

# **PRODUCTIVITY COMMISSION DRAFT REPORT ON MENTAL HEALTH**

## **RESPONSE FROM JOE CALLEJA, RECOVERY MATTERS**

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**Based on the presentation to the Perth hearing 9.45am Thursday, 21 November 2019**

**17 January 2020**

## INTRODUCTION

Thank you for the opportunity to make this submission today. I am social work qualified and a Life Member of the Australian College of Social Work. I have held positions as Principal Social Worker in the child protection department in this state, Executive Manager of a Family Relationship Counselling Service, Senior Executive Service in the Justice Department in Western Australia and more recently was the CEO of Richmond Fellowship of Western Australia which is now called Richmond Wellbeing. That agency is a non-government agency which provides community and residential support to people with complex mental health difficulties and which has a strong recovery focus in its work with individuals. I was CEO for 11 years until I resigned three years ago.

Since then I have worked with organisations to improve their focus on mental health recovery and at the time of the Perth Hearing was the Interim CEO of St Bart's which specialises in homelessness, aged care and mental health.

The Commission has clearly undertaken an enormous amount of research and consideration in the preparation of the report which has been released for public comment. Mental health and suicide are significant social and emotional wellbeing issues which have both a profound impact in personal as well as economic terms. The work of the Commission in this regard has the potential of making a significant impact in future government policy across government not just in the health sector.

The Report is complex and hard to respond to so I have grouped my comments broadly rather than tried to respond to the many recommendations. Although there are some very insightful and helpful recommendations in the report, the key assumption on which the report is based – that treatment within clinical system is the basis for a person's recovery - is contestable. That assumption has resulted in the report being written in a way that has the potential to set back many recovery focussed gains made by consumers, family members and non-government agencies in the mental health sector over the years.

The assumption suggests that the Productivity Commission has not heard what has been said about recovery nor has it been proactive in informing itself but instead has opted to assume the status quo is sound and has tinkered around the edges in

recognition of the role of social determinants and the importance of prevention and early intervention.

A significant omission in the Productivity Commission Report is the failure to mention the child protection system. This is disturbing particularly as so much attention is paid to the role of schools and early intervention for children and young people. Children in the child protection system, particularly this in care, are often traumatised both by their family experiences as well as by the intervention by the state. They spend six hours a day in school along with other children and are often likely to be bullied, or to bully, and often be visible in class as problem behaviours. These issues alone I would have thought might be recognised in the report, but more importantly I would have thought their general need for wellbeing might be explored. It seems they have either been forgotten or the Productivity Commission has wrongly assumed that because they are in the care of the state their care needs are being met. This is a fundamentally unsound assumption.

I would have thought that the Productivity Commission would have had both an ethical and moral responsibility to proactively inform itself rather than assume that the current health system should remain the basis of what should be provided in the future. If the Productivity Commission has spoken to consumers, family members and non-government agencies it has only listened to but not heard their concerns if it assumes the current deficit based treatment approach should remain as the core of future mental health policy and service directions.

I would like to briefly focus on four issues this morning:

1. The assumption on which the report is based that clinical intervention should be the primary response to assisting people mental health difficulties
2. The lack of genuine engagement with the lived experience as the engagement that has occurred is not translated into the recommendations
3. The failure to understand the importance of psycho social support.
4. The assumption that current dominant research approaches in mental health and suicide prevention are genuinely informing future directions .

The draft report has the potential to entrench the current medicalisation of mental health system even in spite of the recommendations which recognise the importance of addressing the social determinants of health. It will simply further disempower consumers and family members and also reduce the capacity of the non-government sector to help people in their journey of recovery. It will consolidate the power differential between consumers and professionals, in which professionals not the person in particular is placed in the centre.

## **Proposals for consideration**

### **1. The contestable assumption on which the report is based which assumes clinical intervention should be the primary response to assisting people mental health difficulties**

The response by health professionals to mental health difficulties is based on the belief that a person is sick or has a biological basis to their diagnosed condition. A whole industry has emerged in which people are categorised and treated using so called evidence based approaches such as the increasingly discredited DSM V. The momentum in perceiving people as being sick as opposed to distressed has also been accelerated through the efforts of the pharmaceutical industry. Many people with mental health difficulties have developed serious physical health problems because of the over prescribing of drugs yet their level of distress has not necessarily been mitigated.

This Hearing is not a forum in which these issues can be actively discussed. However, I would draw to the attention of the Productivity Commission the work of ImRoc <https://imroc.org/> in Nottingham in the United Kingdom where a cross section of government and non-government agencies have for the past several years worked together to achieve organisational change that enables their system to assist people in their recovery without it being viewed from a deficit base. I would urge the Productivity Commission to adopt their key focus around thought leadership in mental health which is:

Our role is to create an environment where recovery concepts, leadership and practice can thrive in the long term. Our ambition with all our clients is to enable self-sustainability.

Unfortunately, the draft paper produced by the Productivity Commission, if its key foundation is carried forward, will have the opposite effect to the above.

In my submission to the Productivity Commission in April 2019 I also cited the work of Rachel Perkins OBE from the UK who is a key consultant to Imroc and whose own articles on peer support along with ImRoc's publications would greatly assist the Productivity Commission achieve a more balanced report about future direction in mental health in Australia.

The following you tube, recorded when Rachel Perkins visited WA in 2013, would assist the Productivity Commission to contextualise mental health problems in people's lives rather than from the perspective of the health system <https://www.youtube.com/watch?v=0xShVBwe8C0> .

The Western Australian government has taken the lead in Australia in introducing Recovery Colleges which adopt an educational approach that allow service providers and the lived experience to jointly understand what works best to support recovery in individuals. The Ten year review of progress of Recovery Colleges presents a compelling case on their value <https://imroc.org/resources/15-recovery-colleges-10-years/>.

Recovery Colleges were first established by Rachel Perkins in the UK when she introduced one in her National Health Trust. The WA Government is in the process of establishing a network of Recovery Colleges in WA and further information can be obtained from the Mental Health Commission of WA <https://www.mhc.wa.gov.au/recoverycolleges> . Initiatives such as Recovery Colleges can help break down some of the power differentials that currently exist at an individual level within the system and may assist at a broader systemic level.

## **2. The lack of genuine engagement with the lived experience as the engagement that has occurred is not translated into the recommendations**

There is evidence of some understanding about recovery and the lived experience in the report. However, it is peripheral in comparison to the overarching message that at the end of the day professionals know best.

There is some recognition of the value of peer support but it is still through the eyes of its presence in a clinically dominated workforce. The Productivity Commission has not recognised that peer support can also occur without the presence of clinicians. Initiatives such as the Hearing Voices Network <http://www.intervoiceonline.org/> are peer support groups which are not clinician led or engaged, they are solely run by peers and have been found to be extremely effective in building hope and confidence and in enabling people to take more control over their lives. Participants might still take medication and see their clinician, but they also have this space with peers which is their own space and allows them to build confidence and take control over their voices which are real to them.

A similar approach is emerging in suicide prevention where peer support groups that do not involve clinicians are being set up in Australia based on the Alternatives to Suicide approach from the Western Massachusetts Recovery Learning Community <http://www.westernmassrlc.org/alternatives-to-suicide> in the US. They are founded on the same principles as the Hearing Voices Groups.

The Hearing Voices approach is now widely accepted in Australia. The Alternatives to Suicide Peer Support approach is slowly gaining acceptance and the NSW Department for Health is looking to roll out the approach in that state.

These peer to peer approaches are initially met with considerable resistance by the traditional clinical based system but will gradually be accepted. I introduced the Hearing Voices Approach to Australia in 2005 from Europe when I was at Richmond Fellowship of WA, and now you can find them in both the public and non-government mental health systems. They are also now a part of the broader research agenda in mental health.

I am part of a group in Western Australia which is introducing the Alternatives to Suicide peer to peer approach. There has been a group for Transfolk people that has been running successfully in Perth since May 2018. There are plans to run train the trainer facilitator programs in Perth, Brisbane and Sydney in 2020.

But to return more specifically to the broader issue of peer engagement whether it be for individuals or families, the Productivity Commission needs to recognise that the lived experience is not an organised bloc like the AMA, College of psychiatrists or the Nursing Federation. It must reach out to these groups if it genuinely wishes to reflect their thoughts in developing a future strategy about mental health in Australia. The Productivity Commission needs to recognise that the lived experience in all areas has had to contend with negative messages about their value and knowledge for years, so they often have to overcome the hurdle of not even feeling confident to express their views for fear of being shot down by professionals who claim to know what they thing. I think it is imperative for the Productivity Commission to reach out in whatever way it can to more fully understand the needs and issues of the lived experience.

This leads me to the issue of psycho social support.

### **3.The failure to understand the importance of psycho social support.**

For whatever reason the Productivity Commission has formed the view that psycho social support really only becomes required when the treatment system fails. This assumption goes to the core of why the fundamentals of the Productivity Commission report are seriously flawed.

Psycho social support is about a person being about to be included in the community and to have a life worth living. It is there throughout a person's journey of recovery . Good psycho social support is more likely to help a person in their recovery than clinical intervention or drugs, but it is not an either or arrangement.

It seems the Productivity Commission sees NDIS as a benchmark for psychosocial support and somewhat dangerously suggests that NDIS should be the sole provider of this at the commonwealth level.

I would remind the Productivity Commission that the Productivity Commission report which created the NDIS had only ten pages on mental health out of a 1,000 page report. The NDIS has had disastrous consequences for many people who have mental health difficulties from the closure of PHAMS and reframing of Partners in Recovery to fund NDIS, as many people who were receiving psycho social support lost it and were not eligible for NDIS. I recall some years back a statement by a consumer who said: "I have spent years trying to prove I am recovering but now to be eligible for NDIS I have to say I am permanently ill."

The National Mental Health Commission in its Contributing Lives Review <https://www.mentalhealthcommission.gov.au/getmedia/6b8143f9-3841-47a9-8941-3a3cdf4d7c26/Monitoring/Contributing-Lives-Thriving-Communities-Summary.PDF> cites a lived experience perspective which should actually underpin the Final Report of this Productivity Commission Inquiry:

*I just want to emphasise that people with mental health issues are a part of the community and that our lives matter. Not only that, but by denying people like me the chance to have a stable life, with stable housing and a reduction in poverty-related stress, you are also denying our kids and loved ones relief from those stresses."* Person with lived experience, Victoria. National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services. Sydney: NMHC Published by: National Mental Health Commission, Sydney.

I hope the Productivity Commission will revisit its view of psycho social support to be a much broader intervention than post treatment failure.

The non-government agencies across Australia provide thousands of people with psychosocial support to help them live a more fulfilling life in the community. In 2010 the Productivity Commission released a research report on the value of the not for profit sector which recognised the complexity and value of its contribution to people's lives and the Australia community in general <https://www.pc.gov.au/inquiries/completed/not-for-profit/report> . So it is



surprising that this Productivity Commission report seems not to understand the importance of psych social support in people's lives in relation to mental health.

Research from overseas shows that where people have personal budgets they spend very little on clinical interventions, instead would purchase gym memberships, education and related local community related activities that help them live a normal life in the community. In between their 30 minute monthly appointment with their psychiatrist or case manager, they have a life to live and psychosocial support assists them to lead that life.

#### **4.The assumption that current dominant research approaches in mental health and suicide prevention are genuinely informing future directions .**

The Productivity Commission report could benefit from accessing a broader research base which reveals more of the social contributors to understanding mental health difficulties, instead of relying on research which is deficit focussed and perpetuates an illness perspective rather than understanding the trauma basis of distress.

I mentioned earlier the need to more closely relate research with the lived experience. I want to spend some time looking at research which draws strong links between early trauma and distress in later life. I believe this research helps us understand why concentrating on risk assessment in suicide rather than understanding what has happened to people in their lives is not helping our current suicide prevention interventions.

1980s Vincent Felitti created a clinic for chronically obese patients at Kaiser Permanente hospital in San Diego.

He noticed a very high dropout rate almost exclusively limited to people who were losing weight successfully. In his review of one patient who had lost significant weight then put it back, he was told that the heightened interest in her by men after her weight loss triggered her action in putting weight back as she had a history of

sexual abuse. Further exploration with other patients revealed they were using obesity as a solution to deeper problems.

Along with others, Felitti led subsequent ace studies. Adverse childhood experiences are common. Across a population of approximately 17,000 health maintenance organisation members from southern California receiving physical examinations completed confidential surveys regarding their childhood experiences and current health status and behaviours. Almost two thirds of study participants reported at least one ace out of the ten aces queried. The following You tube provides a useful overview

<https://www.youtube.com/watch?v=-ns8ko9-ljU>

especially as it is provided from a health perspective.

### **Ace study measures**

physical abuse

sexual abuse

emotional abuse

Physical or emotional neglect

Exposure to domestic violence

Household substance abuse

Household mental illness

Parental separation or divorce

incarcerated household member

The ace score, a sum total of different categories of aces reported by participants, is used to assess cumulative childhood stress. As the number of aces increases so does the risk for a range of issues later in life .

### **Some of the consequences in later life**

Alcoholism and alcohol abuse

Chronic obstructive pulmonary disease

Depression

Fetal death

Health-related quality of life  
Illicit drug use  
Ischemic heart disease  
Liver disease  
Poor work performance  
Financial stress  
Risk for intimate partner violence  
Multiple sexual partners  
Sexually transmitted diseases  
Smoking  
Unintended pregnancies  
Early initiation of smoking  
Early initiation of sexual activity  
Adolescent pregnancy  
Risk for sexual violence  
Poor academic achievement  
And, finally, suicide attempts  
Understanding a person's lived experience involves understanding and listening to their level of distress.

The You Tube referred to above also talks about the insight the ACES study provides into suicide. There is much to learn from the ACES study which could improve the Productivity Commission outcomes for improving responses to mental health and improving the social and emotional wellbeing in the community.

There is an increasing amount of literature in mental health which reflects the voice of lived experience yet none of this research is evident in the Productivity Commission report. This is a major failing of the Productivity Commission particularly as one is aware that its final report is likely to have significant impact on government policy into the future.

The point I wish to make is that the Productivity Commission would need to cast its net wider around research if it is to truly reflect the voice of lived experience in its Final report.

Even simple consideration of the work at the University of Nottingham <http://www.researchintorecovery.com/> would vastly improve the Productivity Commission report. In addition to this, I think it is important for the Productivity Commission to acknowledge the economic value of co-production as co-production as a process will also support people with mental health issues in achieving a better quality of life in the community. I have included an attachment I prepared during the planning for Recovery Colleges in WA which comments on the economic value of co-production through reference to relevant state and commonwealth reports.

## **CONCLUSION**

I thank the Productivity Commission for this opportunity to make a submission. I hope there will be an increased focus by the Productivity Commission in broadening the basis on which it builds its final report and that this will include strengthening the perspective of the lived experience and an increased understanding of recovery and the role played by psychosocial support.

Joe Calleja

## ATTACHMENT

### THE ECONOMIC IMPORTANCE OF CO-PRODUCTION

The concept of Co-Production is explored in the 2008 paper *Co-production: A Manifesto for growing the core economy* which was produced by the New Economic Foundation, London, England.

They state:

“...The term ‘co-production’ was coined originally at the University of Indiana in the 1970s when Professor Elinor Ostrom was asked to explain to the Chicago police why the crime rate went up when the police came off the beat and into patrol cars.

She used the term as a way of explaining why the police need the community as much as the community need the police.

It was used again in the UK by Anna Coote and others at the Institute for Public Policy Research (IPPR) and the King’s Fund to explain why doctors need patients as much as patients need doctors and that, when that relationship is forgotten, both sides fail.

It was then developed and deepened by Professor Edgar Cahn, the Washington civil rights lawyer, who has written the foreword NEF’s manifesto for growing the core economy. He used it to explain how important neighbourhood level support systems are – families and communities – and how they can be rebuilt. Cahn recognised that this is economic activity, but in the broadest sense.

As far back as Aristotle, philosophers have understood that these critical family and community relationships were a second economy, originally called *oekonomika*. Economists have since demoted it by calling it the non-market economy. The environmental economist Neva Goodwin reversed the hierarchy by calling it the ‘core economy’. Co-production points to ways in which we can rebuild and reinvigorate this core economy and realise its potential.

NEF’s manifesto shows how public services can play a part in making it happen. nef’s manifesto charts the development of co-production, its growth in the UK, and sets out a ten point plan for what will be, in effect, the biggest revolution in social policy since William Beveridge introduced the welfare state...” <http://neweconomics.org/2008/07/co-production/>

In the following paragraphs, the linkage between co-production and current WA and commonwealth government policies will be outlined.

### RELATIONSHIP OF RECOVERY COLLEGES (INCLUDING CO-PRODUCTION) TO GOVERNMENT POLICY – WESTERN AUSTRALIA

#### Labor Election Platform

- **Recovery College.** This is referred to within the Health Platform. The Health policy also includes clear reference to developing health policies and services which is informed more fully by patient opinion.

- **Supporting Communities Policy.** The policy clearly outlines the need for greater integration and interaction between government and the community sector, including the importance of developing services which are informed by the people.
- **Multicultural interests.**  
The policy encourages and supports the development of culturally diverse community groups, especially new and emerging communities, and provide opportunities for inclusion and engagement across all sectors of society. Promote practical self-help initiatives and leadership by communities to resolve issues society, especially where communities may be more effective than government agencies and statutory bodies. Every effort should be made to involve community groups in the planning, administration and delivery of government services, including services which support settlement of migrants in Western Australia.
- **Aboriginal Health.**  
Facilitate research into and development of Aboriginal health and health related issues, and investigate the feasibility of establishing a College of Aboriginal Health.
- **LGBTI.**  
WA Labor will endorse the WA Labor Leader for taking overarching responsibility for ensuring the needs of LGBTIQ people are recognised and met as not one Minister has responsibility for ensuring the needs of LGBTIQ people are met and, therefore, all Ministers share responsibility in ensuring LGBTIQ community are supported in line with Labor's Enduring Values.

Establishing a Recovery College will contribute to the health and wellbeing of this vulnerable population group and will be part of the contribution made by the Minister for Health and Minister for Mental Health to the Premier's leadership on this issue.

### **WA Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025**

- This was released in December 2015. Chapter 13.3 *Recovery oriented practice in supporting the consumer voice* resonates with the establishment of a Recovery College and contributes to the rationale for the introduction of the Recovery College.

### **WA Mental Health Commission Suicide Prevention Plan 2020 “Together We Can Save Lives”**

- The plan emphasises the need for increased community awareness and local activity in education and support, which resonates with the aim of the Recovery College.

### **WA Men's Health and Wellbeing Policy**

- Recovery Colleges are more frequently used by women and have been found to be of assistance. They can play an important role in supporting men's health and wellbeing.

## **WA Women's Health Strategy,**

- The WA Mental Health Commission Literature Review on Recovery Colleges indicates that women are higher users of Recovery Colleges than men and recognise the benefits of access.

## **WA Aboriginal Health and Wellbeing Framework 2015-2030**

- The co-production approach of the Recovery College is highly compatible with the Aboriginal way of working.

## **Machinery of Government Review 2017**

- As outlined by the Public Service Commissioner: “The services provided to the community by the public sector are integral to the wellbeing and quality of life of all Western Australians. If we are to continue to meet community needs and expectations, the public sector will need to be collaborative, innovative, flexible and capable of adapting to change. In doing so, the sector must be robust and have leaders who champion, embrace and manage change.” (Structural Change Management Workforce Performance and Renewal Directorate, Public Sector Commission, Western Australia April 2017,(page 5)

## **Services Priority Review 2017**

- Emphasised the imperative to understand and account for the needs of WA citizens. Community expectations for genuine engagement with government were evident throughout the Panel’s consultation. Stakeholders consistently identified the need for better consultation, quality engagement and co-design of solutions to complex problems to deliver better outcomes. The Western Australian Council of Social Service, for instance, submitted that “effort is also needed to address structural and historical barriers to community engagement in public service decision-making processes and develop community capacity and trust.

## **Sustainable Health review (2018)**

- As the Sustainable Health Review Interim Report notes: *Unfortunately, while health costs have more than doubled, health outcomes in WA have not improved at the same rate. The system focus remains on treatment rather than keeping people healthy. Improvements have been made to reduce the time people spend in hospital but opportunities for more contemporary reform have not been fully embraced. Health remains more provider than patient focused, with WA losing its State leadership role in approaches that focus on keeping people healthy and supported in the community wherever possible.* (Sustainable Health Review Interim Report, Government of Western Australia, January 2018, page 2 )

The Recovery College has an important role to play in assisting with the health and wellbeing of persons in the community. Since the Interim Review has been released, there has been increased recognition between the health sector and the community services sector on the need for a stronger interface between the health and community sectors. A discussion is being facilitated between Health WA, Department of Communities and the NGO sector by the Australian College of Health Service Management, with the support of the WA Primary Health Association of WA (Primary Health Networks) culminating in a major forum of these parties in July 2018. Robyn

Kruk, Chair of the Sustainable Health Review, will be a key note speaker and will hear the issues emerging that will be of relevance to the SHR.. The importance of the role of Recovery Colleges is likely to be enhanced as such discussions bear fruit in the coming months.

### **Supporting Communities Forum 2018**

- The government has established a Supporting Communities Forum based on its Election Platform. The community services sector is a key government partner in delivery of services and a significant contributor to economic growth, employment and community wellbeing, particularly for vulnerable Western Australians. The Supporting Communities Forum's function is to support implementation of the State Government's Supporting Communities Policy. The Government is committed to working with the sector to maximise opportunities to deliver quality services, by building a relationship based on partnership, collaboration and mutual respect between both sectors. This work will also support the directions of the Machinery of Government reforms and the recommendations emerging from the Service Priority Review.
- The work is also likely to interface with the outcomes of the Sustainable Health Review and assist in building stronger links between health and the community sector, which will have flow on effects on the importance of the Recovery Colleges in supporting communities and improving health and wellbeing.

## **RELATIONSHIP TO COMMONWEALTH GOVERNMENT POLICY**

### **Person Centred funding Aged Care and Disability sectors**

- Commonwealth government funding in the disability and aged care sectors is increasingly focussed on the provision of personal budgets for the purchase of services. This emphasis on self-directed care is compatible with the notion of co-production which underpins the foundation of the Recovery College.

### **Productivity Commission reports NDIS (2014 & 2017)**

In arguing the case to establish the NDIS in 2011, the Productivity Commission recognised:

- a focus on individual needs and outcomes, allowing people with disabilities to reach their potential through funded supports and/or active interaction with the community. In many cases, this will include supporting individuals in understanding how to take advantage of choice and options Productivity Commission 2011, *Disability Care and Support: Executive Summary*, Report no. 54, Canberra. (Page 15)

Then in its review of NDIS in 2017 it noted:

- The NDIS is based on the premise that individuals' support needs are different, and that scheme participants should be able to exercise choice and control over the services and supports they receive. (Productivity Commission 2017, *National Disability Insurance Scheme (NDIS) Costs*, Study Report, Canberra. (Page 3)

Both of these comments reflect the basis on which the Recovery College are established.



## **Productivity Commission Inquiry into Human Services 2017**

Productivity Commission 2017, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*, states:

This inquiry is about finding ways to put the people who use human services at the heart of service provision. This matters because everyone will use human services in their lifetime and change is needed to enable people to have a stronger voice in shaping the services they receive, and who provides them.

A stronger focus on users, better service planning and improved coordination across services and levels of government is needed. Governments should focus on the capabilities and attributes of service providers when designing service arrangements and selecting providers — not simply the form of an organisation. Productivity Commission 2017, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*, Report No. 85, Canberra. (Page 2)

## **Fifth National Mental Health and Suicide Prevention Plan**

The commonwealth has released the Fifth Mental Health and National Suicide Prevention Plan and has stated its commitment :

- In achieving these outcomes, governments commit to the principle articulated in the National Mental Health Policy that acknowledges that consumers and carers have vital contributions to make and should be partners in planning and decision-making. Consumers and carers should be at the centre of, and enabled to take an active role in shaping, the way in which services are planned, delivered and evaluated. Governance and implementation of the Fifth Plan reflect the intent of the National Mental Health Policy regarding consumer and carer participation—that is, 'Nothing about us, without us'. The Fifth National Mental Health and Suicide Prevention Plan 2017 Commonwealth of Australia as represented by the Department of Health, Canberra.

This is set against the backdrop of the World Health Organisation statement *Preventing Suicide: A Global Imperative* which suggests

...“Indicated” strategies target specific vulnerable individuals with community support, follow-up for those leaving health-care facilities, education and training for health workers, and improved identification and management of mental and substance use disorders. Prevention can also be strengthened by encouraging protective factors such as strong personal relationships, a personal belief system and positive coping strategies... *Preventing Suicide: A Global Imperative* World Health Organization 2014 (page 8).