural shift in one generation for farmers who only ten years ago were completely engaged in the hand to mouth of subsistence farming.

She says at least in that system, after just one bad year, the debts were never as crippling as the devastating debts that mount after just one failed year using new GM mono cropping methods.

The biotech companies deny this saying a recent report they commissioned found that there was no increase in the farm suicide rate when new farm

chemicals like pesticides and glyphosate (weed killer) were released in India.

Dr Vijayakumar has had her own research published in a prestigious medical journal that contradicts this completely, showing a fivefold increase in suicide rates in typical farming regions since the new mono cropping came into vogue.

There is also the debate over whether reducing access to poisons is really addressing the problem of suicide and the causes of the stressors.
Dr Vijayakumar says having the community run the central farm chemical store and having community based mental health workers on the ground in the villages is the other prong in the attack they are taking to reduce these deaths.

She says there are several elements involved in the program all working together.

She points out that even if there is only a modest reduction in deaths of say ten percent that would equate to 25,000 people in all of South East Asia. She thinks the pilot program could be expanded and rolled out internationally in modified forms in countries like China, Vietnam, Bangladesh and Pakistan.

We were also fortunate to be able to travel to a small village to see how community health workers operating outreach programmes make a difference in mental health management in small rural communities.

In India there are so few doctors and psychiatrists and even nurses that the large bulk of the work is done at a community level by locally based health workers.

These health workers are charged with keeping an eye on the people in the community. They let the health professionals know when they are concerned about anyone who may be suffering from a mental health crisis or may be in need of some sort of medical intervention.

We were fortunate to be able to watch as Dr Padmavati conducted a session with the local mental health workers there.

They're almost all women and Dr Padmavati explains that they have been running these programs since the 1980's, and they have found that women,

rather than men, are best suited to this type of work, since patients seem to be more open about their problems with women health workers.

Dr Padmavati tells me that the women must be able to read and write, and they have all completed at least a few years at High school.

They also must have good listening skills and can be relied upon to be confidential about patients' illnesses and health issues, which is sometimes hard in a small community.

Their job is to counsel and question patients with a set range of questions to see if the patient needs more help, or medication, or a referral to a doctor or a psychiatrist. They also make more detailed notes which the doctor can refer to if needed.

Dr Padmavati says without these local community women, the mental health problems in the region would be much worse.

The community health workers are the back bone of the rural mental health system in this part of India and they also provide a sense that the community is caring for its own local residents.

These women are like the early warning system that someone may be at risk and need some extra care and attention.

And Dr Padmavati says that one of the reasons the system works so well is that all clients get a chance to talk to someone face to face in a confidential way.

She says that nothing can replace human interaction when people are really struggling with a mental illness or depression.

Rome, Italy

Former Deputy Prime Minister Tim Fischer is also a long time advocate for improved health services in the bush and has just finished up as the chairman of the Royal Flying doctor Service.

Mr Fischer has only recently been appointed to the position of Ambassador to the Holy See (or the Vatican).

He says increasingly the Royal Flying Doctor Service, of which he was patron, is being asked to help people battling depression and in some case mental illness and suicidal thoughts.

He says, in his experience, which is similar to what we found in India, communities are the best places to start to get a plan up and running and get action on the ground.

He says everyone in the community has to stick together and be focussed on the one goal, and it is no good if there is any division.

Once a community has a plan of action for their local area in Australia then his advice is that they then lobby hard for state or federal government assistance.

He says many local councils have achieved this sort of thing to get a project off the ground, towns like Longreach, Holbrook and various towns in the Riverina in NSW.

He says communities are the best place to start in order to get the help they think is most appropriate, such as more community health workers or even a community leaders program so that trusted people in the region can monitor the status of anyone they think might not be coping.

He says international suicide research has proved that united and caring communities have less of a problem with suicide and he says with a bit of understanding the issue of mental illness should not be taboo anymore.

United Kingdom

Farm Crisis Network (FCN) began its work in 1995 as a Christian response to the high suicide level among farmers. FCN was closely modelled on the work of the Farm Family Supporting Service in Württemberg, Southern Germany and the Gloucestershire Farming Friends.

The FCN was able to support many in the farming community through the Foot and Mouth Disease epidemic in 2001. FCN supported over 7,000 households during that time, providing encouragement, advocacy and help with finding financial assistance.

The Farm Crisis Network in Northampton was founded by farmer Christopher Jones also as a response to his concerns that farming was facing a number of crises in the future.

It was up and running just as foot and mouth disease broke out in the UK and the network quickly grew to be a national farm crisis organisation.

It is a charity run along Christian lines with the idea of providing personalised contact in a time of crisis, whatever form that may take, such as family breakdown, financial, illness or disease outbreaks or natural disaster.

The idea is to “walk with the farmer” through all of the troubles and try to help them through the crisis. It is designed around the concept described in the Bible where Jesus walks with the people.

Once again the concept is very much about personalised contact and one on one counselling and advising from highly trained and experienced farm crisis network staff.

FCN has a network of 250 volunteers throughout the UK and in the last twelve months it provided assistance to over 1,000 farm families suffering from financial hardship, poor health or strained family relationships.

We then travelled down to Wales and Cardiff University to discuss the example of Bridgend, with University tutor and PhD student Ann Luce.

The Bridgend Valley is an enclave of the industrial and rural poor. The mines, factories and businesses that once provided the jobs have largely left, and the young people in the region have little prospect of work and some of the highest unemployment rates in Britain. University researcher, Ann Luce, says when there was a spate of suicides last year, the unemployed youth were targeted by the national UK media as being lazy and feckless, addled with drugs and irresponsible. The real issue behind all that, says Ann Luce, is boredom and unemployment, and little access to appropriate health care.

Ann Luce says in the case of Bridgend, instead of the young people getting the help they needed it became this sensationalised media storm explaining the deaths as a suicide cult, blaming the internet and social networking sites. What the young people at risk in Bridgend needed was

intervention with trained counsellors on the ground, in the community and in the schools.

She says “stigma plays a big role in mental illness but definitely, especially in the case of Bridgend, I mean it was deemed a lower class, we have major class issues here in the UK, but definitely in the case of Bridgend it was Oh well, these people are from ‘the Valleys’, it’s a very poor depressed area, it was annihilated during Thatcherism’, there’s all these descriptions for the area, so you know, middle-class people looked down their noses and say ‘This is a lower class issue, we don’t have to deal with this.’ But domestic violence was considered a lower class issue until the research in the ‘90s, the mid-‘90s, started coming out, and it started showing that actually domestic violence is a middle class issue more so than a lower class issue, it’s just hidden a lot better. So I mean the thing with suicide is, it spans all the social classes, it spans all age groups, all races, all creeds.”

New York, USA

The American Foundation for Suicide Prevention in New York was established in 1987.

The Foundation is the leading national not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide.

In recent years the Executive Director Robert Gebbia says it has become apparent that harnessing the political will to provide funding for prevention programs is a real issue in the United States. That is despite the high level of deaths by suicide in many rural states in the US.

He says the states in the west such as Wyoming, Montana, Nevada and the northern state of Alaska are the areas with the highest rates of suicide per population.

The Foundation is actively trying to get more support in Washington, in the legislature and in the White House.

The National Suicide prevention program was set up by President Clinton in 1993 but many promises for specific program funding are still unfulfilled.

Executive Director Robert Gebbia says a big part of their role is still educating the public about suicide and mental illness and breaking down a strong stigma.

The media manager Wylie Tene says they face a lot of resistance to the “sensitive and intelligent reporting of suicide”, particularly from the tabloid newspapers and some of the TV stations.

Robert Gebbia says what they are hoping to achieve is funding for programs that is commensurate with the problem that suicide represents to the American society. He says they receive nothing like that sort of help at the moment.

He says they are also targeting politicians by mobilising bereaved family members to agitate and lobby for more health care to be made available to communities known to be at a higher risk of suicidal behaviour or ideation.

Montreal, Canada

The President of the International Association for Suicide Prevention is Dr Brian Mishara and he is based at the University of Quebec in Montreal, Canada.

He says there are one million suicides a year worldwide and it is an international phenomenon that rural men are more at risk than any other group.

He says in addition to that the highest risk is in the sub group of indigenous males.

He says they are fighting to raise awareness about the suicide issue generally and will be trying to increase publicity for the cause of suicide prevention through the International Day for suicide prevention now set every year on September 10th.

He is a great advocate of early intervention and raising the issue with children as part of a school program, and doing that in league with, and in addition to, proven prevention programs.

Saskatoon, Canada

Saskatoon is the headquarters of the Canadian Centre for Agricultural Health and Safety. It is headed up by Dr John Gordon and it deals with a whole range of safety, disease and accident issues on farm or in rural areas. Dr Gordon introduced me to a range of top Canadian bureaucrats and I was able to discuss the suicide health care program with them.

Saskatchewan Health's Manager of Community Services Edmee Korsberg was a strong advocate for a primary health care model to deal with stress and mental illness in people who are more isolated in rural areas or on farms. This is centred around the GP but a range of other health care professionals are linked to the same practice and provide specialised services i.e. a psychologist or a trained mental health counsellor. That way the patient could have a range of services available in the local practice and access the sort of care in terms of medication or counselling without having to rely on the hospital system. She says the primary health care model also helps to build a strong sense of community.

I was also fortunate to meet with Ken Imhoff, the former director of the Farm Stress help line.

The Farm Stress help line was established in 1992 in response to the farm financial crisis which began in the late 1980s.

The mission of the Farm stress line is to provide confidential peer telephone counselling, support, information and referral services that respond to the needs of rural people families and communities.

The help line staff and phone counsellors are carefully chosen to have a strong empathy and understanding of rural and farming life. They are also given extensive training in a range of relevant areas such as financial management, farm agronomy, family conflict and stress management.

The Farm Stress Line takes a holistic approach and believes that, "given the applicable information, resources and support, People are empowered; People are able to address and resolve their own issues and problems; People become resilient; People are better able to make choices and changes".

Ken Imhoff says the line has been an enormous success in the last 16 years and he hopes the model will be adopted nationwide. He says the Canadian model could be implemented easily in a country like Australia. He

says the key is gaining the trust of the farming community so that they feel positively about using the service.

Reno, Nevada

Nevada's rural counties, home to 10 percent of the state's population, have the highest suicide rates in the US. The Nevada suicide rate has been up to three times the national average since the state began sending statistics to the US federal government in 1929. Rural Nevada's suicide rate is currently more than twice the national average, a problem compounded by lack of resources, remote locations and the stigma of seeking treatment in a small town. Clinics are often the only source of mental health treatment for rural residents. Few mental health professionals, especially psychiatrists, are in private practice in the 15 non metro counties.

The critical lack of treatment for rural citizens threatens public safety and clogs emergency rooms and jails.

The lack of mental health resources in rural communities takes a toll on public safety and law enforcement budgets when officers are required to leave their patrols to drive citizens hundreds of miles away to the nearest psychiatric hospital during emergencies, authorities say.

More people in Nevada die from suicide than from murder or in car accidents. In 2003, more than 430 people died from suicide.

Dr Bill Evans is a professor at the University of Nevada, Reno and has been involved in suicide prevention for over a decade assisting in the Centre for Disease Control study of Nevada's high suicide rate.

The study found that, contrary to popular belief, the high suicide rate was due to native Nevadans killing themselves and was not due to tourists who had sustained losses at the gambling tables of Reno or Las Vegas. In addition it found elevated rates of suicide in the Native Indian populations on reservations.

Dr Bill Evans says they have consciously focussed on school education programs to reduce the stigma of suicide and giving children coping strategies to deal with depression or stress. He is also keen to embrace programs that incorporate prevention and education methods in mediums

used by high school students and young adults such as social networking web sites and text messaging by mobile phone.

This is in addition to existing prevention methods and the state wide Crisis help phone line. I undertook tour of the Crisis centre and was fortunate to be able to sit in on a suicide survivors' support group meeting.

We were also able to discuss existing programs with Nevada's state co-ordinator of suicide prevention Misty Allen and travelled to a Mental Health Clinic about two hours north of Reno at Pyramid Lake Indian reservation.

The staff at the clinic say, given the history of the treatment of Indigenous people after the settlement of white people in the western states of the US, gaining the trust of the Indian population is the most important issue. They say the best way they have found to deal with the natural suspicion of government health care workers, on Reservations, is to employ mental health counsellors who are from Native American descent.

At Pyramid Lake such a program was instituted four years ago and the suicide rate has drastically reduced in that community in that time.

Ultimately, Dr Evans says, in order for any program to be successful in Nevada they have found they need to support of the community in wanting to address the stigma and health care issues stemming from depression, stress, mental illness and possibly suicide. He says work in schools, the Crisis line, the Indian mental health clinic outreach program and the discussion about stigma in the wider community and the media are all helping to make a difference.

But he is concerned that the Federal government may cut some of the suicide prevention programs due to the economic crisis currently facing the US. He says they have re-doubled their lobbying efforts as a result.