Submission to the Senate Community Affairs Committee Inquiry into Suicide in Australia

20 November 2009

Suicide is the leading cause of death for men and women under the age 34 years, the leading cause of death for males aged under the age of 44 years and costs our nation over $17 billion every year yet ….

Suicide is Preventable

A Joint Submission from Lifeline Australia, Suicide Prevention Australia, The Inspire Foundation, OzHelp Foundation, The Salvation Army, The Mental Health Council of Australia and the Brain and Mind Research Institute, University of Sydney.

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Abbreviations

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ASPAC	Australian Suicide Prevention Advisory Council
BTE	Bureau of Transport Economics
CBT	Cognitive behavioural therapy
DALY	Disability adjusted life year
DITRDLG	Department of Infrastructure, Transport, Regional Development and Local Government
DOH	Department of Health UK
DOHA	Department of Health and Ageing
DSM-IV	Diagnostic and Statistical Manual for Mental Disorders, fourth edition
DTSS	Direct Telephone Support Service
ED	Emergency Department
EI	Early Intervention
EPPIC	Early Psychosis Prevention and Intervention Centre
FEP	First Episode Psychosis
GP	General Practitioner
ICD-10	International Classification of Diseases, 10th Edition
KHL	Kids Help Line
LGBT	Lesbian, gay, bisexual and transgender
LIFE 1	LIFE: Living is for Everyone Framework 2000-2008
LIFE 2	LIFE: Living is for Everyone Framework 2008
NACSP	National Advisory Council on Suicide Prevention
NCIS	National Coroners Information System
NDS	National Drug Strategy
NGO	Non Government Organisation
NPV	Net Present Value
NRSS	National Road Safety Strategy 2001-10
NSPS	National Suicide Prevention Strategy
NSW	New South Wales
NT	Northern Territory
OATSIH	Office of Aboriginal and Torres Strait Islander Health
PTSD	Post traumatic stress disorder
QALY	Quality adjusted life year
Qld	Queensland
RCT	Randomised controlled trial
SA	South Australia
SPA	Suicide Prevention Australia
SPAC	Suicide Prevention Advisory Committee
SPMI	Severe and Persistent Mental Illness
Tas	Tasmania
ToR	Terms of Reference
YLL	Years of Life Lost due to premature mortality
YLD	Years of Life Lost due to disability
UK	United Kingdom
US	United States of America
Vic	Victoria
VSLY	Value of statistical life year
WHO	World Health Organisation
WA	Western Australia

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Executive Summary

The Terms of Reference for the Senate Inquiry into Suicide in Australia focus on the impact of suicide on the Australian community, including high risk groups, such as Indigenous youth and rural communities, and the effectiveness of the current national strategy and programs.

This Submission has been prepared by a group of leading national organisations involved in every aspect of suicide prevention: policy, advocacy, research, front line prevention, intervention and bereavement services. Collectively, the seven organisations who have partnered for this Submission have over 200 years of experience and knowledge. Another 45 organisations and 30 individuals have signed on as supporters of the Submission in a very short period of time.

We commend the Senate for establishing the first inquiry into suicide in Australia. This Submission represents a comprehensive analysis of the issues set out in the Inquiry's Terms of Reference and presents practical ways to reduce the terrible toll on the Australian community from suicide and suicidal behaviour.

The Personal, Social and Financial Costs of Suicide in Australia

Suicide, in this Submission, is defined as the intentional taking of one's own life. *Suicidal behaviour* is a broader term and includes self-inflicted and potentially injurious behaviours.

Suicidal behaviour covers: *suicidal ideation* (serious thoughts about taking one's life), suicide plans, suicide attempts and *completed suicide*. People who experience suicidal ideation and make suicide plans are at increased risk of suicide attempts, and people who experience all forms of suicidal thoughts and behaviours are at greater risk of completed suicide.

In simple language: We are spending just 91 cents per head on suicide prevention, while it conservatively costs $795 per person per year.

Suicide is a leading cause of death globally and in Australia. Official Australian statistics record approximately 1,800 suicide deaths per annum – of which approximately 75 percent are male. It is the leading cause of death for males aged under the age of 44 years, the leading cause of death for men and women under the age 34 years and is a notable cause of death in males over 75 years.

Deaths due to suicide significantly exceed fatalities from motor vehicle accidents and homicides combined.

The number of people who are affected by a suicide is substantially greater and many of those people who attempt suicide need hospitalisation to recover from the resultant injuries. In 2007, 31,509 Australians were admitted to hospital as a result of self-harm (AIHW, 2009).

Suicide and suicidal behaviour both bear substantial human, social and economic costs. It has been estimated that each suicide impacts directly on at least six other people (Corso et al, 2007; Maple et al, 2009). Presently there are no reliable estimates on the cost of suicide and self-harm to the Australian community. However, the Californian

Department of Mental Health (2008) estimated the combined cost of suicides and suicide attempts in that state in 2006 as $4.2 billion per year.

In this Submission, an estimate of the financial cost to Australia as a result of suicide and suicidal behaviour has been calculated at $17.5B (in 2007-08 dollars). This is approximately 1.3% of Gross Domestic Product (GDP), or $795 per person, per year.

Evidence suggests the personal and social costs of suicide in Australia are immediate, far-reaching and significant on families, workplaces and communities. Suicide and suicide attempts can cause not only immense distress to individuals, but also vicarious trauma among the wider community. Individuals in workplaces, for example, often witness and experience the impact of a suicide and are typically left at a loss, asking themselves "how to help", "why could I not see the warning signs" and "what they could have done/said to prevent the tragedy". Those close to the person who has completed suicide will often blame themselves for the decision of the individual to take their own life. The combination of grief, guilt and remorse can remain for years. The impact of a suicide attempt on first responders, such as police, ambulance and fire brigade, should also not be underestimated.

These responses frequently result in secondary losses for many individuals (for example, loss of confidence and self-esteem; loss of trust in their relationship with the deceased; and loss of social support networks and friends who may not be able to cope).

The responses to suicide are further complicated by community stigma[1] and perceptions of the act of suicide as a failure on the part of either the deceased (to cope) or the family (for not having intervened or prevented the suicide).

In rural and remote Indigenous areas, suicide deaths often spark clusters of suicides (Hunter et al., 2001). Suicide deaths, particularly by hanging, are frequently witnessed by many members of an Indigenous community. In some instances, high levels of exposure to both death and suicide have resulted in a de-sensitisation among members of Indigenous communities, where "suicide and self-harm behaviour becomes normal, and even expected (though by no means acceptable)" (Farrelly, 2008). These situations can often lead to the mounting problem of intergenerational transmissions of trauma and grief, and may result in the overuse of drugs and alcohol, incarceration, self-harm, seemingly reckless self-destructive behaviours and, in some cases, suicide.

Such examples clearly demonstrate the need for suicide prevention strategies to address risk at the community level, rather than just that of the individual.

The Accuracy of Suicide Reporting in Australia

The suicide literature shows a clear tension between two opposing views: those who believe that suicide is seriously under-reported, and that the data dilutes or even masks the extent and seriousness of the problem; and those who believe that despite under-reporting, enough is known to establish patterns, the dimensions of the phenomenon, risk factors, and therefore the basis for effective prevention programs (De Leo, 2007; Tatz, 2009).

1 Thornicroft et al (in press) defines stigma has having three components: a problem of knowledge, namely ignorance; a problem of negative attitudes, namely prejudice; and a problem of behaviour, namely discrimination, resulting in exclusion from social & economic participation.

In this Submission, it is argued that the first requirement for effective suicide prevention action is a sound baseline for measuring overall progress and the effectiveness of preventative measures.

Reliable studies now put the number of suicides in Australia for 2007 at around 2500 (Harrison et al, 2009; De Leo, et al in press). This is some 30-40% above the ABS data figures. Coupled with the present economic slowdown, the real number of suicides in Australia may be approaching 3000 deaths per annum, or over 8 deaths every day. It is important to note that during periods of lower economic activity with higher unemployment, higher bankruptcies and business failures, records show a 10-20% increase in suicides over economically prosperous periods (Morrell, et al, 1993).

The reasons for the significant underreporting are complex, but include stigma, religious beliefs and practices, the burden of proof for coroners, a lack of expert investigations and different reporting protocols across states and territories. A recent factor appears to be a decline in coronial reporting of deaths by suicide over the past decade. Family and relatives also often fear that reporting a death as suicide will jeopardise life insurance or other forms of financial compensation (De Leo, et al in press).

Suicide is an event with multiple interacting, often complex, contributing factors. One of the most common and significant contributing factors is mental illness. The results of the ABS National Survey of Mental Health and Wellbeing shows that people with a mental illness are much more likely to have serious suicidal thoughts than other people. Suicidal ideation has a 12-month prevalence of 2.3 percent (or 370,000 adults) and an estimated 91,000 adult Australians make a suicide plan in a 12-month period. A staggering 65,000 Australians attempt suicide each year – this is equivalent to 178 people every day of the year (ABS, 2008).

Data for suicide within some sub-populations is particularly inaccurate – e.g. Indigenous Australians and the gay, lesbian, bisexual and transgender communities.

The underreporting of suicides presents two major problems for policy makers. First, it means we have no way of monitoring, with any confidence, that policy and program initiatives are having the intended effect.

Second, it is highly unlikely that underreporting is really an issue across all population sub-groups. This means that we may be directing the already meagre resources for suicide prevention away from high risk groups in the community.

In an attempt to address the problem of under-reporting, the ABS will begin progressive, restorative work on 2007, 2006 and 2005 suicide data, with the first planned re-release of 2007 data in March 2010. However, delayed case closure from coroners is expected to prevent final counts (and full benefit) for several years. Newly-adopted ABS coding practices may also require evaluation.

In addition to the major problem of undercounting of deaths by suicide, another potentially (but just as significant) contributor to poor policy and program design, is the lack of information in death records on some characteristics of people dying by suicide (De Leo et al. 2009, National Committee for the Standardised Reporting on Suicide).

The Appropriate Role and Effectiveness of Agencies

As is outlined later, there is no actual *national* suicide prevention strategy. It is not a national strategy in the way that other national strategies are formal agreements signed by all Australian governments and, in some cases, by community or industry stakeholders. The current strategy, which carries that name, is the strategy of the Commonwealth Department of Health and Ageing.

In the absence of a clear national strategy, it is unsurprising that roles, responsibilities and accountabilities are poorly defined. Further, unlike in other cross-jurisdictional and cross-portfolio issues, there is no agency at a national or state/territory level with the mandate to address suicide and suicide prevention. This is in stark contrast to the infrastructure, clear strategy with targets and regular public reporting on progress and investment in road safety, which has a lower number of deaths (notwithstanding the underreporting problem with suicide data).

At present, responsibility for suicide is distributed as follows:

- Mortality data collection – this is distributed across an array of organisations.
- Morbidity data – the Australian Institute of Health and Welfare and the Injury Surveillance Unit at Flinders University.
- Funding for program initiatives – a person or small group of public servants within health departments in the Commonwealth Government and in some State and Territory governments. These staff are generally located within the Mental Health Branches. They generally provide small scale grants and the few national initiatives receive little funding.
- Research – some health departments program occasional grants for 'research'. Other funds are provided on a competitive basis from the usual national funding sources. Annual funding would be less than $10m, on the available evidence.
- Services – crisis lines, support services, prevention, intervention and bereavement activities are carried out by a range of NGOs – many are parties to or supporters of this Submission.
- Advocacy – Suicide Prevention Australia.
- Self-help groups and other support groups – small networks of community groups.

A new governance and accountability structure for suicide prevention in Australia is now necessary. The key reasons for this are:

- Engaging a wide coalition of stakeholders across the Australian community – not just a whole-of-government approach, but a whole-of-community approach.
- There is a need to broaden the funding base from non-government sources - that is, from community, philanthropic, unions and other collectives and business sources – to supplement the contributions made by governments.
- There is a need and opportunity to provide greater ownership, engagement, transparency and accountability for and to the Australian community, as well as assisting the community to understand clearly where they need to go to get the services they need or to financially support this crucial social issue.

Currently, there are major reforms of the health system being canvassed in the Australian community. The Rudd Government is placing increased emphasis on the need to re-balance our health system, with a greater focus on prevention and early intervention. New financing mechanisms, new structures and governance arrangements are being canvassed.

In relation to suicide prevention, the parties to this Submission believe new structures need to be developed or re-positioned for:

- Raising and distributing funding – from across the community from a wide variety of sources;
- Structures for governance and accountability need to be established – potentially independent of government and service agencies; and
- Service delivery, capacity building, community awareness and education and advocacy need to be appropriately resourced and not reliant on ad hoc funding arrangements.

The Effectiveness of Public Awareness Campaigns

Members of the general public, and especially people with severe and persistent mental illness (SPMI) and their families, are unaware of suicide's toll on society and the heightened risk of suicide carried by many individuals with SPMI. Increasing awareness of suicide among individuals with SPMI and their families and reducing the social stigma, shame and humiliation associated with having mental illness are key elements of comprehensive suicide prevention.

Australia's only social marketing efforts in relation to addressing stigma toward mental illness occurred some 15 years ago and were sustained for just three years. Other than the efforts of service providers, such as Lifeline Australia to promote helplines or crisis services, there have not been mass, social marketing campaigns to address community knowledge, beliefs in relation to suicide, suicidal behaviour or suicide prevention at any time.

In November 2009, Lifeline Australia commissioned a national *Newspoll* Omnibus Survey to gain some further insights regarding public attitudes towards suicide and strategies for prevention. The *Newspoll* Omnibus surveyed 1,203 respondents aged 18 years and over, from across Australia. Only preliminary data was available at the time of preparing this Submission. Just under two-thirds of respondents (64%) indicated that suicide in Australia is 'mostly preventable'. More alarmingly, one quarter (26%) indicated that suicide is 'mostly not preventable', with 10% undecided.

The parties to this Submission, hold a strong belief that suicide is preventable. This is supported by a strong evidence base that access to crisis support, intervention and education through social marketing and direct programs contribute significantly to preventing suicide. This research demonstrates that one-quarter of the population are poorly informed, and that there is room for improvement with the use of community-wide education around suicide and suicide awareness campaigns.

The *Newspoll* research showed that a low proportion of respondents believe that those who were suicidal would tell someone about it (23%). Seventy percent of respondents

generally doubted that a person who had considered suicide would tell someone else about it. This finding was consistent across most demographic groups.

This again, shows the investment that needs to be made in suicide awareness education and campaigns within Australia. A significant segment of the community are unable to talk about suicide or suicidality. It could also be argued that many respondents are not empowered to 'read-the-signs' of someone who is suicidal and trying to communicate their sense of hopelessness.

The Efficacy of Suicide Prevention Training and Support

An approach that has been shown to reduce suicide rates is suicide prevention and intervention training and education for frontline workers or "gatekeepers" (e.g. emergency workers, health care workers, GPs, etc). "Gatekeepers" are those individuals who respond to, deal with or witness suicide incidents or attempts or who deal with people who are suicidal and who may have the potential to prevent suicide.

As information and communication technology (ICT) plays a central role in the lives of young people, it follows that building the capacity of health care professionals to utilise ICT in their practice could provide a powerful compliment to face-to-face interventions. Recognising the significant role technology plays in the lives of young people, Inspire Foundation's *Reach Out Pro* provides access and advice for health care professionals on a range of technologies and online resources that can be used to enhance the effectiveness of the psychosocial support and mental health care provided to young people.

Reach Out Pro encourages health care professionals to become acquainted with new technologies and their significance to young people and to integrate the use of technology into their practice to better meet the needs of young people and ultimately improve mental health outcomes. *Reach Out Pro* is closely linked to *ReachOut.com* to help provide young people with access to an online community and trusted information and advice.

There are also a number of models, with emerging supportive evidence, currently available to work with employers and employees to better understand how to recognise the signs of risk, to provide valuable support and to provide valuable guidance in health and help seeking actions.

Most people who die by suicide or attempt suicide have contact with a primary health care professional in the weeks or months prior to the event. Better training is one suicide prevention strategy with a supportive evidence base. Routine screening for suicide risk at all primary health care appointments for those individuals who exhibit known risk factors (such as depression or substance abuse) can be effective in reducing suicide and suicidal behaviour.

Suicide risk often goes undetected, even though individuals at heightened risk for suicide frequently seek and receive medical care in primary care settings. Screening of persons with depression and substance abuse in primary care settings can identify individuals at elevated risk for suicide and expedite their referral for definitive evaluation and treatment.

In relation to the training of mental health professionals, particularly those in acute care settings, there is clear evidence that a significant time lag exists in the uptake of evidence-based practices in mental health care. Australia performs poorly in a number of areas of care, including the continued use of restraint and seclusion.

The Role of Targeted Services and Programs

Despite numerous nations across the world having specific suicide prevention strategies (including Australia) and many decades of research and investigation into the complex range of causes of suicidal behaviour, there is still limited high-quality, defensible evidence regarding the most effective and efficient approaches for preventing suicide.

Those approaches that have shown some good or promising results include:

- Reducing access to lethal means
- Gatekeeper training (see above)
- Accessible and effective treatments for people with mental illness
- Pathways to and from primary and specialist health care
- Appropriate use of anti-depressant medication, with better results when used in combination with applied psychological therapies
- Social networks and caregiving to families
- Media guidelines and reporting protocols
- Bereavement support and assertive postvention services
- Crisis centres
- Telephone counselling services
- Call-back and postcard follow-up services for following up people at risk.

Telephone helplines or crisis-lines have been in existence for nearly 50 years in Australia and should be regarded as essential service infrastructure in suicide prevention. The value and evidence to support investment in these services is very sound. Clear evidence regarding the efficacy of new technologies for services and some treatments is also now available. Australia's population distribution, difficulties in accessing mainstream services and workforce shortages make an investment in online, telephone and other communications technologies an obvious choice for Australia. Education of the Australian community to increase the acceptance and utilisation of online services and products should also be considered.

Chapter 4 of this Submission contains a detailed discussion of the services and programs available.

The Adequacy of Current Programs of Research

The causes of suicide are complex and vary among individuals and across age, cultural, racial and ethnic groups. Suicide risk is influenced by an array of factors – sociological, psychological, environmental, cultural and biological. Nonetheless, this complexity masks the reality that almost all people who attempt or complete suicide had one or more warnings signs before their death. This complexity, if we are to better target our suicide prevention efforts, requires a sustained, strategic and transparent program of investment in research.

While the body of international literature is developing and we know a good deal about the nature of suicide and suicidal behaviour, there are vast gaps in our knowledge. These are summarised in Table 1 at the end of this Executive Summary.

There is an urgent need for the continued development of well-planned, evidence-based programs and research evaluating their effectiveness in Australia (Mann et al, 2005; Beautrais et al, 2007; Gunnell & Frankel, 1994).

Suicide prevention initiatives should be multi-modal and complementary, targeting a wide range of high risk groups. The diverse approach to suicide prevention is essential, because there is no single, readily identifiable, high risk population that constitutes a sizeable proportion of overall suicides and yet is small enough to easily target and have an effect (Gunnell & Frankel, 1994).

There is a need to strike a balance between universal, selective and indicated suicide prevention activities, as initiatives in Australia have typically focussed on broad, population-based methods and have somewhat neglected more targeted approaches that are specifically designed for known high-risk groups (e.g. people who have previously attempted suicide, Indigenous populations, rural/remote communities). It is, therefore, important that resources be allocated to a variety of suicide prevention activities across Australia.

There needs to be a coordinated and standardised approach for evaluating the effectiveness, efficiency, cost-effectiveness and sustainability of suicide prevention activities. This includes easy-to-understand guidelines for developing and implementing evaluation frameworks, outlining standardised outcome measures that are dependent upon the program's goals and objectives (e.g. actual suicide rates/numbers, suicide ideation, suicide attempts, incidence of mental illness, protective factors) and methods of measurement and assessment.

There also needs to be adequate funding and resources to conduct high-quality, independent evaluations of suicide prevention activities, so that our understanding and knowledge of effective methods is enhanced and builds upon existing knowledge. Evidence-based evaluations are one of the keys to developing and implementing suicide prevention activities that result in a demonstrable reduction in suicide rates and effectively decreasing the incidence of this tragic, and yet preventable, loss of life.

The Effectiveness of the National Suicide Prevention Strategy

In one sense, there is no need to establish an economic case for investment in suicide prevention. This is for two reasons: 1) the recent report of the Preventative Health Taskforce sets out a compelling case for investment in health promotion and preventative (ill) health initiatives and 2) the economic and social impact of suicide and suicidal behaviour is of such a magnitude.

Estimates of the savings to be made from sound investments in suicide prevention, crisis interventions and postvention services and strategies have not been conducted in Australia. Access Economics (2008) has prepared a report estimating the net savings from investment in services to provide evidence-based services for early psychosis. The methodology has relevance to the question of estimating savings to the community for investments in suicide prevention strategies. Such evidence can help inform decisions by policy makers as to where the greatest potential gain can be achieved through

investment in suicide prevention. Detailed estimates of cost components can also provide useful input to a cost-effectiveness analysis of a proposed specific intervention and its subsequent evaluation (O'Dea & Tucker, 2005).

In this Submission, we argue that a transformation of the National Suicide Prevention Strategy, the funding, governance and accountability is urgently required to begin to effectively address with issue and reduce the impact on the Australian community.

Table 1: A summary of "what we know" and "what we don't know" in relation to suicide and self-harm in Australia

What We Know	What We Don't Know
The level of direct funding for national suicide prevention is less than $1 per person per annum.	The actual number of suicide deaths in Australia. But, we do know more people die through suicide than through road accidents, skin cancer and it is many times more common than homicide.
The predisposing risk factors, warning signs and precipitating events associated with suicide and self harm.	The constellations of risk factors that are most likely to lead to suicide and how we use our understanding of risk and protective factors to actually identify those at risk and prevent suicide
The vast majority of people who attempt or complete suicide either have contact with health services or tell someone about their intentions prior to their attempt (warning signs).	The economic cost of suicide and self harm – in terms of health care and lost productivity for the individual concerned. A conservative estimate based on recent modelling in road safety and overseas would be $17.5B per annum.
Prevalence of mental illness in the community.	
Although many people who attempt/complete suicide may have been thinking about suicide (either vaguely or clearly) for some time, the vast majority make the decision to suicide and develop a clear plan within hours or even minutes of their attempt.	The role stigma plays in discouraging help-seeking behaviour and problem solving for those at risk of suicide and self-harm.
Substance abuse (including alcohol consumption) can be both a risk factor and a precipitant of suicide - i.e. gives an individual the courage to attempt suicide and/or may be seen to reduce the potential pain that may be caused by the attempt.	The economic cost of grief resulting from suicide and self-harm - in terms of health care and lost productivity.
The number of Australians with mental illness not accessing any service or care.	The personal (health and wellbeing) and social cost of suicide and self-harm on those bereaved.
"Gatekeeper training" for front line workers in suicide prevention and assistance – e.g. Police, Emergency Services, GPs.	The role that mental illness plays in the high rates of suicide among Indigenous Australians.
Reducing access to lethal means is an effective preventative strategy.	What effect, if any, has resulted from the NSPS over the past decade on suicide and self-harm rates/patterns.
Access to evidence-based pharmacological (SSRIs, SSNRIs et al) and psychological treatments (CBT, DBT, life skills etc).	The extent to which media reporting, internet promotion of suicide and cyber-bullying impact on suicidal behaviour.
Follow up contact with people who are in crisis or previously attempted suicide or have been in-patients at an acute MH service.	The quality of care – including continuity of care – provided by acute care mental health units.
Media guidelines for responsible reporting.	

Ten Priority Recommendations

The full description and rationale for these priority recommendations are contained in the Full Set of Recommendations, which follows.

Recommendation 1.1 The Australian Government should commission an independent review of the National Suicide Prevention Strategy (NSPS) and LIFE Framework and LIFE Communications program.

Recommendation 1.2. The Australian Government should work with all stakeholders to develop a National Suicide Prevention Strategy. The Strategy should be signed off by all Australian governments and endorsed by community stakeholders.

Recommendation 1.3. The Australian Government must significantly increase funding for suicide prevention services, research, infrastructure and monitoring and should significantly increase its efforts to advance suicide prevention across portfolios and agencies.

Recommendation 1.5. For all governments, community organisations and the Australian population, significantly greater efforts are needed in response to childhood neglect, abuse, loss and trauma to reduce the likelihood of the development of psychological problems and suicide. This relates, in particular, to government policy in early childhood development, child protection and family support.

Recommendation 2.1. The transformation of the existing (mental) health care system away from delivery focused on episodic care in response to acute illness to a more comprehensive system of care focused on prevention and early intervention and designed to meet the holistic and long-term needs of consumers.

Recommendation 2.3. The Australian Government should provide adequate funding for community education and social marketing programs across the Australian community and for at-risk populations. Objectives should include eliminating stigma associated with mental illness, care seeking and recovery from a suicide attempt. A national budget of $10m per annum for at least five years will be required to have a significant and sustained impact on community attitudes and behaviours.

Recommendation 2.5. The development of online communication and the greater use of other new information technologies to greatly enhance timely access across the spectrum of interventions and support services for all Australians, but particularly those in regional, rural and remote Australia.

Recommendation 3.1. A new governance and accountability structure for suicide prevention must be established in Australia to enable a truly national suicide prevention strategy to develop and engage a wide coalition of stakeholders. These responsibilities may be best managed through a number of strategically aligned organisations – a new national coordination body; a peak advocacy body; a national suicide prevention council and resource centre; and a national foundation.

Recommendation 3.2. That investment is made to enable the independent, transparent capture of data to inform decision-makers and the general community about our progress in addressing suicide. Key data elements would combine as part of a Suicide Accountability Framework to enable regular public reporting, contributing to increasing public understanding and diminishing stigma.

Full Set of Recommendations

1. National Policy

Recommendation 1.1 - The Australian Government should commission an independent review of the National Suicide Prevention Strategy (NSPS) and LIFE Framework and LIFE Communications program.

Rationale: The only evaluation of the NSPS took place in 2005. Regrettably, the evaluation report was not released at the time of the redevelopment of the NSPS in 2006-8. Furthermore, there is clear evidence of a continuing high rate of suicide and suicidal behaviour across the Australian community and a lack of evidence to support the current approach.

Recommendation 1.2 - The Australian Government should work with all stakeholders to develop a National Suicide Prevention Strategy. The Strategy should be signed off by all Australian governments and endorsed by community stakeholders.

Rationale: Since its inception, the NSPS has been a Strategy developed by and deployed through the Department of Health and Ageing. It is neither a whole-of-government strategy for the Commonwealth Government, nor a strategy for all Australian governments. Unlike the National Mental Health Plan or the National Road Safety Plan, no other government or party is a signatory. Further, the LIFE Framework is a proxy for the NSPS. It is not a government strategy or policy document.

Recommendation 1.3 – The Australian Government must significantly increase funding for suicide prevention services, research, infrastructure and monitoring and should significantly increase its efforts to advance suicide prevention across portfolios and agencies.

Rationale: Commonwealth Government funding for suicide prevention and research is just over $20m per annum at present, or 91 cents per person. This is disproportionately low when compared to other serious public health threats and social problems. The economic costs to the community are conservatively estimated to be $17.5B per annum.

Increased public funding, and encouraging private-sector and community funding, is necessary to reduce the social, emotional and economic damage done to our community from suicide and suicidal behaviours.

Recommendation 1.4 - Ensure that funding for programs provided under the National Suicide Prevention Strategy and other State and Territory initiatives is recurrent, in order that national and local programs may be adequately coordinated and evaluated and their results be widely disseminated. Successful programs must be replicated nationally.

Rationale: Small one-off, short-term grants have dominated suicide prevention funding in Australia. The results are too small to measure and unsustainable. Five and ten year funding allocations are required to enable program goals to be realised, quality staff to be attracted and retained and evaluations to be worthwhile investments.

Recommendation 1.5 - For all governments, community organisations and the Australian population, significantly greater efforts are needed in response to childhood neglect, abuse, loss and trauma, to reduce the likelihood of the development of psychological problems and suicide. This relates, in particular, to government policy in early childhood development, child protection and family support.

Rationale: The evidence linking exposure in childhood to violence, trauma, abuse and neglect with mental illnesses, self-harm, suicide and a range of other health-compromising behaviours in later life is increasingly compelling. With over 50,000 new cases of serious childhood abuse reported each year in Australia, much more needs to be done to address not only the immediate safety of the child, but the impact of such experiences to minimise the risk of health-compromising behaviours in adolescence and adulthood.

Recommendation 1.6 – Reintroduce universal participation in physical fitness in schools through avenues, such as the National Goals for Schooling agreed to by all Australian governments and the Australian Sports Commission's programs to increase sport participation. In addition, a study to examine the status of religious and/or spiritual studies in Australian schools and the value of a spiritual education should be undertaken and the results prepared for all Education Ministers to consider in the context of the National Curriculum.

Rationale: Within the current National Goals for Schooling and the relevant key performance indicators, there are no agreed KPIs for students in relation to physical health and wellbeing. This is despite abundant evidence on the value of daily physical education for child and adolescent development and the 'protective value' of participation in physical activity. Programs must emphasise participation, enjoyment and develop skills for lifelong physical activity. This is consistent with the recommendations from the Crawford report (2009). The general protective value of spirituality in relation to mental health and suicide prevention has been established in a large majority of studies.

Recommendation 1.7. Review national policy on alcohol and drugs, including comprehensive examination of the possibility of raising the legal age of first drinking.

Rationale: This is proposed in light of emerging knowledge about the early neurodevelopmental effects on children and youth of exposure to alcohol and drugs, and overwhelming evidence of the risks of suicide attempt and suicide associated with drugs and alcohol in particular.

2. Program Development

Recommendation 2.1 - The transformation of the existing (mental) health care system away from delivery focused on episodic care in response to acute illness to a more comprehensive system of care focused on prevention and early intervention and designed to meet the holistic and long-term needs of consumers.

Rationale: Independent reports continue to point to the failure of the public mental health services across Australia to re-orient toward prevention and early intervention. Crisis and poor quality care remain the national benchmark. Whilst

this remains the case, too many suicides will arise from the inaccessibility and quality of public mental health services (estimated to be a third of all suicides).

Recommendation 2.2 - Investment in stepped care services across Australia to minimise the likelihood of hospitalisation for mental illness and to ensure all consumers discharged from acute care have access to appropriate and effective support.

Rationale: Persons with severe and persistent mental illness (SPMI) carry a significantly elevated risk for suicidal behaviours. Stepped care with active management of clients, has been shown to reduce suicide risk. All acute care mental health services have an obligation to people with SPMI, to provide safe transition of clients and are ideally positioned to lead suicide prevention efforts for this sub-population. Access to effective mental health services for people with SPMI can prevent substantial morbidity and mortality associated with fatal and non-fatal suicidal behaviours.

Recommendation 2.3 - The Australian Government should provide adequate funding for community education and social marketing programs across the Australian community and for at-risk populations. Objectives should include eliminating stigma associated with mental illness, care seeking, and recovery from a suicide attempt. A national budget of $10m per annum for at least five years will be required to have a significant and sustained impact on community attitudes and behaviours.

Rationale: Members of the general public, and especially people with severe and persistent mental illness (SPMI) and their families, are unaware of suicide's toll on society and the heightened risk of suicide carried by many individuals with SPMI. Increasing awareness of suicide among individuals with SPMI and their families and reducing the social stigma, shame and humiliation associated with having mental illness are key elements of comprehensive suicide prevention.

Recommendation 2.4 .The Australian Government, in collaboration with the State/Territory governments and the Local Government Association of Australia (LGAA), should develop and implement strategies to reduce access to lethal means of suicide. A national program, similar to the national "Black Spot" road safety program, should be developed and coordinated nationally. Funding and resources from the three-tiers of government would be involved.

Rationale: The removal of lethal means is an effective and established means to reducing suicide. Individuals who have access to lethal means of suicide have higher rates of suicide.

Recommendation 2.5 – The development of online services and the greater use of telephone, video conferencing and other new information technologies to greatly enhance timely access across the spectrum of interventions and support services for all Australians, but particularly those in regional, rural and remote Australia. This includes:

2.5.1 Telephone help lines, SMS messaging services, online communication and new technology platforms must be gazetted by the Federal Telecommunications Minister as essential services and, therefore, be provided at no cost to the caller or user.

2.5.2 This must be matched by a commitment from government to collaborate with telecommunications service providers to improve parity of access to cost-competitive broadband internet networks and infrastructure across rural and remote areas of Australia to support access to information and interactive therapeutic services.

Rationale: Telephone helplines or crisis-lines have been in existence for nearly 50 years in Australia and should be regarded as essential service infrastructure in suicide prevention. The value and evidence to support investment in these services is very sound. Clear evidence regarding the efficacy of new technologies for services and some treatments is also now available. Australia's population distribution, difficulties in accessing mainstream services and workforce shortages make an investment in online, telephone and other communications technologies an obvious choice for Australia. Education of the Australian community to increase the acceptance and utilisation of online services and products should also be considered.

3. Governance and Accountability

In relation to Infrastructure

Recommendation 3.1 – A new governance and accountability structure for suicide prevention must be established in Australia to enable a truly *national* suicide prevention strategy to develop and engage a wide coalition of stakeholders, raise community awareness and undertake education, attract significant government, non-government and community investment and build the capacity of services to reduce the burden of suicide and self-harm in the community. These responsibilities may be best managed through a number of strategically aligned organisations – a new national coordination body; a peak advocacy body; a national suicide prevention council and resource centre; and a national foundation

Rationale: The rationale for this recommendation is:

- Suicide and self harm remain unacceptably prevalent in the Australian community, with the number of suicide deaths significantly higher than the national road fatality rate. The damage to individuals, families and communities is immeasurable. Suicide remains, largely, "a hidden epidemic" in public health terms.
- Suicide, the prevention of suicide and support for the bereaved and attempt survivors, are becoming increasingly important to the Australian community. Media coverage of a number of high profile cases involving prominent and 'successful' Australians have highlighted the complexities, the need to find answers and the need to respond.
- The bureaucracy, specifically health, has been largely responsible for the efforts to date on suicide prevention and related issues. Regular changes in personnel, machinery of government and policy frameworks have impeded progress and outcomes. Health Departments have limitations in being able to provide the leadership for a whole-of-government issue (like suicide prevention) and bring about the structural and broader societal changes necessary to tackle complex issues like suicide and they are limited in their ability to implement whole-of-community programs. To expect them to do so

is beyond the scope of their responsibilities and that of their respective Ministers.

- Suicide is not (only) a health issue. It is a complex social problem with many risk factors and triggers – some which are understood and many which are not. There are a number of sectors – private, public and community – with an interest in suicide and suicide prevention. These include large corporations with employee populations with higher than average rates of suicide; public sector agencies with an interest in sustaining rural and regional Australia, transport, community and education; superannuation trusts and their insurers; Indigenous communities and community organisations providing housing and employment programs and so on. All these organisations are stakeholders in reducing suicide and they need to have appropriate structures to link with, contribute ideas and resources and measure progress.

In relation to Data

Recommendation 3.2 - That investment is made to enable the independent, transparent capture of data to inform decision-makers and the general community about our progress in addressing suicide. Key data elements would combine as part of a Suicide Accountability Framework to enable regular public reporting, contributing to increasing public understanding and diminishing stigma. A list of the initial items to be collected as part of this framework appears in Chapter 7 of this Submission.

Rationale: Regular monitoring and reporting on progress to reducing suicide and suicidal behaviour is critical. This has been demonstrated in road safety and elsewhere.

Recommendation 3.3 - Improve the national coronial database by inviting interdisciplinary and cross-agency collaboration (including those with lived experience), with a view to incorporating a broad range of mental health and socio-cultural factors which are currently not investigated. (e.g. separation from family and children and its linkage to male suicide cases).

Rationale: A National Committee for the Standardised Reporting of Suicide could provide oversight and direction of this initiative, in consultation with the named groups, the Mortality Reference Group (subcommittee) of WHO and all other involved parties[2].

Recommendation 3.4 - That standard definitions be developed and deployed in all Australian jurisdictions.

Rationale: A key goal is to devise a standard classification that all parties use in order to classify a death as suicide. Information inputs need to be improved and standardised, as do methods for classifying a death as suicide. There is a need for more primary data on suicide indicators from a range of sources – for example, police reports, forensic pathologist reports, general practitioners and psychological autopsies – to assist in determinations. As well as improved data inputs, cross-jurisdictional agreement on standard and operationalised criteria

2 A list of the membership of the National Committee for the Standardised Reporting of Suicide is contained in Appendix 4.

and reporting formats for suicide could improve the accuracy of coronial determinations.

The use by police, National Coroners' Information System and the Australian Bureau of Statistics of more detailed, consistent and accurate collection and coding methods will also enhance data quality. This has, in part, been foreshadowed by these organisations. For example, ABS announced in March 2009, the inception of a policy to update the cause of death based on the arrival of new information from 2007 data onwards.

Recommendation. 3.5 - That funding be provided for a comprehensive national review of all suicides for an adequate time period (viz. three years).

Rationale: This would aim to determine individual, social and service-related factors in a diversity of cultural groups, with a particular view to identifying modifiable, systemic risk factors.

Recommendation. 3.6 - Education and training, leadership and potentially cultural change within organisations will be necessary for change in reporting to occur.

Rationale: Changing systems is the first step. Investment and leadership commitment to cultural change is equally necessary.

Recommendation 3.7 - Specific programs to support coroners and those recently bereaved by suicide, and to overcome stigma in relation to suicide will also be important. Specific consultations and procedural changes may have to occur to ensure the effective identification of Indigenous suicides.

Rationale: All this will require monitoring over some years. For example, the Queensland State Coroner has employed coronial directives, with the aim of attaining standard practice around this issue. It is unclear at this point how effective this may be.

Recommendation 3.8 - The development of a Diploma in Coronial Studies in Australia and a requirement for all Coroners and Assistants to undertake this program over the next ten years.

Rationale: The development of professionals for an increasingly specialist role is required.

In relation to research

Recommendation 3. 9 - Significantly increased investment in suicide and suicide prevention research and evaluation. This should include:

i. **An independent monitoring and evaluation program for the National Suicide Prevention Strategy;**
ii. **A national suicide prevention research strategy involving stakeholders from all relevant areas, including those in the superannuation and insurance industries;**
iii. **Quantifying the impact and cost of suicide and self-harm on the Australian community;**

iv. **Understanding and identifying those intervention components that result in enhanced outcomes. Consideration should also be given to the outcome measures indicative of risk and protective factors for suicidal behaviour included in clinical studies;**

v. **Examining the impact of psychosocial risk factors as they relate to mental illness and suicide, including issues such as religious and/or cultural beliefs and suicidal people's experience of stress due to negative life events; the effects of social stigma on help-seeking among those with mental illness; greater understanding of the influence of the internet on suicidal behaviour, and greater encouragement and promotion of its potential to deliver beneficial effects; the consistency and accuracy of media reporting of mental illness and suicide; the extent to which media reporting influences community attitudes towards mental illness and suicide; and factors likely to protect against the development of mental illness and suicidal behaviours—for example, coping skills, problem-solving capabilities, and social support, inclusion and community connectedness;**

vi. **A better balance in research funding with greater emphasis on mixed methods (qualitative and quantitative approaches), in-depth research methods for social issues (such as case study, longitudinal studies, ethnography etc), and cultural studies (gender, transgender, inter-generational etc);**

vii. **An evaluation and review of suicide deaths and suicide attempts by persons refused admission, whilst in psychiatric care and following hospital discharge in order to identify potentially modifiable risk factors and assess the effectiveness of current and proposed interventions;**

viii. **Evaluation of general hospital services for patients who present with deliberate self-harm, including improved recording of self-harm presentations; and**

ix. **More comprehensive and integrated data to ascertain client outcomes and consumer satisfaction in a range of health care settings.**

Recommendation 3.10 - Provide a central clearing house for the dissemination of current and new initiatives, programs and research relevant to suicide prevention.

Rationale: To enhance the dissemination of new knowledge and the promotion of evidence for policy, service development and skilling purposes.

4. Service Development

Recommendation 4.1 Through the Department of Education, Employment and Workplace Relations (DEEWR), the Australian Government can promote and support workplace-based programs for promoting health and wellbeing among all employees, as well as responding to employees who may be at risk. Employer organisations and employers need to recognise that occupational health and safety, duty of care and social obligations making it incumbent upon them to adopt positive steps to ensure an informed and healthy workplace.

Rationale: There are a number of models, with emerging supportive evidence, currently available to work with employers and employees to better understand how to recognise the signs of risk, to provide valuable support and to provide valuable guidance in health and help seeking actions.

Recommendation 4.2 - Develop accredited and fully evaluated training programs for front line staff in a range of settings (e.g. workplaces, Child Support Agency, Centrelink, Australian Defence Force, child sexual assault services, sports organisations, Corrections facilities and Police) to better enable staff to identify and support those who are vulnerable or at risk.

Rationale: Front line staff in these settings often deal with Australians in crisis or distress. Their skills in responding to a crisis may be the best line of defence when a person has moved to imminent risk of suicide or self-harm.

In relation to Mental Health Services

Recommendation 4.3 - The public mental health system should support and collaborate with crisis hotlines to ensure individuals at risk for suicide, including those who have made a suicide attempt, can readily access high quality crisis support services.

Rationale: Individuals with SPMI, who are also at heightened risk for suicide, can benefit from a robust continuum of care that extends beyond the boundaries of the traditional health and mental health care systems. For example, crisis hotlines provide relatively low-cost, effective services to individuals seriously contemplating suicide and are available to all regardless of geographical barriers, appointment availability, or ability to pay.

Recommendation 4.4 - Implement strategies to improve training of mental health professionals in evidence-based treatments that reduce rates of suicidal behaviours among the mentally ill.

Rationale: There is abundant evidence that a significant time lag exists in the uptake of evidence-based practices in mental health care. Australia performs poorly in a number of areas of care, including the continued use of restraint and seclusion.

Recommendation 4.5 - The elimination of forced seclusion and restraint in all acute care mental health units, as per international best practice by 2015.

Rationale: There are an estimated 33 cases of seclusion and/or restraint in Australian public hospitals every day. There are jurisdictions in the US where no cases are recorded. Cultural, skills and the adoption of evidence based care are required to eliminate these practices and hence reduce the risk of self-harm whilst in care and following discharge.

Recommendation 4.6 - The development and national implementation of practice guidelines for responding to mental health crises in all mental health services.

Rationale: As shown in Recommendation 4.5 above.

Recommendation 4.7 - That through the National e-Health Strategy, the Australian Government lead efforts to improve collaboration and information sharing and surveillance between and among systems of care for all persons, but especially for persons with SPMI.

Rationale: Poor communication and lack of information sharing between social service agencies, law enforcement, justice, education, health care and mental health care providers and others precludes key opportunities to advance suicide prevention efforts for persons with SPMI.

Recommendation 4.8 – That discharge from an acute care mental health facility must require: an appropriate discharge plan, a warm-hand over of a consumer/client to a step down service provider, appropriate advice to enable family or carers to provide informed support for the consumer, and active follow-up from the acute care service within 7 days and again without 28 days of discharge.

Rationale: Lapses in continuity of care, especially after discharge from emergency departments and inpatient psychiatry units, contribute to significant suicide-related morbidity and mortality.

In relation to Primary Health Care

Recommendation 4.9- Improved education, training and resourcing for primary care physicians, general practitioners and general practice teams to enhance the primacy of team-based, multidisciplinary (mental) health care and early interventions to mental illness and suicidal ideation.

Rationale: Most people who die by suicide or attempt suicide have contact with a primary health care professional in the weeks or months prior to the event. Better training is one suicide prevention strategy with a supportive evidence base.

Recommendation 4.10 - Routine screening for suicide risk at all primary health care appointments for those individuals who exhibit known risk factors, such as depression or substance abuse.

Rationale: Suicide risk often goes undetected, even though individuals at heightened risk for suicide frequently seek and receive medical care in primary care settings. Screening of persons with depression and substance abuse in primary care settings can identify individuals at elevated risk for suicide and expedite their referral for definitive evaluation and treatment.

In relation to Higher Risk Groups- Indigenous Australians

Recommendation 4.11 - Commit to reducing the soaring levels of suicide among Indigenous men by endorsing and supporting existing programs that are currently addressing suicide and the high levels of trauma experienced by Aboriginal communities. In particular:

4.11.1 Aboriginal controlled health services and government operated health services need to observe the views of Aboriginal and Torres Strait Islander men in relation to providing access and culturally appropriate methods of dealing with gender issues.

4.11.2 Psychologists and counsellors in their interventions should pay particular attention to the factors that are weighing down the Aboriginal and Torres Strait Islander peoples.

4.11.3 All ways and means of assisting Aboriginal and Torres Strait Islander males to reconnect with family, country and culture should be investigated.

4.11.4 Cross government funding resources should be made available to enable specific programs to address the needs of Aboriginal and Torres Strait Islander males and establish strategies suitable to their communities to combat self harm, violence and suicidal tendencies.

4.11.5 Aboriginal health workforce training programs require development, based on established standards.

Rationale: The rate of Indigenous suicide is a national emergency requiring the most assertive response from all governments and the broader community.

Recommendation 4.12 – That systematic and independent evaluations of the effects of alcohol restrictions in Indigenous communities be undertaken to assess impact of this strategy on health and wellbeing including suicide and suicidal behaviour.

Rationale: An evaluation of the effects of alcohol restrictions in the Fitzroy Crossing Community in the Kimberley Region of WA has shown measurable positive effects on health and social outcomes, community perceptions and alcohol-related behaviours after just 12 months. Similar restrictive policies on alcohol and other anti-social behaviours have been applied in other Indigenous communities, but not systematically evaluated.

In relation to Higher Risk Groups – Gay, Lesbian, Bisexual and Transgender

Recommendation 4.13 – That gay, lesbian, bisexual and transgender communities be recognised as a higher risk group in suicide prevention strategies, policies and programs, and that funding for targeted approaches to prevent suicide in LGBT communities be made available.

Rationale: LBGT people attempt suicide at rates between 3.5 and 14 times those of their heterosexual peers. Although it is difficult to gather statistics on completed suicides by LGBT people, LGBT people are clearly a higher risk group when considering other evidence.

Recommendation 4.14 – Training programs that improve the cultural competency of mainstream service providers to provide non-discriminatory and culturally appropriate services to the LGBT community need to be developed and implemented as a matter of urgency.

Rationale: Discrimination and stigma are barriers to service access by LGBT people. To ensure that the LGBT community can access essential services, mainstream services require support to build their capacity to understand and deliver services to the LGBT community in a non-discriminatory and culturally appropriate manner.

Recommendation 4.15 – Develop and fund anti-homophobia and anti-transphobia campaigns across educational settings in Australia, and online environments.

Rationale: Schools are a very common location for homophobic abuse and violence for same-sex attracted youth in Australia. Reducing homophobic abuse and violence in schools would address key risk factors for suicide, including discrimination, abuse and violence and peer rejection. Similarly, LGBT young people are high users of the internet and associated technologies and

increasingly this environment is also an environment for abuse and violence. This environment needs to be utilised to better effect, as a setting for suicide prevention work for LGBT young people.

In relation to Higher Risk Groups – Men

Recommendation 4.16 - Related to the development of the National Men's Health Strategy, endorse and fund the development of a National Men's Health, Wellbeing and Suicide Prevention Strategy, that recognises the importance of parity in gender funding, and which facilitates, promotes, researches, integrates, develops models and advocates for men's wellbeing nationally. Recognition of the diversity of cultural experiences for Australian men is to inform the Strategy, including ensuring that practitioners are skilled in, and are accountable for, delivering culturally appropriate care.

4.16.1 Establish outreach models to put support people into the above settings. These support people would practically advise on issues like finance, access to children, health, etc, would be accessible to men and would also be able to link people to other agencies when necessary.

4.16.2 Encourage and actively support through social policies, men's social engagement through participation in existing networks, such as service clubs, sporting, arts community groups, social clubs and online communities.

4.16.3 Protect the health of the male workforce by amending occupational health and safety legislation to include mental health and wellbeing benchmarks, and to have life skills training mandated and supported in the workforce.

Rationale: Men are four times more likely to die by suicide than women in Australia. Suicide is the largest cause of death for men under the age of 30 years. In recognition that suicide prevention is broader than mental health alone, the Strategy must take a joined-up approach across the three levels of government and the various portfolios. The Strategy should reflect best practice principles and include measurable targets, goals and milestones, alignment of program elements, a research/evaluation element, comprehensive models of service provision and resourcing.

Many men are low users of health care services. Services not only must reach out to men, but re-package themselves to be relevant and responsive to men's needs. For example, rather than promoting help-seeking, an emphasis should be placed on problem solving. Support men's access to services through expanding the current number of men-specific services and programs, encouraging flexible service delivery (that is, programs must go to where men are) and ensuring that all generic government-funded services are men-friendly.

Social isolation is a known risk factor for suicide. Supporting community social networks may assist in reducing the risk of self-harm and suicide.

Workplaces are a suitable setting for raising awareness, changing attitudes and behaviours. Workplaces have been a key setting in reducing smoking rates among men over the past 40 years and they have potential for suicide prevention, which has largely being untapped.

In relation to Higher Risk Groups - Rural Populations

Recommendation 4.17 - Promote suicide prevention specifically in small rural and remote communities, by supporting partnerships with established bodies (e.g. the National Rural Health Alliance) and new groups (e.g. the Rural Mental Health Network). There is a need for governments to support the development of strategies to increase connectedness and help-seeking, reduce isolation and establish services that respond to community needs.

> Rationale: Traditional primary care, community and hospital-base health services are not frequented by rural populations generally, and men in particular.

Recommendation 4.18 – That State and Territory governments continue and expand the appointment of dedicated mental health and suicide education coordinators within each local Area Health Service (or its equivalent) to assist in the promotion of mental health literacy, the connection of people to existing resources, and the delivery of coordinated suicide prevention and mental health first aid training and awareness initiatives among members of rural and remote communities (see, for example, the model adopted in Bundanoon, Southern Highlands, New South Wales).

> Rationale: Similar programs, such as the Act-Belong-Commit program in WA, have shown the benefit of community based project officers.

Recommendation 4.19 - That individuals, such as Rural Financial Counsellors, support workers, teachers, sports coaches and small businesspeople in remote, rural and regional areas, be provided with the requisite training to independently refer clients in crisis to the most appropriate and available mental health and health care services and resources.

> Rationale: Often these are the front line workers in smaller communities – many roles are undertaken voluntarily, whereas in larger communities these are paid positions.

In relation to Higher Risk Groups – People Bereaved by Suicide

Recommendation 4.20 – The Australian Government should review the National Bereavement Strategy as a matter of urgency and actively promote and implement Australia's *National Suicide Bereavement Strategy* via a commitment to recurrent or long-term funding and improved transparency and coordination.

> Rationale: The *National Suicide Bereavement Strategy* was completed in 2006. It has never been released by DOHA and no explanation has been provided to stakeholders.

Recommendation 4.21 – The Australian Government should sponsor or develop evidence-based 'best practice' principles as the foundations for all suicide bereavement outreach services and postvention initiatives and promote quality assurance and training of bereavement support groups.

> Rationale: An array of programs has developed in recent years in postvention, often without access to a sound knowledge basis.

Recommendation 4.22 – Introduce formal mechanisms for the provision of information about support services available to families and friends bereaved by suicide, and provide a single point of contact for future assistance.

Rationale: Presently families can be left without any advice or support following a suicide. In other cases, materials are received months after the death, giving rise to grief and anguish again. The prompt provision of evidence-based material and support will reduce the risk of suicide for bereaved persons.

Recommendation 4.23 – Improve support mechanisms for coronial staff and other practitioners, including first responders, therapists, clinicians, (mental) health services staff and general practitioners following the suicide of a client or patient, to assist with their own grief and emotional responses and to prevent personal and professional burnout.

Rationale: These staff are subject to many emotionally demanding situations and preventative programs, such as resilience training, are necessary, as well as post-event support.

Recommendation 4.24 – Introduce mandatory suicide (and attempted suicide) postvention guidelines across all Australian educational institutions and schools, as well as initiatives that assist in improving the communication of grief, loss and suicide bereavement among children and adolescents (particularly following the suicide of a parent).

Rationale: Schools need to be prepared to respond immediately to a suicide or attempted suicide in an informed and effective way to reduce the risk to students and the school community.

Recommendation 4.25. Specific support for postvention responses to the enduring grief experienced within Indigenous communities as a result of suicide and self-harm, with particular consideration for the needs of children and young people impacted by suicide.

Chapter 1 – Introduction to Suicide and Self-Inflicted Harm in Australia

Suicide, in this Submission, is defined as the intentional taking of one's own life. *Suicidal behaviour* is a broader term and includes self-inflicted and potentially injurious behaviours.

Suicidal behaviour covers: *suicidal ideation* (serious thoughts about taking one's life), suicide plans, suicide attempts and *completed suicide*. People who experience suicidal ideation and make suicide plans are at increased risk of suicide attempts, and people who experience all forms of suicidal thoughts and behaviours are at greater risk of completed suicide.

Suicide is a leading cause of death globally and in Australia. Official Australian statistics record approximately 1,800 suicide deaths per annum – of which approximately 75 percent are male. It is the leading cause of death for males aged under the age of 44 years, the leading cause of death for men and women under the age 34 years and is a notable cause of death in males over 75 years.

Deaths due to suicide significantly exceed fatalities from motor vehicle accidents and homicides combined. Young male and overall suicide rates rose particularly from the 1980s to the late 1990s, then appeared to decline (Australian Bureau of Statistics, 2003). The reasons for these reported declines have been the subject of debate and are discussed in this Submission (Goldney, 2006; De Leo, 2007; Harrison et al, 2009; De Leo, et al, in press).

Reliable studies now put the number of suicides in Australia for 2007 at around 2500 compared with 1881 recorded deaths through suicide in official statistics (De Leo, et al in press). This is due to a number of factors, most among them, an apparent decline in coronial reporting of deaths by suicide over the past decade. Coupled with the present economic slowdown, the real number of suicides in Australia may be approaching 3000 deaths per annum or over 8 deaths every day. It is important to note that during periods of lower economic activity with higher unemployment, higher bankruptcies and business failures, records show a 10-20% increase in suicides over economically prosperous periods (Morrell, et al, 1993).

Attempted suicide is far more common than fatal suicide events and it is currently believed that for every completed suicide, there are between 10 and 20 attempted suicides. The number of attempted suicides in Australia is estimated to be more than 60,000 each year, with more than two-thirds of these attempts by women. Attempted suicide is more common amongst younger people, with a quarter of all suicide attempts occurring in people between the ages of 15 and 24 years and half of all suicide attempts occurring in people between the ages of 25 and 44 years (Slade et al, 2009).

Self-harm is now recognised as a form of behaviour in its own right, distinct from attempted suicide. It is a leading cause of morbidity, especially for young women. Hospital presentations for self-harm have risen by over 50% for young women in the past decade and some 28% for young males. Self-harm can be defined as the deliberate destruction or alteration of ones' own body tissue without suicidal intent (including

cutting, branding and beating oneself) and is a risk factor for further episodes of self-harm and attempted and completed suicide.

It has also been recently suggested that self-harm may also be seen in some emerging forms of body art, including the placement of metal under the skin and the ritualistic practices, such as the placement of steel hooks in the flesh and hanging the weight of the person – all without pain-relieving drugs (commonly known as *body suspension*).

Distinguishing between a suicide attempt and a self-harm episode can be difficult, as establishing the intent of the behaviour (i.e. an intention to die) is often problematic. The intention to cause fatal harm can be considered a continuum, rather than a black and white issue, and while some people who attempt suicide have the intention of causing fatal harm, others aim rather at mobilising help and others are ambiguously aimed to a certain extent, at both (Hjelmeland et al., 2002; Shneidman, 1993; Wyder,2004). Nevertheless, there is general consensus amongst the suicide prevention and self-harm field that there is a distinction between self-harming behaviour with the intent of death (i.e. suicide attempt) and those self-harming behaviours that do not have the intention of causing death.

However, even though self-harm and suicide are different, people who self-harm are more likely to feel suicidal and more likely to attempt and complete suicide than people who don't self-harm (Nock, Joiner, Prinstein, & Richardson, 2007). Self-harm is a complex behaviour that places a significant burden on individuals and families and on the health care system and is a serious risk factor for completed suicide.

Suicide and self-harm both bear substantial human, social and economic costs. It has been estimated that each suicide impacts directly on at least six other people (Corso et al, 2007). Presently there are no reliable estimates on the cost of suicide and self-harm to the Australian community. However, the Californian Department of Mental Health (2008) estimated the combined cost of suicides and suicide attempts in that state in 2006 as $4.2 billion per year.

Currently, the suicide literature shows a clear tension between two opposing views: those who believe that suicide is seriously under-reported, and that the data dilutes or even masks the extent and seriousness of the problem; and those who believe that despite under-reporting, enough is known to establish patterns, the dimensions of the phenomenon, risk factors, and therefore the basis for effective prevention programs (Tatz, 2009).

The causes of suicide are complex and vary among individuals and across age, cultural, racial and ethnic groups. Suicide risk is influenced by an array of factors – sociological, psychological, environmental, cultural and biological. Nonetheless, this complexity masks the reality that almost all people who attempt or complete suicide exhibited one or more warnings signs before their death. This complexity is also often seen as a barrier to investing in suicide prevention efforts.

Chapter 2 - Prevalence and Consequences of Suicide in Australia

Prevalence

Death through suicide remains a relatively uncommon occurrence in the Australian population, accounting for 1.3% of all deaths. However, in practical terms this is between 6 and 7 deaths every day. The number of people who attempt suicide is believed to be at least 10 to 20 times higher than this and the number at imminent risk, much higher again. The 2007 National Survey of Mental Health and Wellbeing found that 3.3% of the adult population has attempted suicide at some point in their lives. (ABS, 2008)

The most recent ABS data (released March 2009) reported the number of suicide deaths for 2007 at 1,881. The approximate annual number of deaths due to suicide over the past decade has been between 2500 and 1800 per annum. Suicide is now the leading cause of death among young people under the age of 34 (male and female and the leading cause of death for men under the age of 44 years. Men are four times more likely to die from suicide than women (see Figure 1).

The number of people who are affected by a suicide is substantially greater and many of those people who attempt suicide need hospitalisation to recover from the resultant injuries. In 2007, 31,509 Australians were admitted to hospital as a result of self-harm (AIHW, 2009). Suicide attempts and self-harm are far more common amongst women than men.

It is generally accepted that the ABS suicide numbers are some 30-40% below the actual number of suicides. The reasons for this are complex, but include stigma, religious beliefs and practices, the burden of proof for coroners, a lack of expert investigations and different reporting protocols across states and territories. Family and relatives also often fear that reporting a death as suicide will jeopardise life insurance or other forms of financial compensation (De Leo, et al, in press). It is also likely that during the economic downturn, although at this point more moderate in Australia than elsewhere, there will be an increase of between 10-25% in the total number of suicides, based on previous economic recessions.

Suicide is an event with multiple interacting, often complex, contributing factors. One of the most common and significant contributing factors is mental illness. The results

Key Points in this Chapter:

Everyday, an estimated 6-7 people die by suicide in Australia.

Everyday, an nearly 180 people attempt suicides.

Everyday, more than 80 Australians will be admitted to our hospitals from self-inflicted harm.

Suicide is now the leading cause of death among young people under the age of 34.

Suicide rates among Indigenous Australians are twice that of non-Indigenous Australians and seven times greater in the Kimberley region.

Our suicide data collection is poor – the ABS data is estimated to be 30-40% below the actual number.

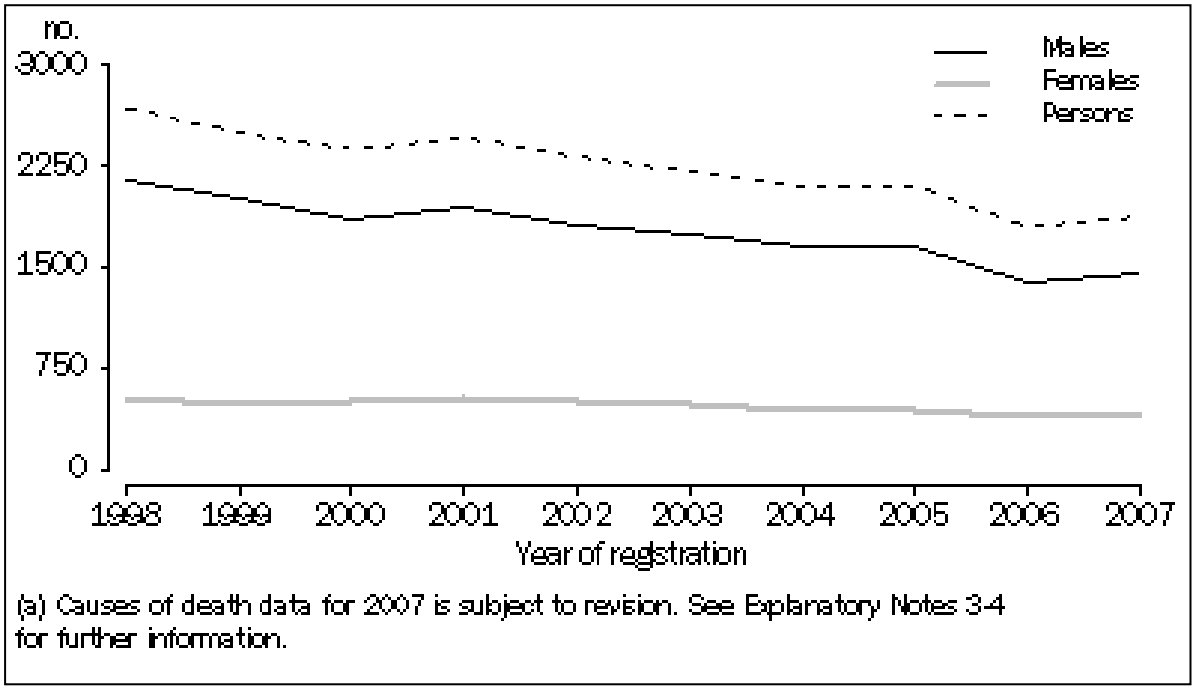
Suicide is an event with multiple interacting, contributing factors. One of the most common factors is mental illness.

A recent theory of suicide (Joiner) cites 4 factors or conditions for suicide:

- that the person has acquired the capacity to enact lethal self-harm;
- the sense that one has became a burden to others;
- the sense that one does not belong or fit in; and
- that the person has formed the view that there is no alternative.

of the ABS National Survey of Mental Health and Wellbeing shows that people with a mental illness are much more likely to have serious suicidal thoughts than other people (8.3% as compared to less than 1%). Other Australian research indicates that about 65% of those who die by suicide have symptoms consistent with major depression at the time of death.

Figure 1: Suicides, number of deaths – 1998-2007(a)



Source: ABS, Cause of Death, Australia 2007. ABS Bulletin, 3303.0

Table 2: Prevalence & population estimate of lifetime & 12-month suicidality

(Australians 16-85 y.o., n=8,800)

	Lifetime prevalence %	Population estimate	12-month prevalence %	Population estimate	Days out of role
Suicidal ideation	13.3	2.1 million	2.3	370,000	
Suicide plans	4.0	Over 600,000	0.6	91,000	8.2 days per month
Suicide attempts	3.3	Over 5000,000	0.4	65,000	8.5 days per month
Any suicidality	13.3		2.4	Over 380,000	6.7 days per month
Note: Any suicidality is lower than the sum, as people may have reported more than one type of suicidality in the 12 months.					

Source: The Mental Health of Australians 2, 2008

However, it is important to understand that the relationship between mental illness and suicide is not causal. The vast majority of people who experience a mental illness do not experience or show signs of suicidal thoughts or behaviours and a person does not have to have a mental illness to have a suicide risk. While mental health conditions are believed to be present in the majority of suicides, a significant number (estimated to be around 80%) are untreated at the time of death.

Because each individual is unique, there is no single reason as to why a person completes suicide. However, there are several factors that may contribute to a person engaging in suicidal behaviour. These include, but are not limited to:

- A personal crisis often associated with a major life transition, such as loss of a loved one, breaking up of a significant relationship, losing a job, etc.; A major life change may leave individuals feeling overwhelmed, unsupported, alienated and not be aware of alternative coping options;
- Family history including exposure to self-inflicted harm, childhood adversity, including violence, trauma and abuse;
- Social isolation and/or exclusion;
- Mental illness often amplifies and distorts the distress - most notably schizophrenia, bipolar disorder, substance abuse disorders, personality disorders, depression and anxiety;
- Alcohol and substance use can cause a person to lose self control and engage in high risk behaviours and impulsive suicidal behaviours.

Joiner (2005) describes four factors or conditions for suicide:

- that the person has acquired the capacity to enact lethal self-harm – that is, the person has effectively overcome the fear and pain associated with inflicting lethal self-harm;
- the sense that one has became a burden to others and the community generally;
- the sense that one does not belong or fit in - social isolation and disconnection;
- that the person has formed the view that there is no alternative

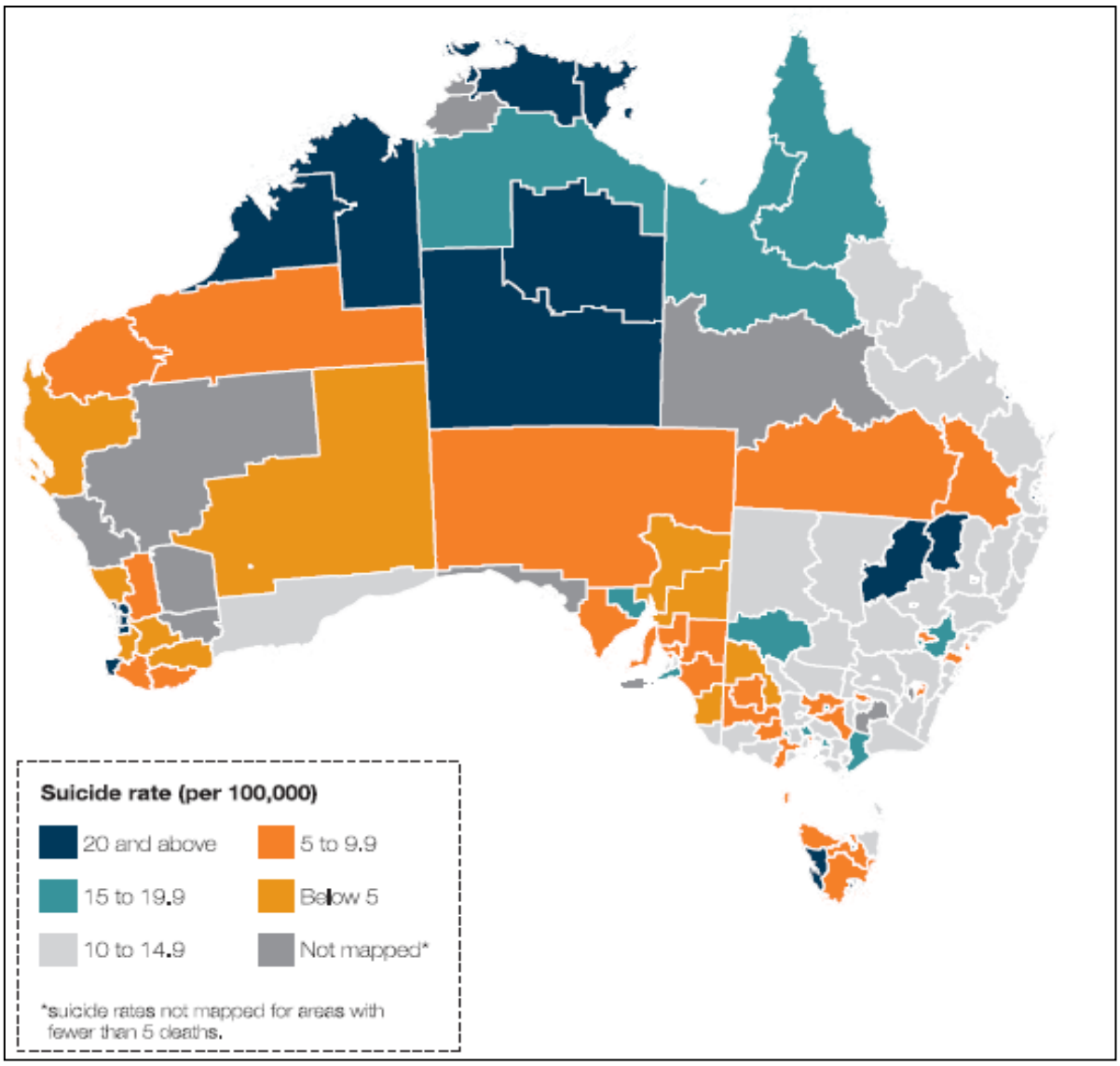
Suicide as Proportion of Total Deaths

While suicide accounts for only a small proportion (1.3%) of deaths of persons of all ages, it accounts for a greater proportion of deaths from all causes in specific age groups (see Figure 4). For example, suicide deaths make up more than 20% of deaths from all causes, in each five year age group for males between 20 to 34 years. Similarly for females, suicide deaths comprise a much higher proportion of total deaths in younger age groups compared with older age groups.

Locality Data

Suicide rates vary considerably across communities in Australia. Figures 2 shows some locality variations across different regions of Australia. As highlighted in Figure 2, many rural and remote communities, particularly Indigenous communities in the Northern Territory, Western Australia and Queensland, experience suicide rates significantly higher than the national rate of approximately 9 per 100,000.

Figure 2: Age-standardised suicide rate per 100,000 population across Australia by ABS statistical subdivisions (2001-2004)



Source: Department of Health and Ageing, 2008

Age Specific Rates

The age-specific suicide rate for males 35-44 years was 20.8 per 100,000 and represented 15% of total deaths for that age group (see Figure 3). The age-specific suicide rate for males was lowest in the 15-24 years age group (12.5 per 100,000). However, this cause represented 20.2% of all deaths in this age group.

For females, the highest age-specific suicide death rate in 2007 was observed in the 45-54 years age group and the 55-64 years age group, both with 5.7 deaths per 100,000. The lowest age-specific death rate for female deaths was in the 75-84 years age group (3.3 per 100,000).

Age-Standardised Rates

The age-structure of the Australian population has changed over time. Age standardisation allows comparison of rates between populations with different age

structures. The age-standardised suicide rate (for persons) in 2005 was 1% lower than the corresponding rate for the previous year and 30% lower than in 1997.

The age-standardised suicide rate in 2007 for males was 13.9 per 100,000, while the corresponding rate for females was 4.0 per 100,000 (see Figures 3 and 4).

Throughout the period 1995 to 2005, the male age-standardised suicide death rate was approximately four times higher than the corresponding female rate (see Figure 3).

Figure 3: Age specific suicide rates 2007

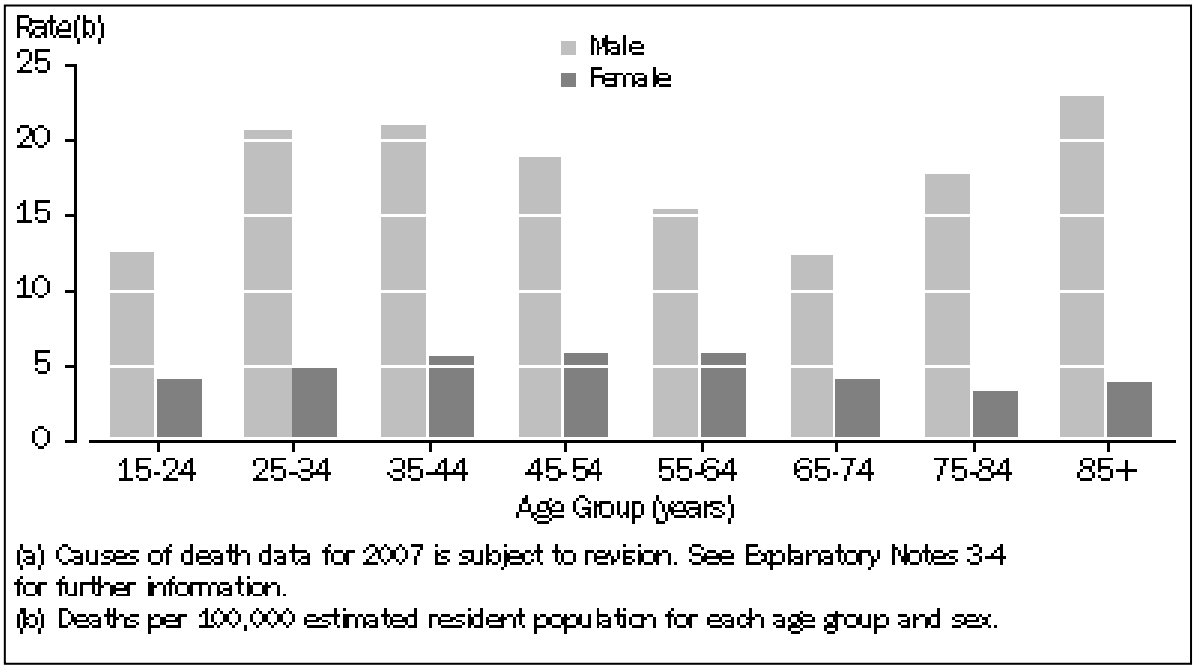
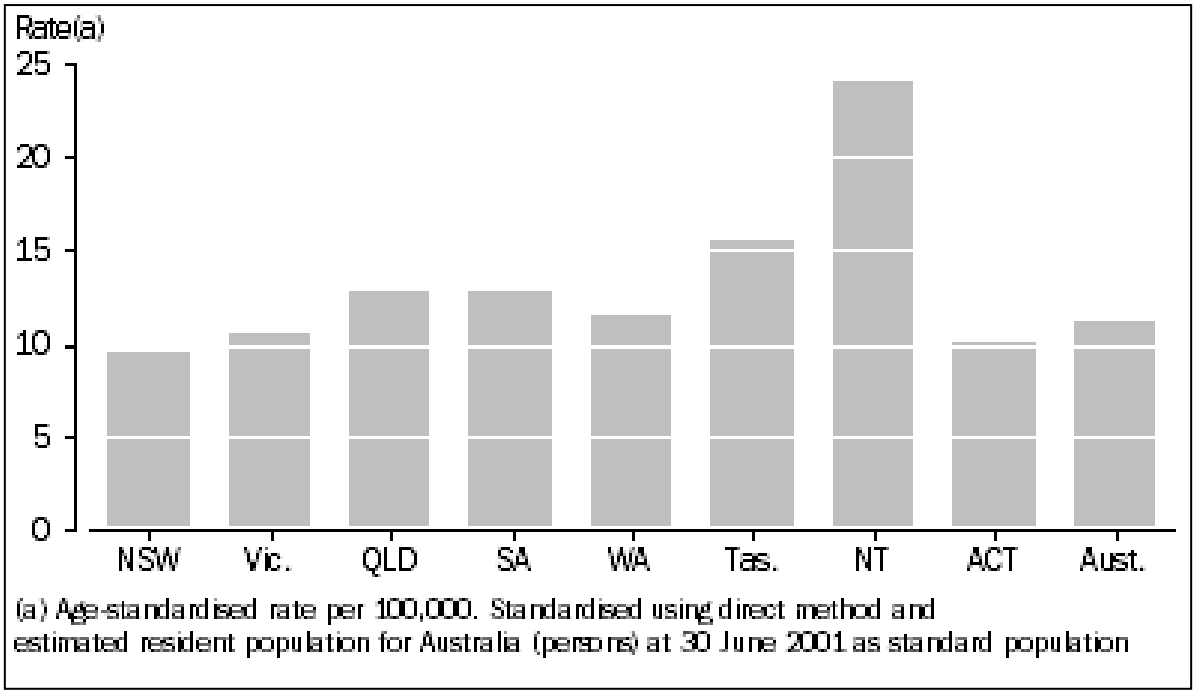


Figure 4: Suicide by state and territory (2001-2005), age-standardised rates



Self Harm and Suicide Attempts

Non-fatal self-harming behaviour leads the causes of morbidity for young women. The rate of hospitalisation for deliberate self-harm among young women increased by 51 percent in the decade 1995-6 to 2005-6 (AIHW, 2008). Hospitalisation for self-harm among people aged 12-24 increased by 43 percent, while the figure for males was up by 27 percent.

Self-harm frequently involves cutting and poisoning, but may also involve hanging and a range of other behaviours and activities.

In 2005-06, 7,299 young people were hospitalised for self-harm, a rate of 197 per 100,000 people. Girls aged between 15-17 were the group most at risk, while the danger for males increased in the 18-24 age group. The incidence of cutting represented about 15% of all hospitalisations (compared with 79% for self-poisoning) and is thought to be under-reported.

In 2007-8, the AIHW report on Hospital Admissions Data shows there were a total of 31,509 hospital separations for intentional self-harm for all hospitals (i.e. public and private), with an average length of hospital stay of 4.5 days.

Table 3: Separations for females for intentional self-harm 2007-8

Age

<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Total
0	3	505	5,794	4,073	4,315	2,803	1,090	374	265	87	**19,309**

Source: AIHW (2009). Hospital Separations Data, 2007-8.

Table 4: Separations for males for intentional self-harm 2007-8

Age

<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Total
0	5	113	2,783	3,056	2,880	1,866	812	347	246	89	**12,197**

Source: AIHW (2009). Hospital Separations Data, 2007-8.

Factors that can increase the risk of self-harm include:

- mental illness;
- substance use;
- childhood trauma, neglect and abuse, including sexual abuse;
- a family history of suicide or suicidal behaviour; and
- low educational levels.

Indigenous Australians are twice as likely to self-harm than non-Indigenous Australians, while young people living in remote areas had double the self-harm rates as their metropolitan peers.

The middle-teen years are a period of particular difficulty for young women. Research conducted by Patton, from the Centre for Adolescent Health, has shown that puberty can spark self-harming tendencies among teenage girls. The AIHW figures support this view, with rates of self-harm significantly higher for girls aged 15 to 17 (426 in every

100,000 young women were found to have self-harmed in 2005-06) and were more than double the general youth population.

There is some conjuncture as to the reasons for the increase in self-harm hospitalisation data among young Australians. Increased community awareness of depression and mental illnesses generally has been claimed to be an indication of more early intervention for depression (Baigent & *beyondblue*, 2008). However, it is the view of some (Patton, 2008) that young people often turn to self-harm as a way of controlling complex emotions or distracting themselves from those feelings, rather than as a symptom of clinical depression as such. According to the report, self-harming is not always intended to be fatal. Young women were particularly likely to "cut" if they had suffered trauma such as physical or sexual abuse. Thus, self-harming might be a young person's way to communicate personal distress.

Counting the Cost – the personal, social and economic cost of suicide

Suicide and self-harm bring with them massive human, social and economic impacts. Estimates indicate each suicide impacts directly on at least six other people (Corso et al, 2007). A completed suicide has a multiplier effect, impacting the lives of any number of individuals – from family to friends, colleagues, clinicians, first responders, coronial staff, volunteers of bereavement support services and other associates – who inevitably suffer intense and conflicted emotional distress in response to a death of this kind. The economic costs are enormous given that the greatest number of suicides and self-harm episodes occur before the age of 44 years.

The human cost of suicide and suicide attempts

Evidence suggests the personal and social costs of suicide in Australia are immediate, far-reaching and significant on families, workplaces and communities. Suicide and suicide attempts can cause not only immense distress to individuals, but also vicarious trauma among the wider community. Individuals in workplaces, for example, often witness and experience the impact of a suicide and are typically left at a loss, asking themselves “how to help”, “why could I not see the warning signs” and “what could I have done/said to prevent the tragedy”. Those close to a person who has completed suicide will often blame themselves for the decision of the individual to take their own life. The combination of grief, guilt and remorse can remain for years. The impact of a suicide attempt on first responders, such as police, ambulance and fire brigade, should also not be underestimated.

These responses frequently result in secondary losses for many individuals (for example, loss of confidence and self-esteem; loss of trust in their relationship with the deceased; and loss of social support networks and friends who may not be able to cope or assist).

The responses to suicide are further complicated by community stigma[3] and perceptions of the act of suicide as a failure on the part of either the deceased (to cope) or the family (for not having intervened or prevented the suicide). The complexities of the emotional relationship with the deceased prior to death can also compound the

3 Thornicroft et al (in press) defines stigma has having three components: a problem of knowledge, namely ignorance; a problem of negative attitudes, namely prejudice; and a problem of behaviour, namely discrimination resulting in exclusion from social & economic participation.

ability to cope among those bereaved by suicide, particularly in families where the deceased had a prior mental illness (Rubel, 1999). Blame for the loss is often ascribed on the bereaved, who may therefore be viewed more negatively by themselves and/or by others (Jordan, 2001).

This stigma towards suicide (individual and societal) introduces a unique stress on the bereavement process and also on the recovery process for suicide attempt survivors. These circumstances can lead to increased, or in some cases, complete isolation of individuals during the period immediately following the suicide or suicide attempt. Similarly, suicide bereavement can result in complications other than the personal deterioration of mental and physical health. These can include financial problems, the prospect of unemployment, an increasing sense of hopelessness and, at worst, increased suicide risk (Cvinar, 2005; Mitchell et al., 2005). Bereaved families also face particular dilemmas, such as what to tell others and the intrusions by police and legal processes surrounding 'sudden death'.

In rural and remote Aboriginal areas, suicide deaths often spark clusters of suicides (Hunter et al., 2001). Suicide deaths, particularly by hanging, are frequently witnessed by many members of an Indigenous community. In some instances, high levels of exposure to both death and suicide have resulted in a de-sensitisation among members of Indigenous communities, where "suicide and self-harm behaviour becomes normal, and even expected (though by no means acceptable)" (Farrelly, 2008). These situations can often lead to the mounting problem of intergenerational transmissions of trauma and grief, and may result in the overuse of drugs and alcohol, incarceration, self-harm, seemingly reckless self-destructive behaviours and, in some cases, suicide.

Such examples clearly demonstrate the need for suicide prevention strategies to address risk at the community level, rather than just that of the individual. The resulting legacies of wide-ranging emotional responses to suicide (not restricted to grief alone, but also inclusive of shame, sorrow, fear, rejection, anger and guilt) transcend the immediate loss.

The personal and social costs for suicide attempt survivors are also significantly profound and debilitating, particularly with regards to human rights issues. Evidence alarmingly shows that those who have survived a suicide attempt are sometimes involuntarily detained and may also receive various (often physical) treatments, often without legal representation or their own input to the decision-making process. Although, admittedly, there is currently little information on the long-term impact of involuntary treatment on suicide attempt survivors, the absence of lawyers means a loss of freedom that ultimately undermines Australia's commitment to human rights (Walters, 2009). When individuals are scheduled and/or detained for their own protection, all decisions need to be taken based on the basic principles of human rights and suicide attempt survivors should be given a 'voice', where possible, in their own treatment.

The economic costs of suicide in Australia

There are no reliable national estimates available on the financial costs associated with suicide and suicide attempts in Australia. This is in stark contrast to the economic costs of road accidents, which have been the subject of modelling and analysis as far back as 1978 (Atkins, 1981).

There have been some Australian studies examining the economic cost of suicide in relation to specific mental disorders. Access Economics has reported on the economic costs of schizophrenia (Access Economics, 2002) and bipolar disorder (Access Economics, 2003). However, there is no record of a similar exercise being carried out in Australia for any of the other psychotic disorders or other mental illnesses.

The Access Economics report for SANE Australia (2002) indicates that the direct and indirect costs of schizophrenia and associated suicides are enormous. In 2001, for example, real financial costs of illness totalled $1.85 billion, about 0.3% of GDP, and nearly $50,000 on average for each of more than 37,000 Australians with the illness (Access Economics, SANE Australia, 2002).

The direct and indirect costs of bipolar disorder and associated suicides are also substantial. In 2003, for example, real financial costs totalled $1.59 billion (0.2% of GDP) and over $16,000 on average for each of nearly 100,000 Australians with the illness. Moreover, the burden of disease – the pain, suffering, disability and death – associated with bipolar disorder is greater than that of ovarian cancer, rheumatoid arthritis or HIV/AIDS, and similar to schizophrenia and melanoma; resulting in 4,843 years lost due to suicide and self-harm (Access Economics; SANE Australia, 2003).

Quantitative data is also available on the national injury burden or burden of disease in Australia, which is notably dominated by suicide and self-inflicted injuries, road traffic accidents and accidental falls (Cripps & Harrison, 2008; Begg et al., 2007). Others, such as Yang & Lester (2007), have suggested that net cost estimates of suicide should go beyond accounting for direct medical costs and indirect costs from loss of earnings of those who suicide. Yang & Lester (2007) also suggest that the premature death resulting from suicide may actually derive savings to society from the avoidance of having to treat the depressive and other psychiatric disorders of those who suicide; avoidance of pension, social security and nursing home care costs; and assisted suicide.

The most recent mental health survey of Australians (ABS, 2008) estimates the number of Australians personally experiencing suicidal thoughts, making suicide plans and making a suicide attempt. The estimate of days out of role in the 30 days previous to the survey interview gives some indication as to the impact that suicidal behaviour has on people's lives. However, it belies the psycho/social impact of experiencing such deep psychological pain that one is preoccupied with the internal battle of ambivalence between wanting to die to end the pain and wanting to find a way to live.

As well as costs to the individual, it is important to contextualise suicidal behaviour and appreciate the ripple affect caused in the lives of friends, family members, colleagues and acquaintances. As mentioned earlier, the number of people immediately affected by any one suicide has conservatively and historically been estimated as up to 6 (Corso et al 2006; Maple et al 2009).

This measure probably underestimates the number of people grieving each suicide death, the ramifications of which are likely to extend more broadly. Potentially, three to four generations can be bereaved: siblings, parents, grandparents, and in some instances, the person's own offspring (Cantor et al. 1999). Relatives, friends and the wider community are also affected. Frank Campbell (*Changing the legacy of Suicide*, 1997) states that there are as many as 28 relationships impacted by one suicide. People will be impacted in many and various ways by a single suicide and the research has

simply not been done to articulate the actual number of people impacted, nor the breadth, depth and length of this impact. Nor has the research addressed the impact of multiple suicides that occur in one family, community or one geographic region. The ripple effect of one suicide affects future generations of that family.

Likewise, the number of people impacted by any one suicide attempt, notwithstanding the individual, and the way in which they are impacted has not been extensively researched.

Clearly, research is required into not only the economic costs of suicide and suicide attempts in Australia, but more comprehensively, the financial costs associated with the complex trajectory of suicidality – from prevention to intervention and postvention.

The Case for Prevention

In one sense there is no need to establish an economic case for investment in suicide prevention. This is for two reasons: 1) the recent report of the Preventative Health Taskforce sets out a compelling case for investment in health promotion and preventative (ill) health initiatives and 2) the economic and social impact of suicide and self-harm is of such a magnitude.

Estimates of the savings to be made from sound investments in suicide prevention, crisis interventions and postvention services and strategies have not been conducted in Australia. Again, Access Economics have prepared a report estimating the net savings from investment in services to provide evidence-based services for early psychosis (Access Economics, 2008). The methodology has relevance to the question of estimating savings to the community for investments in suicide prevention strategies. Such evidence can help inform decisions by policy makers as to where the greatest potential gain can be achieved through investment in suicide prevention. Detailed estimates of cost components can also provide useful input to a cost-effectiveness analysis of a proposed specific intervention and its subsequent evaluation (O'Dea & Tucker, 2005).

Past Australian Work

The financial cost of suicide has never been fully calculated in Australia. In health economics literature, the compilation of costs of illness or burden of disease estimates is not necessarily a useful exercise for policy making purposes. Policy makers need proposals for specific interventions, which can then be assessed in terms of their expected benefits and costs, relative to alternative interventions or to 'doing nothing'. However, estimates of the cost of suicide (both attempted and completed suicide) can be useful in two ways. Firstly, the estimate give some idea of the conditions and the populations for which the burden of disease is greatest, and can therefore give some guidance as to where research on developing new interventions might be focused to give the greatest potential gain. Secondly, the detailed estimates of cost components can provide useful input to a cost-effectiveness analysis of a proposed specific intervention, and to its subsequent evaluation.

A 1998 report by Flinders University's Research Centre for Injury Studies "Estimated cost of injury by suicide or self-harm Australia 1995-96" placed direct and indirect costs at $2.5B. This reporting using data supplied by the National Injury Surveillance Unit and a methodology developed by the Monash University Accident Research Centre.

A report from the University of NSW's Injury Risk Management Research Centre (IRMRC) states that in NSW, suicide was the leading cause of injury-related death during 1998-2002, with 3,822 deaths, giving a mortality rate of 11.7 per 100,000 population (Schmertmann et al, 2004). The lifetime cost of fatal and attempted suicide in NSW has been estimated at $588 million—$25 million in direct costs and $563 million in mortality and morbidity costs (Potter-Forbes & Aisbett, 2003).

International literature and potential costing models

Despite the limited estimates and detailed research on the economic costs of suicide in Australia, some excellent material, somewhat comparable to the Australian cultural context, is available internationally, from jurisdictions including California, Ireland and New Zealand.

International studies of the cost of suicide can be broadly summarised as adopting the following methods, which may or may not function as a useful guide to proposed Australian measures:

- The **use of a human capital approach** to valuing lost life years, rather than a willingness-to-pay approach.
- The **extension of the human capital approach** to valuing the lost life years, even for those years in which the person would not be in paid employment – for instance, for those years past the age of retirement (usually assumed to be 65 years), or for the ages 15 to 64 when not actually in paid employment. This brings up the question of the value of **time not in paid employment**.
- The **use of a cut-off** of 75 years of age, beyond which lost years of life are not counted.
- The **discount rate** used for discounting future earnings or life years.

The New Zealand study estimated that, in 2002, the total cost of suicide was around $1.4 billion, incorporating both economic costs (i.e. services used in cases of suicide and attempted suicide, and lost production from exit or absence from the workforce) and non-economic costs (i.e. lost years of disability-free life and grief of family and friends). To put this in perspective, at the time of the study, figures suggested that around 500 deaths in New Zealand were attributable to suicide annually, working out to nearly $2.5m per suicide (O'Dea & Tucker, 2005).

Corso et al (2007) also provide a formula and estimates of the cost of both suicide and suicide attempts for California. This work was used to inform the development of the Californian Suicide Prevention Strategy, released in mid 2008.

> *"The economic burden of suicide is spread throughout a variety of systems, including education, hospitals, primary care, mental health, and corrections. To estimate these costs, a formula has been derived based on costs incurred by individuals that attempted or died by suicide, families, employers, government programs, insurers, and taxpayer. Estimates of the cost of self-injuries take into account hospitalizations and follow-up treatment; coroner and medical examiner costs; and transport, emergency department, and nursing home costs. Lifetime productivity estimates take into account lost wages, fringe benefits, and costs related to permanent or long-term disability for each individual who attempts or dies by suicide."*

Using this formula based on suicide data from 1999 to 2003, Corso et al estimated the average medical cost per suicide in California was $4,781 and the average lifetime productivity loss for each individual was more than $1.2 million. The resulting cost of suicide deaths in a given year is nearly $15 million per year in medical costs and $3.8 billion in lost lifetime productivity for the individuals who die by suicide in a given year. This estimate did not include the 'ripple effect' on others, in terms of services needs and lost productivity. In 2003, there were over 16,000 hospitalisations for suicide attempts in California. The average medical cost per hospitalization was more than $12,000 and the average work loss per case was over $14,000. The resulting cost of suicide attempts in a given year in California is $435 million. Based on these figures, the combined estimated cost of suicides and suicide attempts in California is $4.2 billion per year.

Obviously, it is important to remember in these studies that the economic burden of suicide is spread throughout a number of systems, not least of all, employment, education, primary care, hospitals, mental health and criminal justice. The appropriateness of adding together such different cost concepts (i.e. economic costs, relative to personal and social costs) warrants some attention also; suggesting that a more appropriate approach may be to measure economic and non-economic costs separately (O'Dea & Tucker, 2005).

The Statistical Value of a Life

> *"The valuation of life is generally an emotive issue fraught with philosophical and conceptual problems. Consequently, it is an issue riddled with controversy and debate. It is also associated with seeming irrationalities. For example, society will usually go to great lengths to save identified lives such as sailors stranded in mid-ocean or a child in need of expensive surgery. However, when the lives to be saved are anonymous, as for example in the case of funding research into cures for disease that would save lives in the future, public response may not be quite as generous. This apparent irrationality may be due to the greater sense of responsibility and claims of conscience associate with identified lives as opposed to anonymous lives." Motha (1990:1).*

The concept of a 'statistical' life has developed in order to distinguish the value of the life of an anonymous or unknown individual from the life of a known or particular person, for the purposes of policy making.

There continues to be some debate amongst economic theorists as to how to most accurately estimate the Value of a Statistical Life (VoSL). In recent years, there has been heightened interest in the development of health outcome measures that combine morbidity (quality of life) and mortality (quantity of life) in a single measure. Candidates include the Quality of Life Years(QALYs) and Disability Adjusted Life Years, DALYs. Discounting is commonly employed to reflect society's preference for health gains that accrue sooner rather than later in time and costs that occur later, rather than sooner, in time. A variety of methods have been used to value life and health e.g. human capital (foregone earnings), willingness-to-pay (WTP) estimated through indirect market methods and cost or illness.

The most recent research re-evaluating the cost of human lives lost in car accidents calculates the average cost of a life at $6million, four times the $1.5 million that was previously used to estimate the cost of road accident deaths (Hensher et al 2009). Hensher states that "the figure of $1.5 million used by many policy makers is more of an

accounting figure, putting a present value on income lost when and individual dies in a road accident."

The methodology used in this research increases the cost of death and, therefore, should alter the cost-benefit analyses of proposed safety measures designed to lower road deaths. Hensher cites the use of this formula in the US, UK, New Zealand and Sweden.

Comparison with Road Deaths

Thanks to three decades of sustained investment and coordinated policy and program action, Australian roads are now among the safest in the world. The annual economic cost of road crashes in Australia has been conservatively estimated to be at least $18 billion in 2005 (Australian Transport Safety Bureau, 2009). As a consequence, a sustained, well-founded program within a robust policy framework has existed and continued to develop over the past 30 years.

Road injuries and deaths receive extraordinary scrutiny, analysis and timeliness of reporting and ease of access to detailed reporting. The Bureau of Infrastructure, Transport and Regional Economics (BITRE) provide up-to-date road safety statistics and a publicly accessible database of over 500 research, evaluation and monitoring reports.

The National Road Safety Action Plan 2009 – 2010 states:

> *"General investment in road infrastructure maintenance and improvement, and targeted investment in road safety improvements (such as black spot remediation and application of low-cost, high-effectiveness treatments to lengths of road) are both important for safety outcomes. The economic benefit of such expenditure is estimated to average around $5 per dollar spent,(ref 7) with an accumulating safety benefit of about 24 deaths prevented per year from a $287 million program. Sustained expenditure of $287 million per year over four years would reduce annual deaths by almost 100. Greater investment in these programs would produce commensurately larger benefits."*

Investment in *Black Spot Road Safety* programs have been one example of dollars invested and calculation of an economic benefit return. In a 3-year period (1990-1993) Federal funds were allocated, amounting to $270 million for the Federal Road Safety Black Spot Program. An evaluation done of that program (by the Bureau of Infrastructure, Transport and Regional Economics – BITRE) reported:

> *"The results indicate that the entire Black Spot Program has delivered net benefits to the Australian community of at least $800 million generating returns of around $4 for each dollar of expenditure. The results of the evaluation strongly suggest that the Program has achieved its aim of improving locations with a history of crashes involving death or serious injury."*

http://www.bitre.gov.au/publications/48/Files/R090.pdf

An Estimation of the Monetary Cost of Suicide

The following table shows the application of the most recent formula available and extrapolated to the number of suicides in Australia in a given year, using the published ABS data, the revised AIHW data for 2004 and a plausible figure that includes the likely impact of the Global Financial Crisis. For the latter, an increase of 10% in total suicides for 2009 has been assumed. This would be at the lower end of 'expectations', based on the historical data.

Table 5: An estimated cost of suicide using different annual numbers

	ABS	AIHW	Plausible
Number of Suicides annually	1,800	2,458	2,704
Cost (VoSL) @ $6m/life	**$10.8B**	**$14.75B**	**$16.2B**

The calculation for attempted suicides, suicide plans and suicidality amounts to between $770M and $1.2B. This is based on the 2007 ABS National Mental Health and Wellbeing study, which provided prevalence rates and the numbers of days out of role and Average Weekly Earnings[4]. Again this would be a conservative estimate as it excludes all health care and emergency services costs and any productivity losses or others affected by the suicidal behaviour. Based on AIHW hospital admission and cost data, then a further $133.3M would be added for cases of self-inflicted harm. Therefore, based on these figures, a conservative estimate for the economic cost of suicide and suicidal behaviour on the Australian community is **$17.5B every year**.

Clearly, more work is required to more accurately and fully cost the economic impact of suicide and suicidal behaviour on the Australian economy. The Table below lists the components that may be used to calculate the total cost of suicide and self-harm to the Australian community.

Table 6: Possible components for costing suicide and self-harm in Australia

Total number of suicides	Lost Production Value	Cost of Ambulatory services
Years of Life Lost due to premature mortality (YLL)	Estimated social losses for self harm and suicide	Productivity losses for survivors (bereaved and attempters)
Years of Life Lost due to disability	Cost of insurance and superannuation claims	Cost of prevention & intervention programs
Hospital separations for intentional self-harm	The present value of future work efforts	Cost of bereavement programs
Emergency services for intentional suicide & self harm	Severity of Self-Harm Injuries ICD -10	Value of a statistical life year

4 AWE was based on published ABS data for full time work and applied to 70% of the time out of role indicated against each 'condition' in the ABS Mental Health Survey.

Chapter 3 - Why People Suicide and Self-Harm

Introduction

The question of "why" is common when discussing suicide. Family, friends, colleagues, even those people who attempt suicide or engage in self-harming behaviours themselves, often struggle to find the reasons why some people have suicidal thoughts or exhibit suicidal behaviours and others do not. Researchers, health workers, policy makers and service providers have spent substantial time and effort endeavouring to undercover the causes underlying suicidal thoughts and behaviours and provide a defensible explanation for those left behind.

People engage in self-harming or suicidal behaviour for a variety of reasons, including wanting to relieve others of a "burden", wanting relief from physical pain, acts resulting from the symptoms of mental illness or wanting to "punish" others. However, current research suggests that the one of the main reasons behind attempted and completed suicide acts are the result of wanting to end an intolerable and uncontrollable emotional or psychological pain. This psychological pain can outweigh the physical pain of self-harming behaviours and even the fear of death. Often, people who attempt suicide feel that death is their only option.

Risk factors, warning signs, precipitating events and imminent risk

The reasons behind suicidality are complex and interrelated. To date, we are yet to identify a defined, discrete set or constellation of characteristics or circumstances that precipitate suicidal thoughts and/or behaviours. However, research studies have determined that there are a variety of predisposing factors, warning signs and precipitating events that may increase the risk of suicidal behaviour or alert others of the possible risk of suicidality in someone else. Figure 5 shows the transition from risk factors, through warning signs to precipitating events and finally, the point of imminent risk of suicide. It also provides some typical examples within each category.

Key Points in this Chapter:

The reasons for suicide and suicidal behaviour are complex and interrelated.

We are yet to identify a defined discrete set of characteristics or circumstances that lead to suicidal behaviours.

There is a defined set of risk factors that may predispose a person to suicidal behaviours and a transition from risk factors to warning signs, precipitating events and imminent risk. There is also a set of defined protective factors and how they can be increased in vulnerable people.

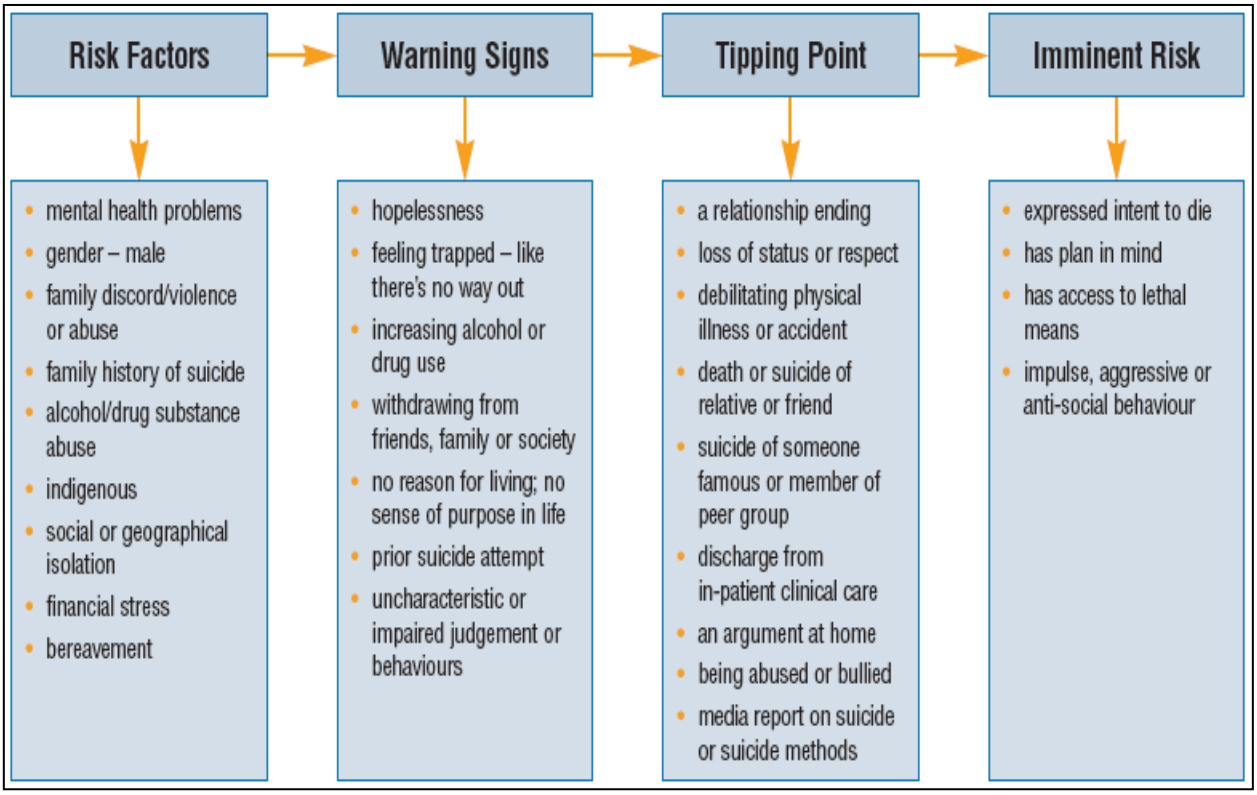
Mental illness is a major risk factor for suicidal behaviour, however it is not a simple causal relationship.

People with severe and persistent mental illness have a 10-15 times greater suicide risk than people with no disorder.

Alcohol and other drug use is a major risk factor for suicidal behaviour.

There are sub groups in Australia with significantly higher risk of suicide – Indigenous and non-Indigenous males in rural and remote areas; gay, lesbian, bisexual and transgender populations; people bereaved by suicide and those who have attempted suicide or engage in other suicidal behaviours are at significantly higher risk.

Figure 5: The transition from risk factors to the point of imminent risk



Source: Draft Life is for Living, 2007

Risk and protective factors

Risk factors are personal characteristics or circumstances that may predispose an individual to suicidal behaviours or increase the likelihood of suicidality. Many risk factors have been identified and extensively researched. In addition, a range of protective factors have been identified – those characteristics or circumstances that prevent or reduce the likelihood of suicidality. Risk and protective factors may be related to the personal characteristics of the individual, events or incidents that have occurred during their life or their social environment. Often, risk and protective factors for suicide represent opposite ends of the same concept. The Table below summarises some of the known risk and protective factors that can either increase or reduce the risk of suicidal behaviours. Figure 6 illustrates the extent of empirical and scientific evidence supporting our understanding of the link between suicidal behaviour and some recognised risk factors.

Risk factors have previously been defined as either ***non-modifiable*** or ***modifiable***. Non-modifiable risk factors are those that cannot be or are extremely difficult to change. These include issues such as genetic factors and predispositions, neurobiology, gender, age, gender identity/sexuality, ethnicity/culture, personality traits (e.g. impulsivity, neuroticism, hopelessness, aggression and problem-solving ability) and existing mental and/or physical illness. Modifiable risk factors are those that are able to be changed or those where an individual can change their perception or reaction towards a particular situation. Modifiable risk factors include issues such as social/geographic isolation, employment status, housing status, substance abuse and/or other addictive behaviours (e.g. gambling), past or current adverse life events (e.g. family violence/breakdown,

physical, sexual, emotional abuse, neglect, financial problems), socio-economic status and broad environmental/political issues (e.g. natural disasters, global financial crisis, war). Although the classification of risk factors for suicide as either modifiable or non-modifiable is informative and assists in our understanding of suicide risk and suicide prevention, it is often difficult to use this definition in practice. Many "modifiable" risk factors, such as substance abuse or geographic location, can prove quite challenging to alter in a real-life setting and the modification of these issues may inadvertently introduce further risk factors for a particular individual.

Table 7: Examples of risk and protective factors

Type of factor	Risk factors	Protective factors
Individual	Gender (male)	Gender (female)
	Mental illness	Mental health
	Substance abuse	No harmful substance use
	Hopelessness	Positive attitude to life
	Poor coping skills	Adaptive coping skills
	Lack of meaning/purpose in life	Sense of meaning/purpose in life
	Impulsivity	Controlled Behaviour
Life events or circumstances	Physical, sexual or emotional abuse	Physical and emotional security
	Family breakdown/conflict	Family harmony
	Social isolation	Social connectedness
	Family history of suicide/mental illness	No family history of suicide/mental illness
	Unemployment	Job security
	Homelessness	Safe and affordable housing
Social and environmental factors	Low socio-economic status	Mid to high socio-economic status
	Lack of support services	Access to support services
	Exposure to environmental stressors (e.g. floods, bushfires, war, global financial crisis)	Limited exposure to environmental stressors

Research to date has overwhelmingly focused on identifying and understanding risk factors (those issues that increase the risk of suicidality). Studies focusing on protective factors and how they can be increased in vulnerable individuals to prevent suicidal behaviour have only occurred relatively recently. ***Resilience***, or the ability to cope with and even respond positively to potentially adverse life events, has been identified as a key protective factor for suicide and research into how it develops and how it can be increased across the population is growing.

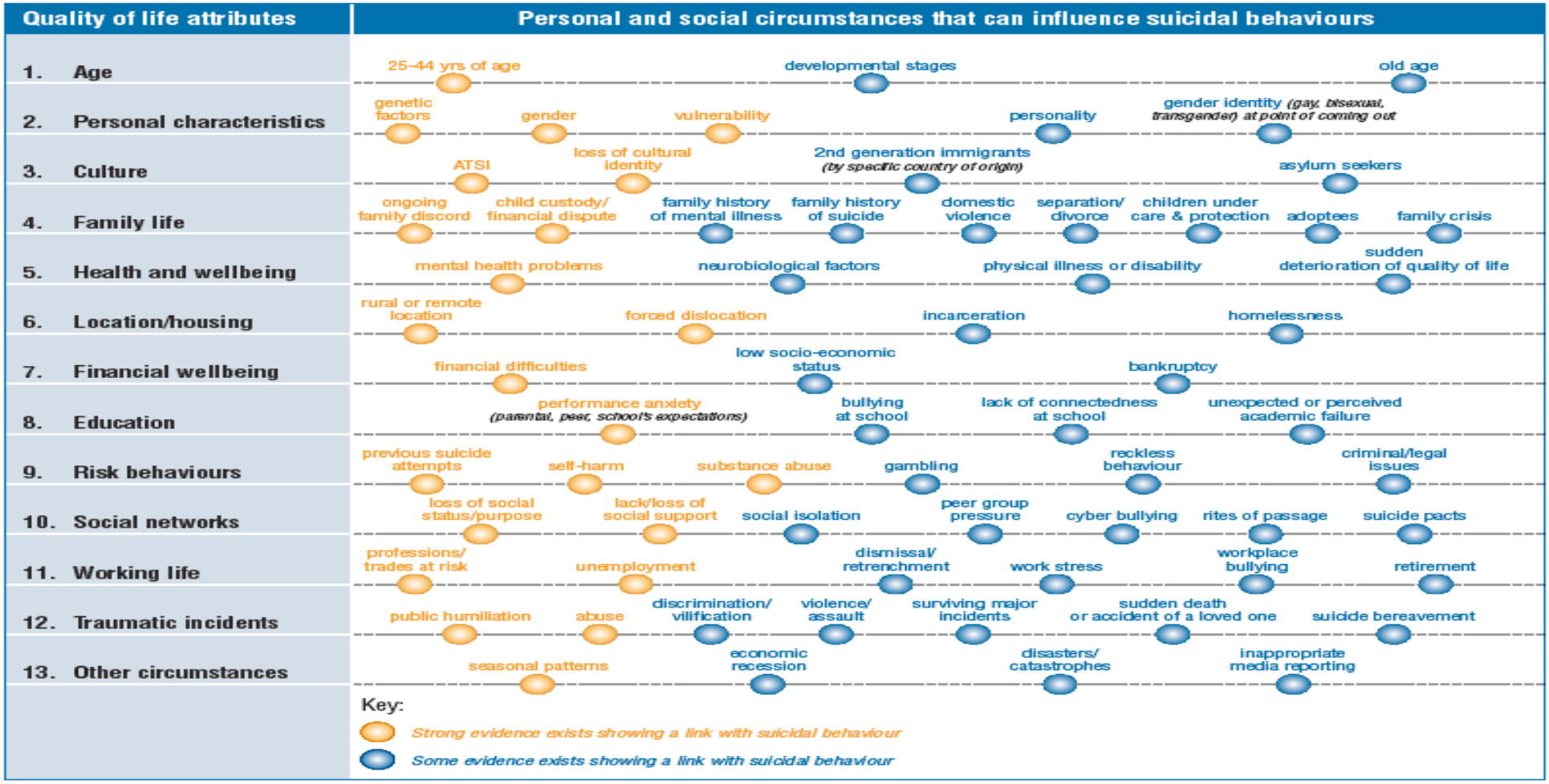
People respond to different life events in many ways and using a variety of adaptive and maladaptive coping mechanisms. Work by Bonanno (2004) shows that there are four main ways people respond to adverse life events: resilience, recovery, delayed response and chronic disruption (see Figure 6). Recent studies have shown that resilience is by far the most common reaction to adverse life events. Following a significant difficult or upsetting incident or event, the majority of people experience a brief disruption, but then quickly recover to their normal level of functioning. However, there are some people who experience greater levels of disruption to their functioning, including those individuals who endure ongoing disruption and dysfunction following the occurrence of negative circumstances (sometimes called ***vulnerability***). It has been suggested that it is these individuals who may be at the highest risk of suicidal behaviour.

The interaction between a person's predisposing risk and protective factors (particularly their level of mental health or illness), their level of resilience or

vulnerability and their cumulative experience of positive or negative life events can provide an indication of the potential risk for suicide (as shown in Figure 7). This model suggests that those individuals with a high level of vulnerability, with many predisposing risk factors, are experiencing mental illness and who have experienced one or several adverse life events, are likely to have a higher risk of suicidal behaviour.

It is important to note that risk and protective factors do not necessarily remain static throughout a person's life – they may change according to a person's experiences and how they deal with those experiences. Even those risk factors that are generally considered "non-modifiable" (e.g. neurobiology, gender identity/sexuality) may undergo changes throughout life – for example, a person who, at a particular point in time, struggled with their sexuality, may subsequently find ways to cope positively with this issue (e.g. through discussions and acceptance from family and friends, development of successful relationships, etc) and their sexual identity may no longer be considered a risk factor for suicide. In fact, their sexual identity may become a protective factor, due an increased sense of self, improved self-confidence and self-esteem and a feeling of belonging amongst family and friends. This example highlights the dynamic nature of risk and protective factors and the challenge for researchers, policy makers and health care providers in accurately identifying those issues that may increase the risk of suicidality for populations, groups and individuals.

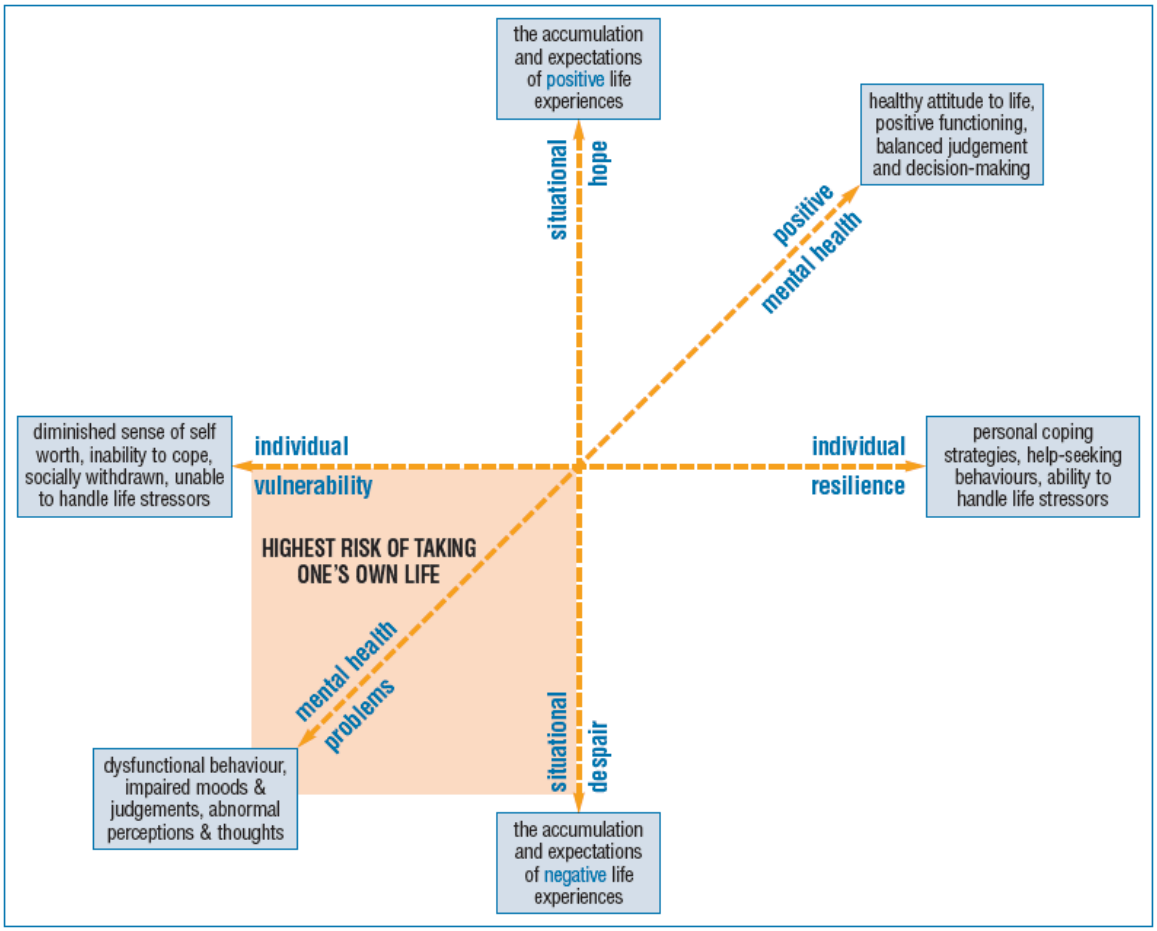
Figure 6: Strength of evidence supporting the link between various risk factors and suicide (based on available evidence)



*(**Note:** This diagram is illustrative only. Life events shown are not of equal weighting in their potential contribution to suicidal behaviour)*

Source: Draft Life is for Living Framework, 2007

Figure 7: The interaction between individual resilience/vulnerability, mental health/illness and the accumulation of positive and negative life events



Warning signs for suicide

While there may be a number of reasons why a person has suicidal thoughts and/or exhibits suicidal behaviours, studies have shown that the majority of people who attempt or complete suicide exhibit one or a number of common warning signs prior to their attempt. Unfortunately, most people are unaware of what these warning signs are and how to respond to them. Suicide warning signs may be a cry for help from a suicidal person and can provide the opportunity for family, friends, associates and professionals to intervene and potentially save someone's life.

Any behaviours or actions that are particularly out of character or unusual could potentially be a warning sign for suicide. However, there are some behaviours that appear to be common signs of a potential risk of suicide. Some of these more common warning signs include:

- someone talking or writing about death, dying or suicide (especially when this is out of character or unusual for the person)
- feelings of hopelessness or that there is no way out of their problems or situation
- increased alcohol/drug use
- withdrawal from family/friends/community (e.g. not wanting to attend family events, sporting activities, etc.)
- prior suicide attempt

- uncharacteristic impaired judgement and/or risk-taking behaviours (e.g. reckless or risky behaviours)
- dramatic changes in mood, such as sudden feelings of happiness after a long period of sadness or depression – this may indicate that a person has made the decision to suicide and is experiencing a sense of relief about having made the decision
- signs of anxiety or agitation
- abnormal sleep patterns – not sleeping or sleeping all the time
- giving away possessions or saying goodbye to family/friends
- lost sense of purpose or meaning in life (e.g. "What's the point, anyway?" or "Everyone would be better off without me").

Most people show some of these behaviours at some point in their lives, particularly when they are upset, stressed or tired. However, if a person exhibits a number of these behaviours at once or within a short period of time, this may indicate the potential risk for suicidal behaviour.

Precipitating events ("tipping points")

In many cases, people who have suicidal thoughts or have considered suicide experience a significant life event that may precipitate a suicide attempt. These life events are sometimes known as "tipping points" or the "final straw" that may lead someone who is considering suicide to take action.

Some of the more common precipitating life events that may lead to a suicide attempt include:

- an argument with a loved one or significant person (e.g. parent, sibling, partner, teacher)
- breakdown of a relationship
- suicide of a family member, friend or public role model
- media report or story about suicide
- onset or recurrence of a mental or physical health problem
- unexpected change in life circumstances
- transition phase or change from one life stage into another
- experiencing a traumatic life event, such as abuse, bullying or violence.

Some of these precipitating events may seem relatively innocuous for others, but for someone who has been considering suicide, an upsetting or negative incident can potentially push them to the point of imminent risk. The precipitating event may be the last in a series of difficult circumstances that have accumulated to cause the person's suicidality. In addition, the person may lack the resilience to cope with these potentially traumatic life events.

Imminent risk

Imminent risk is the point when the risk for a suicide attempt is greatest. Despite common misconceptions, many people who are seriously considering suicide tell someone about their suicidal thoughts or suicide plan, either through their words or their actions. The following behaviours or actions indicate a strong potential for a

suicide attempt and should be responded to immediately by anyone who is aware of them:

- someone threatening to hurt or kill themselves or expressing an intent to die
- someone looking for ways to attempt suicide, or talking about their suicide plan
- someone having access to lethal means (e.g. firearms, rope, car)
- impulsive, aggressive or anti-social behaviour, particularly when it is uncharacteristic for the person or the person is displaying a sense of urgency or crisis.

In addition, the point immediately following a suicide attempt is also a time of extremely high risk for further suicidality. This is particularly the case in situations where the suicide attempt involved highly lethal methods (e.g. firearms), the attempt was medically serious with knowledge of lethality, there was significant planning and/or preparation, there was prior communication of intent to suicide, there is the continuing wish to die or end pain and/or there have been multiple previous attempts.

Mental Illness as a Risk Factor

Suicide and suicidal behaviours arise from a range of factors that have multiple and complex interactions. One of the most cited factors is mental illness. However it is important to understand that the relationship between mental illness and suicide is not necessarily causal. The vast majority of people who experience a mental illness do not experience or show signs of suicidal thoughts or behaviours and a person does not have to have a mental illness to have a suicide risk.

To understand the relationship better, a short overview of mental illness in the Australian population is presented here.

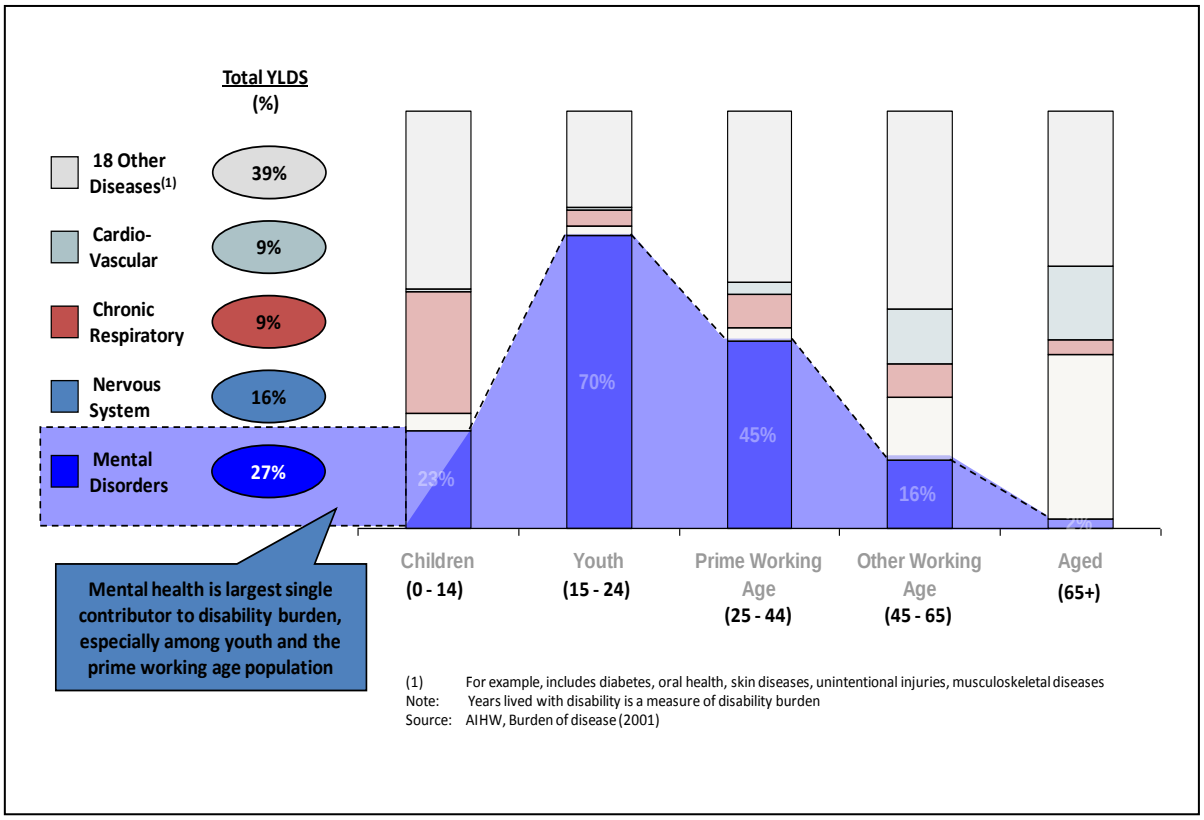
Mental Illness – an overview

Mental health conditions are among the most common health conditions. 'Mental illnesses' or 'mental health conditions' are both umbrella terms that cover a wide spectrum of illnesses.

The most recent Australian survey (ABS, 2008) shows that nearly half of all people aged over 16 will develop a mental health condition at some point in their life. In any one year, one in five Australians experience a mental health problem and one in four of these people (or 5% of the adult population) will experience more than one mental disorder at the same time.

These are high rates of prevalence for any health condition. As a consequence, mental health conditions contribute more than any other health condition to the level of disability in the Australian community (see Figure 8).

Figure 8: Mental health and disability



Results from the 2007 ABS survey show that in a 12 month period:

- One in seven or 14.4% of adult Australians had an anxiety disorder;
- More than one in twenty or 6.2% had an affective disorder (e.g. depression);
- One in twenty or 5.1% had a substance use disorder;
- There are important differences between males and females (shown in Table 9);
- The incidence of mental illness decreases with age – with the highest percentage of mental illness reported for those aged 16-24 years (26.4%) and 25-34 years (24.8%), as compared with 5.9% for those 75-85 years;
- Women are more likely than men to have experienced anxiety disorders (17.9% compared with 10.8%) while men are more likely than women to experience substance use disorders (7.0% compared to 3.3%);
- 3.3% of the adult population has attempted suicide at some point in their lives.

The ABS Survey also showed that a number of social factors were highly associated with having a mental disorder in the past 12 months – unemployment, prior homelessness and previous time in prison.

Table 8: Prevalence of mental health disorders by sex in the previous 12 months

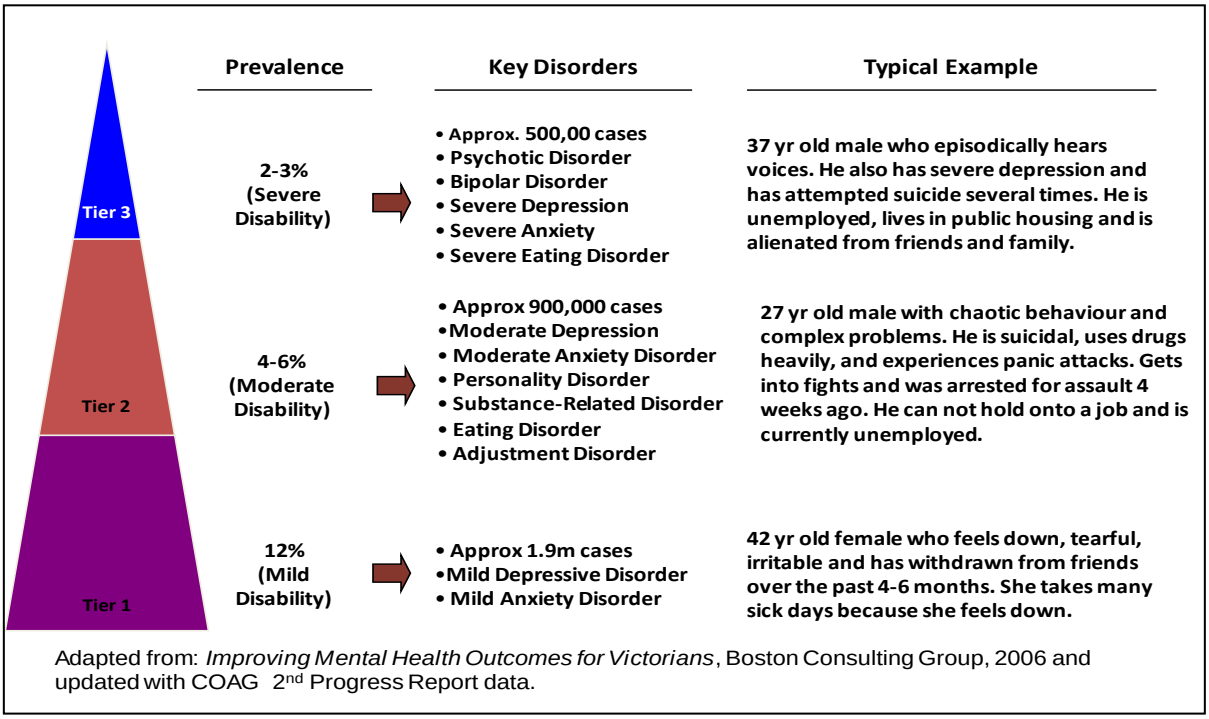
Mental Disorder	Males		Females		Total Persons	
	%	Pop'n estimate	%	Pop'n estimate	%	Pop'n estimate
Any affective disorder	5.3	420,100	**7.1**	**573,800**	6.2	995,900
Any anxiety disorder	10.8	860,700	**17.9**	**1,442,300**	14.4	2,303,000
Any substance use disorder	**7.0**	**556,400**	3.3	263,500	5.1	819,800
Any mental disorder	17.6	1,400,100	**22.3**	**1,797,700**	20.0	3,197,800

Source: ABS, National Survey of Mental Health and Wellbeing 2007, Oct 2008.

In addition to the three most common mental health disorders shown in the ABS Survey (i.e. affective disorder, anxiety disorder and substance use disorders) known as the high prevalence disorders, about 3-4 in every 100 people in the Australian population experience low prevalence disorders, such as bipolar affective disorder, schizophrenia, drug psychosis, other psychoses and personality disorders, at some time during their lifespan.

It is important to understand that the severity of disability from mental illness varies from mild to severe. This is shown in Figure 9. Schizophrenia, for example, whilst relatively uncommon with a prevalence of less than 1 in 100, usually results in severe disability for people who develop the condition. On the other hand, people who experience anxiety disorders and most affective disorders, often respond quickly to treatment and experience only mild disability. In practical terms, they are able to resume work, education and other forms of participation in the community.

Figure 9: The three tiers of mental illness



Adapted from: *Improving Mental Health Outcomes for Victorians*, Boston Consulting Group, 2006 and updated with COAG 2nd Progress Report data.

Research over the past 20 years has helped to better understand the causes of a number of mental illnesses and, most importantly, develop more effective treatments. Combinations of talk therapy, such as cognitive behavior therapy (or CBT) and new medications, have dramatically improved recovery from a mental illness. Exercise has also been shown to be highly effective in the treatment of depression, anxiety disorders and bi-polar affective disorder. A significant number of studies (almost 30) have shown jogging, weightlifting, walking, stationary bicycling and resistance training have all been found to be effective. In older people, exercise has been found to be as helpful as antidepressant medication or social contact (Donovan et al, 2007). Employment and social engagement have also been shown to be highly effective in the treatment of mental illness. Research has also shown that web-based therapies, or virtual therapies, are just as effective in treating many mental illnesses as therapies provided face-to-face by a professional in a consulting room (Christensen, 2009).

The evidence is clear that with early treatment, most people recovery from a mental illness and are able to fully participate in the social and economic life of the community. However, the stigma associated with mental illness inhibits help-seeking action by too many Australians. The ABS Survey showed that just over a third of those with a mental illness in the previous 12 months sought support services (ABS, 2008). Earlier work in Victoria calculated the number of people missing out on any service – even for those with severe psychotic disorders, 44% of people received no service (see Figures 10 and 11 - BCG, 2006).

Figure 10: Percentage of Victorians with mental illness receiving service

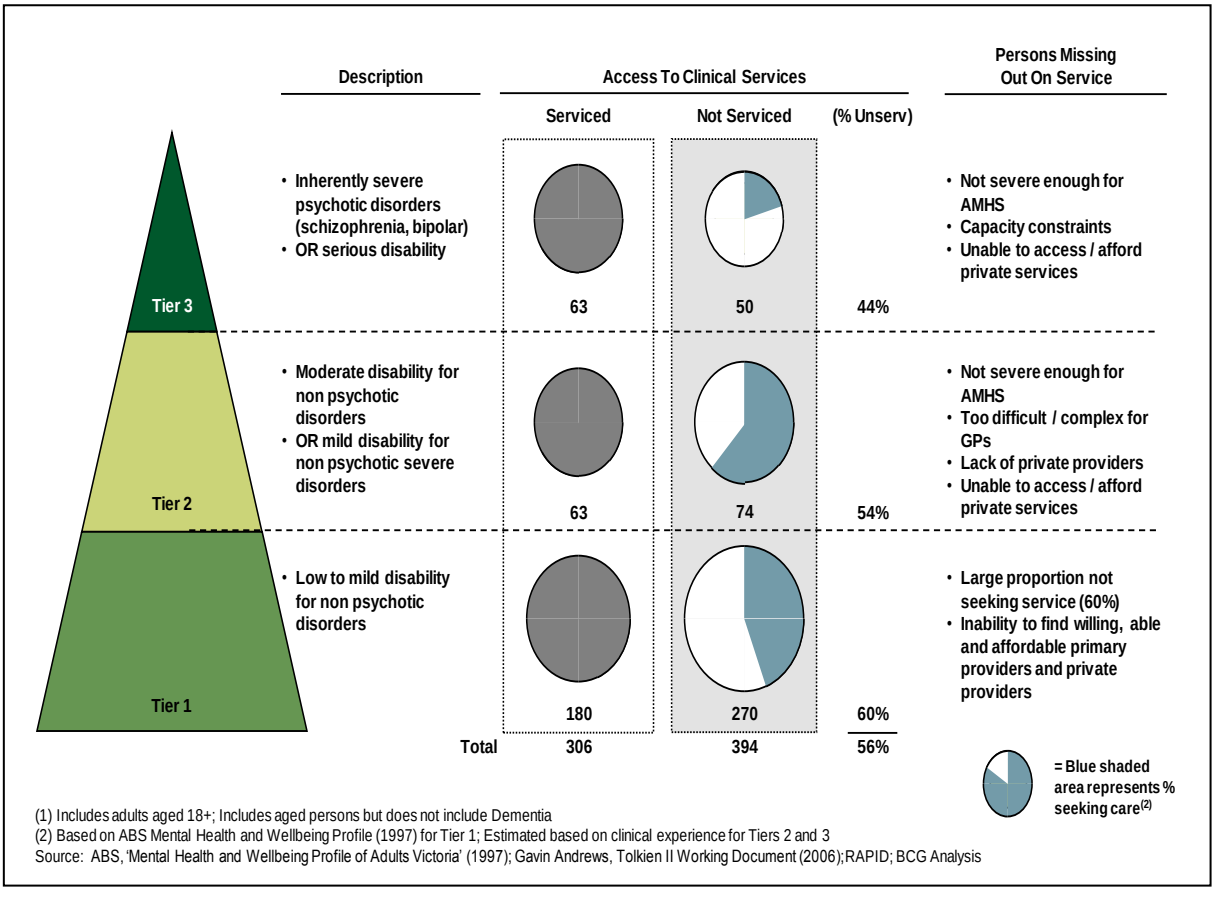
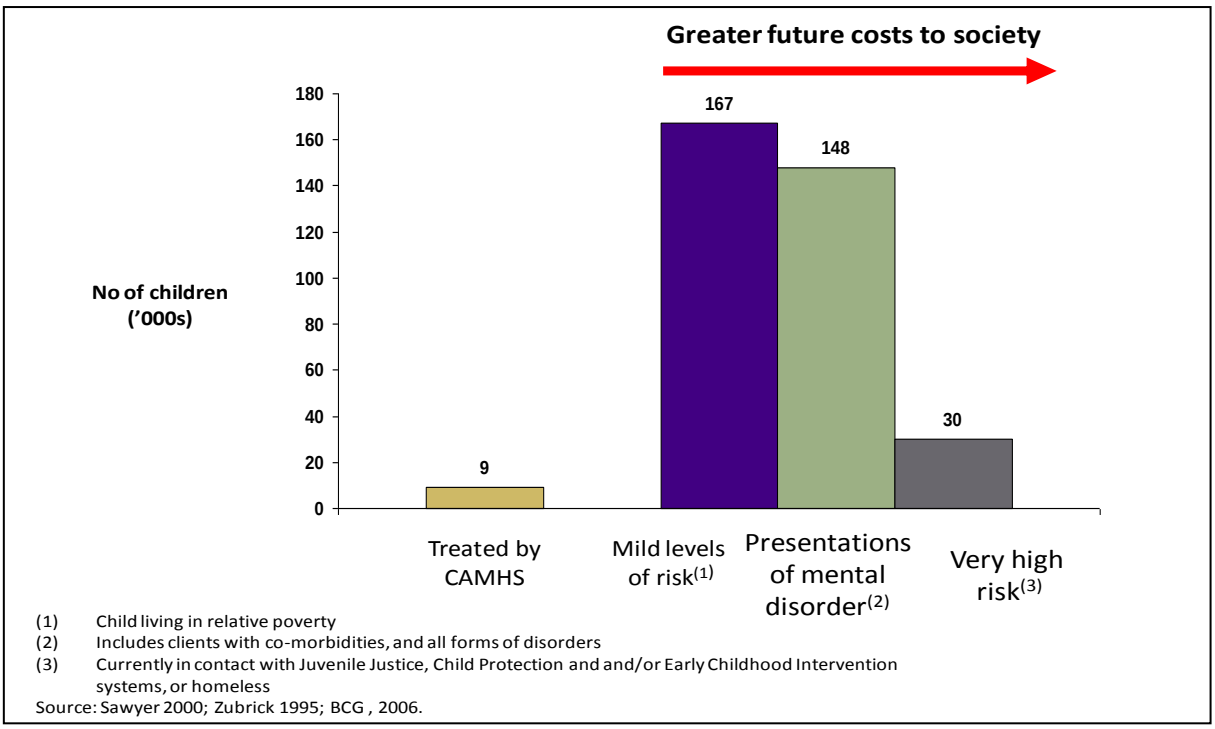


Figure 11: Proportion of children and adolescents seen by Child and Adolescent Mental Health Services



(1) Child living in relative poverty
(2) Includes clients with co-morbidities, and all forms of disorders
(3) Currently in contact with Juvenile Justice, Child Protection and and/or Early Childhood Intervention systems, or homeless
Source: Sawyer 2000; Zubrick 1995; BCG , 2006.

Importantly the range of mental health services has developed remarkably since the days of the psychiatric hospital. As with any health condition, early diagnosis and treatment of a mental illness reduces the impact of the condition, the likelihood of complications and promotes recovery.

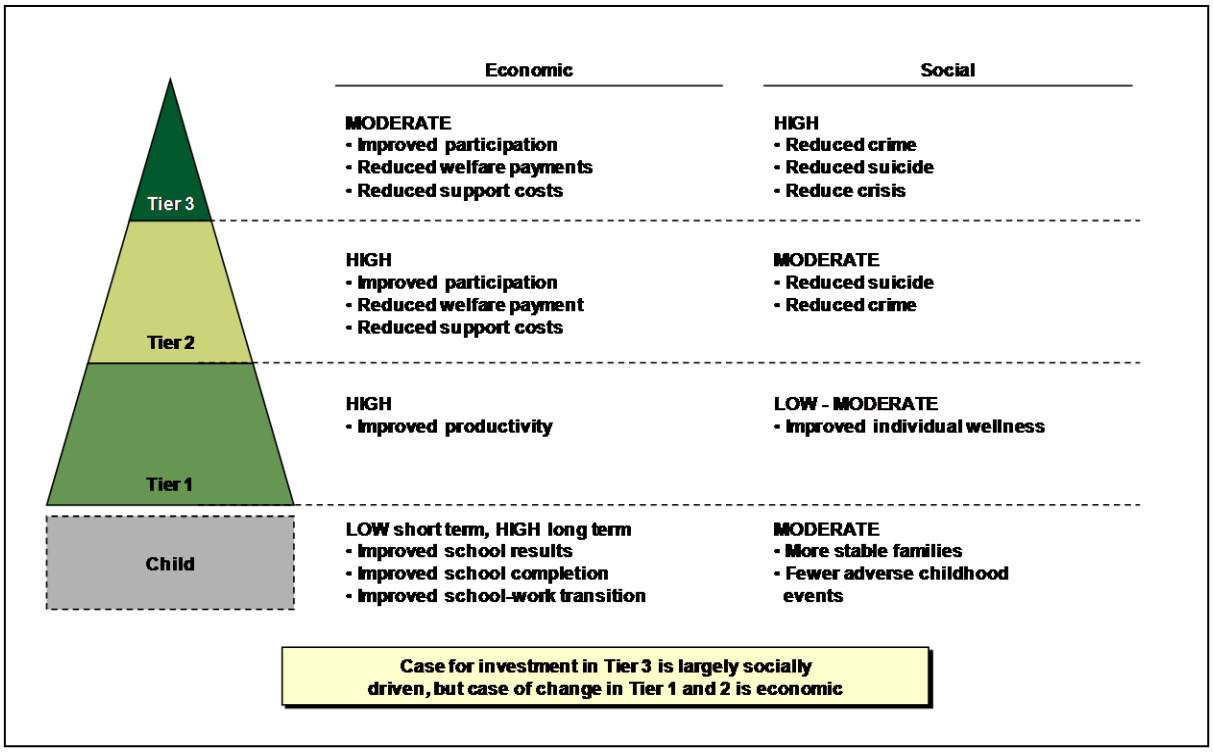
In recent years, the concept of 'recovery' has developed in mental health services. Research has shown that the overwhelming majority of people who experience a mental illness recover and fully participate in community life. Even for those people with the most severe and persistent mental illnesses, it has been clearly shown that they can live well in the community, sometimes with little or no on-going support. The economic and social impact of treatment is shown in Figure 12 (BCG, 2006).

In comparison with other developed or OECD nations, Australia does relatively poorly when it comes to employment participation for people with mental illness. Overall, only 29% of all those with a mental illness participate in open employment. In the Netherlands, it is over 60% and within the OECD it is 53% (MHCA, 2009). In Australia, only 9% of those experiencing schizophrenia participate in the workforce – in the Netherlands, it is over 30%. The reasons for this are essentially structural and attitudinal. That is, community and workplace attitudes and structural barriers within the welfare systems and, to a lesser extent, insurance industry practices, are the key factors contributing to our comparatively low rate of workforce participation for people with a mental illness.

Economic analysis shows that employees with depressive symptoms who are not receiving treatment, are absent from work for 5.5% of total working time, which is 4.3% more than their non-depressed counterparts. This equates to an annual wage loss of at least $1.5 billion due to absenteeism in Australia. Moreover, employees with depressive

symptoms have a reduction in the ability to function at their usual level of capacity while at work (Waghorn, et al 2007).

Figure 12: Impact on mental outcomes by tier of mental illness severity



The relationship between mental illness and suicidality

Results from the 2007 *National Survey of Mental Health and Wellbeing* show that people with a mental illness are much more likely to have had serious suicidal thoughts than other individuals (8.3 percent, compared with less than 0.8 per cent). Almost three-quarters (72 per cent) of the survey's respondents who had had serious thoughts about suicide had a mental illness (Australian Bureau of Statistics, 2009). Additional research further suggests that "about two-thirds of those who die by suicide have symptoms consistent with major depression at the time of death" (Goldney, 2008, p. 27).

The strongest links between mental illness and suicide have been shown to include affective disorders (e.g. clinical (major) depression, bipolar disorder), schizophrenia, alcohol and other substance use disorders (see later section of this submission for further details regarding the link between alcohol and other substance use and suicide), borderline personality disorder and behavioural disorders in children and adolescents. People who have been diagnosed with affective disorders or schizophrenia experience suicide rates many times that of the general population. For example, a recent review of fourteen reports from seven countries of 3,700 patients found that "those with bipolar disorders had a suicide risk 15 times that of those with no disorder" (Goldney, 2008, p.29). In addition, research shows that suicide is the leading cause of early mortality for people with schizophrenia, particularly within the first ten years following diagnosis (National Association of State Mental Health Program Directors Medical Directors Council, 2008). In fact, there is some evidence to suggest that effective treatment of 50% of people experiencing those mental health conditions most associated with

suicide (i.e. mood disorders, alcohol/substance use disorders and schizophrenia) could potentially reduce the suicide rate by up to 20% (Bertolote et al., 2004).

There is also a growing recognition that anxiety disorders (e.g. general anxiety disorder, social phobia, post-traumatic stress disorder, obsessive compulsive disorder) also increase the risk of suicidality, independent of the risk incurred through other cormorbid (simultaneously occurring) disorders. Often these disorders have a significant negative impact on an individual's functioning and ability to lead productive lives, which can lead to suicidal thoughts and actions. Other mental health conditions, such as borderline personality disorder in young women, are most associated with self-harm and/or suicide attempts, rather than completed suicide. There are a range of other, less common, mental health conditions in which there is anecdotal or limited scientific evidence to suggest that they, too, may increase the risk of suicidality. For example, many of the conditions that involve body image, such as anorexia nervosa, bulimia nervosa and body dysmorphic disorder (a condition where an individual is preoccupied with a perceived defect in their appearance), may also lead to suicidal behaviours and/or other mental health conditions that are known to increase the risk of suicide (e.g. depression).

Suicide risk rises with an increasing severity of mental health conditions and where individuals experience more than one mental disorder (often called "comorbidity"). Many mental health conditions are known to frequently occur together. In particular, alcohol or substance abuse disorders are often comorbid with other conditions, such as depression, bipolar disorder, schizophrenia and anxiety disorders. In a New Zealand study, some 57 percent of people who had made serious suicide attempts had had two or more disorders. Furthermore, although the odds ratio for people with a mood disorder to make a serious suicide attempt was 33 compared with people with no mental disorder, when individuals had had two or more disorders, the odds of a serious suicide attempt increased to 89 times the odds of those with no disorder (Goldney, 2008).

Furthermore, individuals experiencing mental illness are at the greatest risk of suicide immediately following discharge from psychiatric inpatient care (and some detention settings—e.g. prisons and immigration detention centres). This phenomenon is discussed in more detail later in this report.

Despite the strong evidence to support the link between mental illness and suicide, it is important to understand that this relationship is not necessarily causal. The vast majority of people who experience a mental illness do not experience or show signs of suicidal thoughts or behaviours and a person does not have to have a mental illness to exhibit a high suicide risk.

Characteristics of mental illness vary according to primary diagnosis, which in itself bears a number of complexities, given that the parameters of what constitutes a 'mental illness' can be said to be both broad and encompassing of a diverse range of viewpoints, narratives and varying uses of terminology (e.g. *mental illness* vis-à-vis *mental disorders*—which are used interchangeably in this submission). For example, Generally speaking, however, it is commonly accepted that a mental illness can significantly affect a person's ability to interact successfully with their family, friends, workmates and the

broader community; can cause extreme distress and disability; and can lead to isolation of, and discrimination against, those affected (Australian Bureau of Statistics, 2009).

Individuals experiencing mental illness may specifically demonstrate irrational behaviour, disturbed mood, poor judgement, abnormal perceptions or thoughts, disturbed emotions and ability to relate to others, and an inability to cope with adverse life events (Australian Government Department of Health and Ageing, 2007a). Depending on the mental illness and its severity, individuals may require specialist management, treatment with medication and/or intermittent use of health care services (Australian Bureau of Statistics, 2007)—although the gap between presentation of symptoms and treatment of illness (or continuity of care where it is sought) is often overwhelming.

It is important to note that, while clinically diagnosable, the prevalence of mental illness in the community is likely to be underestimated by the figures presented in a clinical and research setting, given that, while mental disorders are present in the majority of suicides (see Mann et al., 2005; Goldney, 2005; Cheng, 1995; Beautrais et al., 1996), a significant number (estimated to be more than 80 per cent) are untreated at time of death. References to mental illness in the context of suicide prevention research therefore typically relate to *identified* and/or *clinically diagnosed* mental illnesses.

One possible explanation for this is that, while improvements in mental health literacy have been demonstrated (e.g. via awareness-raising campaigns such as those of *beyondblue: the national depression initiative*), there have typically been fewer correlative changes in appropriate treatment behaviours among those most in need of intervention—i.e. individuals experiencing major depression and suicidal ideation (Goldney & Fisher, 2008).

For instance, the most recent *National Survey of Mental Health and Wellbeing* revealed that, among participants aged 16 to 85 years, access to care remains unchanged from the 1997 survey—around only 35 percent of people with a need for mental health care received any care. The survey also clearly showed that, while 75 percent of all mental illness manifests before the age of 25 years, it is precisely this younger age group that is least likely to access care (Australian Bureau of Statistics, 2007).

This may be attributable to the misconceptions and enduring stigma surrounding mental illness—but also suicide, in particular—which can lead to family tensions (including the concealment of cause of death in the case of suicide) and can discourage help-seeking among mentally ill individuals. For example, social stigma remains a major inhibiting factor in the reluctance towards help-seeking exhibited by many people in Australia's rural and remote communities, and may potentially preclude successful suicide prevention and crisis intervention strategies.

Another possible inhibitor towards help-seeking among those experiencing mental illness and suicidal ideation may be the cost and availability of access to appropriate (mental) health services in Australia. Mental illness (as with many other health conditions) is more common amongst lower socio-economic groups, who, in turn, may not be financially able to access available treatments, particularly ongoing treatment options, such as psychological therapy or counselling and/or expensive medication regimes. Availability of treatment options is also a significant factor in preventing effective management of mental health problems. Regional, rural and remote areas of

Australia typically have limited access to specialised mental health care and people from culturally and linguistically diverse backgrounds may be unable to access services that are culturally appropriate and available in their first language.

Several decades have now passed since the process of deinstitutionalisation of mentally ill individuals commenced, "shifting the care and support for these patients from psychiatric custodial institutions to community based settings". The extent to which appropriate care can be provided within a community setting remains highly sensitive to and dependent on resource constraints and work practices (Queensland Health, 2005, p. 10).

Thus, while suicide cannot always be prevented amongst people experiencing mental health problems, well-functioning policies, partnerships and management can improve the chances of prevention, particularly in the clinical context. Writes Bertolote et al (2003, p. 382): "The association of suicide and mental disorders has been widely discussed and documented, leaving the key role of the management of mental disorders in the prevention of suicide uncontested."

Alcohol, substance use/abuse and suicide

Alcohol

Alcohol is the most commonly used and abused substance and a major cause of death, injury and illness in Australia. In 2007, 32% of people aged 14 years and over drank at risky or high risk levels for short term risk such as injury, acute pancreatitis, suicide and death. A further 10% of persons in that age range drank at risky or high risk levels for long-term health problems. This was the result of high levels of regular daily drinking.

The National Alcohol Indicators Bulletin No. 12 discussed alcohol-attributable death and hosptialisations from 1996 to 2005. Over those years alcohol-related suicides were the third-leading alcohol-related cause of death for males. This study also reported that alcohol-related suicide attempts were the fifth most common cause of hospitalisation for females in Australia (NDRI, 2009).

Co-occurring substance use and mental health problems is a major drug and alcohol issue. According to the National Survey of Mental Health and Wellbeing, more than half of Australians seeking help for mental health problems also have substance use problems (Teesson, M., Hall, M., Lynskey, M., & Degenhardt, L. 2000). Both substance misuse and mental health are known risk factors for suicide and their co-occurrence further increases the risk. Complicating the approaches to address this co-morbidity issue is the lack of integration between AOD and mental health services (Hamilton, M 2009).

A Scottish report, "Lessons on Mental Health Care in Scotland", found that of 1,373 suicides studied, there was a history of alcohol misuse in 57 percent of cases and drug abuse in 38 percent. Approximately 80 percent of people who complete suicide are over the legal drink-driving alcohol limit. Alcohol increases impulsivity, reduces complex thought/problem-solving ability, increases aggressive behaviour and reduces pain perception, all of which may increase the risk of suicide.

Cannabis

Cannabis is the illicit drug most commonly used in the Australian community. In 2007, 34% of the population aged 14 years and over had used cannabis – some 5.5 million people . Whilst cannabis use has declined significantly in the past decade, Australia's cannabis use remains one of the highest of any developed nation.

Cannabis has long been thought of as the "safe" illegal drug, with cannabis typically eliciting lower levels of physical addiction and a lower potential for severe adverse reactions (e.g. violence, physical health problems, etc). However, there is mounting evidence that, in predisposed individuals, cannabis use has the strong potential to invoke psychotic episodes and may trigger the onset of schizophrenia and other mental health conditions. Even amongst individuals who do not possess a genetic or familial predisposition for psychotic disorders, regular or chronic cannabis use can lead to a range of other health and mental health conditions, including depression, anxiety, mood swings, poor concentration and alertness and a variety of cancers (e.g. lung, mouth) ..

The Mental Health Council of Australia released a comprehensive report, *Where there's Smoke,* on the relationship between cannabis and mental illness in December 2006. The report's clear messages from an analysis on all available data were:

- Cannabis use increases young people's risk of mental illness;
- Cannabis use makes almost any mental illness worse; and
- Cannabis use is associated with other adverse outcomes, such as poor school or work performance, early school leaving, unemployment and other illicit drug use.

Indeed, even the notion that cannabis is "not addictive" is now being challenged, with the demand for treatment for cannabis-related problems continuing to increase. In fact, one in every five treatment episodes in Australia is now for a primary cannabis-related disorder. Although the addictive properties of cannabis are substantially less potent than those of other drugs (e.g. nicotine, heroin, methamphetamine), the psychological and physical effects of habitual cannabis use are now known to be substantial and long-term users may experience significant withdrawal and other symptoms following the discontinuation of use.

Ongoing cannabis use may also increase the probability that an individual will experiment with other, harder, illicit substances, which may then further increase their risk of experiencing mental illness and/or suicidality.

Methamphetamine Use

Growth in the use of methamphetamine in the 1990s, and an increase in the use of crystalline methamphetamine has been associated with a range of mental health and related problems arising from drug use. Symptoms of psychosis are one of the particularly troubling consequences of methamphetamine use and dependent methamphetamine users may also suffer from a range of co-morbid mental health problems.

Among methamphetamine users who take the drug monthly or more often, the prevalence of psychosis is 11 times higher than among the general population . The symptoms usually last hours to days, and in severe cases, can lead to hospitalization.

Users who have schizophrenia, mania or other psychotic disorders are more likely to experience the recurrence of psychotic symptoms, or more severe symptoms, making treatment substantially more difficult.

Reported use of methamphetamine peaked in 1998, with 3.7% of people aged 14 or more reporting use in the previous 12 months. In 2004, 9% reported having used the drug at some point in their life. These general statistics on overall use mask a high use of methamphetamine among young adults. In 2004, one in five people aged 20-29 years reported having used the drug at some stage in their life.

The 2007 AIHW survey points to a decline in recent methamphetamine use in Australia - in 2007, use of the drug in the preceding 12 months was 2.3%, down from 3.7% in 2004. For young adults aged 20-29 years, 7% reported using methamphetamine in the previous year, down from 11% in 2004. Nonetheless, methamphetamine use continues to have numerous negative impacts for both individual users, their families and the community.

Other substances

Numerous other illicit substances have an association with both mental illness and suicide. Heroin use in Australia has increased in recent years, with an increase in the drug's availability and a decrease in price . Heroin users are up to 14 times more likely to complete suicide than the general population and they also have substantially higher rates of suicide attempts. They typically possess or have been exposed to a large number of known suicide risk factors (e.g. homelessness, family violence/abuse, sexual/physical assault). With strong depressant properties, heroin (and other opiates) is common in drug overdose deaths, which may, in some cases, be unrecorded suicides.

Cocaine and other stimulants have also been shown to induce certain symptoms of mental illness, such as psychosis and depression (when "coming down"). There have been some studies that show that up to 20% of all completed suicides have cocaine in their systems at death. Other drugs, such as anabolic steroids, may also cause mental health problems (e.g. depression) and increase aggression, irritability and mood swings – all of which are known risk factors for suicidal thoughts and behaviours.

Interestingly, nicotine use and dependence is much higher amongst people who have been diagnosed with a mental health problem than the general population. There is some evidence to suggest that the effects of nicotine may be beneficial for relieving the symptoms of some mental health problems (e.g. schizophrenia, anxiety disorders) and some of these effects are marketed by tobacco companies to encourage smoking amongst these populations. However, there has also been the suggestion that nicotine dependence may play a role in the cause of mental health problems, although the mechanism by which it may do this is unclear to date.

Substance use and Suicide

A study conducted in 2006 looking at suicide deaths in Queensland found that 60 percent of successful self-harm victims had at least one drug present in their system at time of death. Of the drugs recorded at death, alcohol was present in over 80 percent of drug completed suicide incidents (Oei et al., 2006). Furthermore, people who are alcohol dependent have been shown to have higher rates of suicide than the general population.

Similarly, another research paper in 2006 found alcohol was present in 33-69 percent of suicide reports from a sample of nations. The report also found a strong association between high levels of alcohol consumption per capita and high numbers of suicide per capita (Sher, 2006). Data from the National Drug and Alcohol Research Centre (NDARC) found that two-thirds of violent suicides (those by gun, cutting or hanging) had a psychoactive substance in their blood. Again, the most common factor is alcohol, followed by poly-substance abuse (Darke et al., 2009).

A recent German epidemiological study using data from two large national representative samples, looked at the association between average daily alcohol consumption, binge drinking and alcohol-related social problems. The social problems include poor educational or work performance, drink-driving, being a victim of dating violence, using illicit drugs and attempting suicide. The study found that the more frequent the binge drinking occasions, the more likely a person was to have such social problems (Kraus et al., 2009). The occurrence of these social problems may further increase the risk of suicide, through the potential exposure to known risk factors (e.g. sexual abuse, rape, physical health problems caused through injury, assault, violence, road traffic accidents, other traumatic incidents).

Alcohol and/or other substance (ab)use can act as both a risk factor for suicidality and also as a precipitant for suicidal behaviours. Substance abuse disorders and addiction substantially increase the risk of experiencing mental health problems (including depression, schizophrenia, bipolar disorder, psychosis, anxiety disorders), which are known to be one of the main risk factors for suicide, particularly when they occurs concurrently with substance abuse. In addition, substance use and abuse themselves increase the risk of suicide, independent of the influence of mental illness.

In addition, substance use prior to a suicide attempt can increase an individual's ability to engage in self-harming behaviour through a variety of mechanisms. For example, alcohol consumption can reduce cognitive function and decision-making capabilities, increase impulsivity, reduce pain perception and increase aggressive behaviours. Other legal and illegal substances can have similar and/or alternative effects that may precipitate suicidal behaviour. Those drugs that have the propensity to elicit psychotic episodes (e.g. methamphetamine, cannabis, heroin) may also increase the risk of suicidality, through delusional thoughts or hallucinations.

Substance use disorders are much more common amongst men than women and men who attempt suicide typically have higher rates of substance use and substance abuse disorders than women who attempt suicide. This may suggest that men use substances (including alcohol) to both "self-medicate" (i.e. attempt to cure or treat their mental health issues and/or emotional pain rather than using other forms of "treatment") and also to assist them in carrying out their suicide plans (i.e. give them the courage to go through with it). Further details about men and suicide are provided later in this report.

Identifying Higher Risk Populations

In addition to mental illness and substance abuse, a range of social factors contribute to the risk of suicide. Several population groups within Australia have been identified as having a high risk of suicidal ideation, having completed or attempted to complete suicide. Often the risk groups overlap and individuals may be part of more than one

group, further increasing the suicide risk. The high-risk groups include - men, Indigenous Australians, people who have previously attempted suicide, gay, lesbian and transgender persons, rural and remote residents, youth, people bereaved by suicide, ethnic (culturally and linguistically diverse) backgrounds, and those who have recently left health or institutional care. Due to the diversity of these identified groups, specific individual needs and risk factors are also associated with each risk group.

Men and suicide

Between 75% and 80% of all completed suicide victims in Australia are men. More broadly, suicide accounts for almost a quarter of all deaths among young Australian men aged 20 to 34 years, with middle aged men increasingly identified as being particularly at risk of suicide and self harm. Statistics additionally identify isolated older men in some parts of Australia as being more likely to take their own lives, while male suicides in remote areas continue to increase at alarming rates. There are many contributing factors and/or catalysts to male suicidality and men typically become suicidal in response to a range of complex intrapsychic, emotional, interpersonal and social factors.

The ratio of completed suicides to attempted suicides is much higher for men than for women. This discrepancy can be attributed to many factors, but the most significant factor is the choice and availability of methods of suicide used by men. Men are far more likely to choose a more lethal means of attempting suicide (e.g. hanging, firearms) than women, who tend to choose less lethal means (e.g. drug overdose).

Available evidence shows that clinical depression, substance use disorders and other mental health problems continue to be common and recurrent risk factors in male suicide. Other issues that have a significant impact on male suicide include: illness and disease, social isolation, lack of support and services and willingness to use the services provided, discrimination, housing issues, previous physical and sexual abuse, imprisonment, divorce or relationship breakdowns, bullying behaviour, sexuality, gender identity issues, employment and financial concerns, coping with stressful life issues, cultural dislocation and agricultural economies and drought.

One of the most significant risk factors associated with male suicide is a lack of support and the reluctance and/or inability of men to recognise and identify their own risks and seek help. There is evidence to suggest that many available support services (e.g. telephone crisis lines) are used primarily by women and may be, inadvertently, inappropriate or inaccessible for men.

Indigenous Australians and Suicide

Within Aboriginal and Torres Strait Islander communities, available evidence suggests that the rate of suicide among Indigenous peoples may be around four times higher than the rates for non-Indigenous Australians in major cities . In particular, suicide among young Aboriginal males has increased alarmingly over the past 30 years and for young Aboriginal and Torres Strait Islander men under 35, the rate of suicide is estimated to be three times that of non-Indigenous males of the same age.

The accuracy of suicide reporting in regional and remote Australia is fraught with difficulty and contributes to underreporting of suicide. Reporting of Indigenous suicide is particularly problematic, as increasing Indigenous rates may be hidden within statistics of overall suicide rates of jurisdictions that appear stable. This is because non-

Indigenous suicide rates are falling, which contributes to the anomaly. Indigenous status is usually well recorded in health system demographic data in the Northern Territory, but the Indigenous (Aboriginal) status is not recorded in the National Coroners Information System demographic data and as yet there is no requirement for, or ability to record Indigenous status. All jurisdictions in Australia are now using the Victorian Institute of Forensic Medicine's National Coroners Information System (NCIS) electronic database, but it requires manual examination of each electronic record to determine Indigenous status and therefore is a barrier to accurate research and reporting of Indigenous suicide in each jurisdiction in Australia. This is a grave disadvantage for rural and remote Australian Indigenous people, who have had dramatically high rates of suicide that have gone virtually unnoticed by the mainstream decision makers, due to inaccurate or non-existent statistical data.

The causes and requirements for suicide and suicide prevention within Aboriginal and Torres Strait Islander communities are unique to Indigenous culture. Whilst many of the risk factors are common between Indigenous and non-Indigenous Australians, a separate approach is required for dealing with Indigenous suicide and the associated risk factors. In particular, whilst mental disorders are contributing factors to suicide, Aboriginal suicidality and mental illness seem to have a tenuous connection and Aboriginal suicidology has provided little evidence to date to suggest any direct correlation between Aboriginal suicide and diagnosable mental illness. Suicide deaths within Aboriginal culture, particularly by hanging, are frequently witnessed by many members of an Indigenous community, and places where people have died by suicide often take on local meanings and associations. In some instances, high levels of exposure to both death and suicide have resulted in a de-sensitisation among members of Indigenous communities and suicidal behaviours can become normalised (Farrelly, 2008).

The collection of reliable suicide statistics for these communities remains problematic, although available evidence shows that risk factors such as alienation and anger; dispossession; grief and lack of purpose; separation of children from parents; social disadvantage; poverty; lack of meaningful support networks; suicide deaths in custody; the impact of erroneous government policies; illiteracy; lack of publicly recognised role models and mentors; sexual assault; lack of meaningful employment; widespread use of drugs; and heavy drinking are major social and environmental contributors that have been implicated in the development of suicidal and self-harming behaviours in Indigenous individuals . An additional risk factor is suicide itself, with suicide deaths often sparking clusters of suicides in Aboriginal communities. This shows that the risk of suicide is often at the community level, rather than that just of the individual.

Indigenous understandings and definitions of suicide attempts remain under-researched and poorly understood. It must be acknowledged that there are certain cultural protocols that vary from Indigenous community to Indigenous community and these must be respected as a central feature of any initiative seeking to address the problem of suicide among and by Indigenous peoples. Suicide prevention initiatives should therefore be supported by an Indigenous suicidology that recognises differences in suicide aetiology and that have the capacity to deliver *tangible outcomes* for at-risk individuals and affected families in Indigenous communities (Elliott-Farrelly 2004). This requires cultural sensitivity (extending to responsible media reporting of

Indigenous suicide, particularly Aboriginal suicides in custody) and a demonstrated respect for the fundamental principle of self-determination.

The training and support for frontline workers in Indigenous settings is inadequate and staff are at real risk of suicide themselves, with high levels of burnout, blame and vicarious trauma. They require critical incident debriefing regularly, but as a rule, rarely receive it, and yet are consistently at the coal face. Even when they have finished their daily work, they can be called upon at any time, night or day, due to the high rates of attempted suicides in Indigenous settings. The risk for these frontline workers and their families is manifold, as they often live in a community "at risk" and contagion is always a factor. As frontline workers, they may also be exposed to "sorry business", grief and loss in the most existential way, yet there is no systematic process for postvention response and self care guidelines to safeguard them from burnout and vicarious suicide risk.

There is also a dearth of research into suicide contagion and clustering of suicides, particularly in traditional Indigenous communities across Australia. There appears to be a reluctance to investigate the suicide deaths that are occurring in the Northern Territory, particularly since the rates of suicide have accelerated dramatically in recent years. The Coronial Inquest in the Kimberley region has provided some invaluable insight into the antecedents of Indigenous suicide in that region, revealing the startling rates of suicide in the area.

People who have previously attempted suicide or self-harm

Individuals exposed to a history of suicide, be it their own previous suicide attempt, a family history of suicide, a recent suicide in the community, those bereaved by suicide or those who have been exposed to reports of suicide in the media, have a higher risk of attempting or completing suicide themselves. In particular, those who have previously attempted suicide (referred to as suicide attempt survivors) have a very high risk of attempting or completing another suicide event.

Repeated attempts

It is estimated that more than 170 people attempt suicide every day in Australia and, for every suicide death, 8-25 attempts occur . Past suicidal behaviours increase the risk for later suicidality, including death by suicide. Going through with a suicide attempt overcomes an individual's instinct of self-preservation, which means that further attempts and/or completing suicide may become more likely. Suicide attempt survivors describe varying degrees of suicidal intent and motives. Some suicide attempts are aimed at dying, some are aimed at mobilising help, while others are ambiguously aimed to a certain extent at both.

Attempted suicide is more prevalent among women than men and approximately half of all suicide attempts occur among people between the ages of 25 and 44 years. A quarter of all suicide attempts occur in young people between the ages of 15 and 24 years, with young women particularly at-risk. As previously discussed, men are far more likely to die through suicide. However men with a previous history of suicide attempts are a high risk category for subsequently completing suicide. Based on these mortality and morbidity figures, women are often viewed as 'attempters', while men are typically seen as 'completers'. It is important to note, however, that any suicide attempt is significant and warrants attention. Repeat attempters are more likely to experience enduring

difficulties, such as unstable living conditions and traumatic life events (including broken homes and family violence). Repeat attempters are also more likely to have higher levels of hopelessness and feelings of powerlessness and they are more inclined to use and/or abuse licit and illicit substances.

Accessing support services, discrimination and stigma

Those who have completed a suicide attempt, or have been exposed to a history of suicide, often experience stigma associated with suicide through health professionals, their community and their peers. This can act as a significant barrier to obtaining the most appropriate support that they require. There is increasing evidence that early treatment and intervention can be of great benefit, however, people with a mental illness and suicide attempt survivors have historically both been viewed negatively by the general public and health care professionals, often alienating and leading to loss of contact with people who could otherwise have been helped. For the suicide attempt survivor, experiencing stigma can also lead to self-stigmatisation, low self esteem, isolation and, at worst, further suicide attempts.

Less than half of those who attempt suicide receive medical attention and many do not seek help or come to the attention of health care professionals. Factors influencing help-seeking include the severity of the injury, the availability, accessibility and quality of health care services and the fear of possible negative consequences . Other barriers that have been identified include fear of being stigmatised, fear of hospitalisation, issues of trust and confidentiality, stigma and perceived loss of esteem.

Exposure to suicide

Individual risk factors for suicide attempts are mediated by the larger social context. Such factors may include national and community wealth/poverty, media reporting of suicide, availability of services, and availability of methods to suicide, among others. Suicidal behaviours of others may be copied by vulnerable groups. The knowledge of a suicide may normalise the behaviour and facilitate the occurrence of subsequent suicide attempts. The clustering/imitative effect, defined by an increase in the number of suicide attempts following a suicide, is particularly potent for young people. Not surprisingly, people who attempt and who have been exposed to suicide show significantly higher levels of distress, hopelessness and depression than the general population, thereby increasing the risk factors for a repeated suicide attempt.

Generally, there are higher rates of attempted suicides and suicides among first and second generation relatives of individuals who have previously completed suicide . There is also evidence that a history of suicide in the family may predict an earlier onset of suicidal behaviour. Suicide attempts can also cause significant distress in the wider community, such as community groups, sporting groups, workplaces, first responders and supporting services. Despite these findings, there is currently limited information on the impact of suicide attempts on loved ones and further research is required on the impact of a suicide attempt on family, friends and/or the wider community.

In contrast to completed suicide, the presence of psychiatric disorders is less documented among suicide attempt survivors. It has been suggested that the presence of mental illness and the range of proportions of psychiatric diagnoses reported in different studies is wide. In fact:

- Psychiatric disorders may be low in those who engage in suicide attempts for the first time, whereas the prevalence of psychiatric morbidity is higher in those who make repeated attempts (Kerkhof, 2000).
- Similarly, findings from the World Health Organization (WHO) series of World Mental Health Surveys show that the rates of mental disorders among suicidal people in the general population are much lower than those documented in clinical studies. In this study, only around half of those who had attempted suicide also had a prior mental illness (Nock et al., 2009), compared with some psychological autopsy studies of completed suicides, in which up to 90% of people who suicided experienced some form of mental illness.

Much research on suicide has focused on risk factors and quantitative data, which has helped guide clinical interventions. However, suicide attempt survivors have traditionally felt excluded from the suicide prevention process. When they have participated, they sometimes have felt unwelcome or that their perspective was considered less valid than that of individuals who were bereaved through the suicide of a loved one. However, information about lived experience or understandings of internal suicidal processes is also crucial, and suicide attempt survivors can uniquely contribute and identify their individual needs and guide the development of effective prevention and aftercare strategies. Research has shown that consumers have enormous potential to influence their own health outcomes if they are actively involved in shared decision-making and are provided with quality information and appropriate self-management tools. This has previously been demonstrated by people with chronic diseases who have been actively involved in their own care.

Deliberate Self-harm and Suicide

Non-suicidal deliberate self-harm (e.g. often repetitive or habitual self-harming acts, such as cutting, scratching or injuring oneself) is most common amongst young women and there is a strong relationship between borderline personality disorder and self-harming behaviours . Self-harm is often used as a coping mechanism, particularly where a person has not learned or is unable to engage in more appropriate coping strategies. People who self-harm give a number of reasons why they engage in these behaviours, including using self-harm as a way to release internal tension or pressure, to reduce emotional pain, to punish themselves due to feelings of guilt and shame, to avoid communicating their feelings to others or to give themselves a sense of control over their lives.

Self-harm is linked to suicidal behaviours, although this relationship is unclear at present, with limited conclusive research or evidence. In many cases, self-harm is not related to suicidal thoughts or any intention to cause fatal harm. In fact, self-harm may protect against suicide in cases where an individual uses self-harming behaviours to control their suicidal thoughts or emotional pain. However, despite having no intention to die, up to 41% of individuals who engage in self-harm report suicidal thoughts at the time of self-injuring and between 55% and 85% of people who self-injure have a history of at least one suicide attempt (Stanley et al, 2001). In addition, both people who engage in self-harming behaviours and people who have attempted suicide score higher on measures of depression and suicide ideation than the general population. However, attempters tend to have a more negative attitude to life and report more traumatic life

experiences (Muehlenkamp & Gutierrez, 2004). Whatever the exact relationship between self-harm and suicide, it is clear that adequate support and care for people who self-harm is essential to prevent repeated, and possibly fatal, behaviour.

Sexuality, Sex, Gender Diversity and Suicide

Research findings demonstrate that suicide attempt and self-harm rates among lesbian, gay, bisexual and transgender (LGBT) communities are significantly higher than among non-LGBT populations, revealing that LGBT individuals attempt suicide at rates between 3.5 and 14 times those of their heterosexual peers. Self harm statistics show that 28 percent of lesbians versus 8.3 percent of heterosexual females, and 20.8 percent of gay men versus 5.4 percent of heterosexual males report deliberate self-harm. Bisexual young people exhibited an even higher prevalence of self-harm than their exclusively gay and lesbian-identified peers, at 29.4% and 34.9% for bisexual males and females respectively. Transgender populations are also known to have high rates of suicidality and self-harm.

It is important to note, however, that there are numerous, distinct sub-groups within the umbrella term of LGBT, each of which have varying levels of risk and different needs for support and services.

Reliable suicide mortality statistics for these populations remains highly problematic, as sexual orientation, sex identity and gender identity, unlike other demographic characteristics, are not identified in most existing data collection mechanisms. Evidence also suggests that many suicide attempts by LGBT people occur while still coming to terms with their sexuality and/or gender identity, and prior to disclosing their identity to others (Dyson et al, 2003; Cole et al, 1997). Sexual orientation and gender identity — unlike other demographic characteristics — are not readily observable, and may not be known by family and friends at the time of death.

Risk among sexuality, sex and gender diverse people is compounded by unique issues, such as both external and internalised homophobia and transphobia and 'minority and gay-related stress, particularly amongst young people and those in rural and remote locations. Evidence shows that LGBT people experience a higher prevalence of risk factors related to suicide than their non-LGBT counterparts, in particular, discrimination and stigmatisation (Dyson et al., 2003). Other related factors include: social isolation/exclusion, alcohol and other drug use, previous suicide attempts or deliberate self-harm, current or past mental health difficulties (notably, depressive and affective disorders), exposure to attempted or completed suicide by a friend or relative, family/relationship stress, harassment, physical or sexual abuse and discrimination (DoHA, 2007b). Research also shows that marginalisation and discrimination experienced by LGBT people contributes to barriers to the access of health and support services, further increasing the vulnerability of LGBT people experiencing suicidal ideation (Leonard, 2002; McNair, Anderson, & Mitchell, 2003).

Younger LGBT people are at a particularly elevated risk of suicide and self-harm, with studies demonstrating that attempted suicide rates for this group are up to six times as high as their heterosexual peers (Dyson et al., 2003). The physical and psychosocial development that takes place during adolescence is believed to compound issues surrounding sexual orientation and gender identity; particularly in relation to developing a positive sense of self (Di Ceglie, 2000; Holman & Goldberg, 2006; Morrow,

2004). Family and peer rejection, harassment and bullying on the grounds of gender non-conformity and/or sexual orientation remain common experiences for many LGBT young people; further exacerbating feelings of isolation, self-loathing and shame, which substantially increases vulnerability to suicide and self-harm for this age group (Hiller et al., 2005).

There is also rising concern amongst health and community workers that body image issues may also contribute to poorer mental health amongst LGBT communities. Indeed, there is growing evidence that same sex attracted men appear to be at greater risk of experiencing body image dissatisfaction and related depression and low self-esteem than their heterosexual peers (Russell & Keel, 2002). Older LGBT people have themselves referred to the impact of ageing amidst a youth-oriented gay cultural milieu, which harms self-esteem through the promotion of negative ageist stereotypes (Harrison, 2005).

Membership of other social groups experiencing significant discrimination and/or social exclusion compounds the risk of suicide (e.g. Aboriginal and Torres Strait Islander people who are also LBGT).

Suicide in Rural and Remote Australia

Suicide rates for marginalised groups in rural and remote areas of Australia, particularly within the high risk groups of Indigenous people and disadvantaged males, are rising. For farmers, approximately two-thirds of suicides by farmers occurred predominantly in older age groups (55+ years). However, both young (15-24 years old) and older (55+) rural people are 30 to 50 percent more likely to end their life by suicide than their urban counterparts. Access to firearms and pesticides can contribute to suicide through increased lethality and 75 percent of male suicides in rural cities, municipalities, and shires typically involve a firearm. The rates of suicide by firearm have tended to increase five-fold for rural dwellers, with no corresponding increase for urban dwellers.

The suicide statistics for rural areas are thought to be underestimated and the incidence of actual suicides in these areas is thought to be considerably higher than the number of registered suicides. This is likely due to a variety of reasons. It can be difficult to determine the true intent of some deaths, particularly those by drowning, drug overdose and single vehicle, single driver car accidents, which may be incorrectly coded as accidental or unspecified deaths. In addition to this, the social stigma, guilt and shame attached to suicide and the resultant socio-economic and emotional implications on surviving family members, and the community more broadly, can also prompt a reluctance to provide a verdict of suicide in rural communities. The collection of reliable suicide statistics for Indigenous Australians continues to be problematic, however, suicide rates in some remote communities are thought to be significantly higher than the already high rates of urban Indigenous Australians.

Many of the cited risk factors associated with rural problems tend to be similar to those cited previously for men, indicating that masculinity is an issue in rural and remote areas. The stoic attitudes, attachment to the land, and 'broad shouldered' behaviours, particularly those expressed by many rural men, may mask mental health issues. Frequently cited contributors to suicide and barriers to effective treatment in rural areas also include depression, social stigma and concerns regarding confidentiality when seeking help, drought-related trauma, financial issues, alcohol and other

substance abuse, same-sex attraction among rural youth, isolation, violence and the availability and accessibility of mental health education. In addition to this, other social and economic concerns, such as the devaluing of rural contributions to Australian society, the declining profitability of core industries in rural Australia, the lack of understanding and support for these industries by metropolitan communities, the impact of depopulation on the social disintegration of rural communities and the impact of "living at work" (particularly during times of hardship), increase the risk and stresses placed on rural individuals.

Male youth suicide in rural areas has similarly been identified as a pronounced problem and is estimated to be double that of metropolitan figures (Dudley, Kelk, Florio, Howard, & Waters, 1998; Sidoti, 1999). Rural inland towns with populations of less than 4,000 have experienced the most significant increases in male youth suicide. Research shows that the gradual depopulation of a number of rural areas has also resulted in the loss of primary relationships and increased loneliness for many rural residents, particularly young men. Other risk factors for young people include interpersonal problems, the break-up or breakdown of the family unit, unemployment, media representations of suicides, greater availability of lethal methods of self-harm in rural communities (e.g. firearms) and barriers to access and use of mental health and health care services. Subsequent discrimination, marginalisation and social exclusion experienced by same-sex attraction can also be a significant contributing factor to increased rates of suicide, self-harm and mental health problems amongst LGBT individuals living in rural areas.

Due to geographic constraints, rural areas often suffer from a shortage of health care facilities, such as hospitals and clinics, and have difficulties in attracting and retaining new service providers and health care professionals. Lack of professional development opportunities and peer support also contribute to poor recruitment and retention rates of health professionals in rural and remote areas. Where mental health and health care organisations do exist, these are usually under-funded, compared with urban areas, contributing to poor identification, treatment and support of at-risk rural and remotely located individuals. In addition to fewer services, rural residents often tend to postpone seeking medical or associated services for illness, disability or psychological problems until it is economically or socially convenient.

Young People and Suicide

The large number of years of life lost through youth suicide significantly increases the impact and costs of youth suicide in society. Although suicides under age 14 are not reported in Australia, suicide rates rise through the teen years and into the 20s. For youth aged 15-24 years, suicide accounts for 20% of deaths. Suicide is the main cause of mortality for males aged 25-44 years, whereas suicide attempts for female youth are more likely to result in non-fatal self-harm (Sawyer et al, 2000; Grunbaum et al, 2002). It should be noted that Australian suicide rates from 2002 to 2007 were conservatively 30-40% under-reported (Elnour & Harrison, 2008; ABS, 2009; De Leo et al, 2007, 2009, in press), indicating that although official youth suicide rates have decreased in recent years, youth suicide remains a significant concern. Indeed, a recent discussion paper released by the Commission for Children and Young People and Child Guardian in Queensland outlining suicide deaths amongst children up to 15 years of age, shows that suicide rates amongst this group have increased considerably in recent years, despite not being reported in official ABS suicide statistics .

Risk factors for youth suicide are large, varied and often interrelated. They include, for example, mental illness (in particular, mood disorders, psychoses, eating disorders, conduct disorders, post-traumatic stress disorder, access to lethal means of suicide (firearms, pesticides, etc), bullying, accidents, violence, child abuse, substance abuse, past adolescent suicidal behaviour, criminality, family disruption, learning disorders, physical health problems, sexual orientation and gender identity issues, parental psychopathology, social disadvantages and personality traits (e.g. daredevil/ risk-taking behaviours, neuroticism, hopelessness). The geographic, ethnicity and Indigenous status of youth also has a significant effect on suicide rates. There is also some evidence to support the notion that different types of youth cultures can either increase or decrease the risk of suicide.

Same-sex attracted and transgender youth are also at an elevated risk of suicide and self-harm. Same-sex attracted youth attempt suicide at between 3.5 and 14 times the rate of their heterosexual peers, while the prevalence of attempted suicides among transgender people ranges between 16 and 47 percent higher (Suicide Prevention Australia, 2009).

The media is also an influential factor on youth suicide and extensive international research finds media publicity about suicide, through factual (newspapers, TV) and/or fictional channels, promotes suicides and suicide attempts among vulnerable adolescents and young adults (Schmidtke and Hafner, 1988), particularly using similar methods to those depicted through the media reports.

Help seeking and help pathways are a concern for youth and statistics show that after a suicide attempt, fewer than 50% may be referred for further help and, of these, up to 75% may not attend their appointment. Stigma, shame and fears about confidentiality and coercion may prevent help-seeking amongst young people. In addition, the dependency of youth on parental figures for transport and guidance may also prevent youth from obtaining help. Older male adolescents are the least likely to attend their appointments with support services and are at the highest suicide risk (De Leo et al., 2005; Trautman et al, 1993; Piacentini et al, 1995; Donaldson et al, 1997).

The use of technology (e.g. mobile phones, internet, video games) has often been considered a cause for concern for young people, due to the potential risks associated with cyber-bullying, pornographic (including child-related) material, cyber-stalking, suicide pacts and other potentially damaging material and information. However, there is substantial recent evidence to suggest that not only is technology a "way of life for young people" (Burns et al, 2008, p. 14), but technology can also provide considerable help-seeking options for young people at risk. Young people today typically feel comfortable, competent and empowered using various forms of technology to communicate, connect and find information. For example, young people are far more comfortable divulging personal information via the internet (e.g. through social networking sites, such as facebook, MySpace, twitter) and the relative anonymity of the internet provides young people with the opportunity to seek information and engage with others in the safety and comfort of their home and without fear of potential discrimination, stigma or other negative consequences. As such, the development of evidence-based, online support networks and services have the potential to increase help-seeking behaviours amongst young people, as well as increasing social connectedness and inclusion, and thus, potentially reducing the risk of suicide. There

are a number of examples of these services in Australia, including the Reach Out website and the Kids Helpline website.

People Bereaved by Suicide

Suicide bereaved individuals are at increased risk of developing adverse physical and mental health reactions, including prolonged grief disorders and complications to pre-existing health problems. This is a major public health issue, especially since such reactions can substantially heighten the risk of suicidal ideation, behaviours and attempts among those bereaved by suicide.

While those bereaved by suicide may not be clinically unwell, they are at a high risk of becoming so. Indeed, the adverse physical and mental health reactions typically associated with suicide bereavement can increase the likelihood of development of other health risks during bereavement (Clarke, 2009). For instance, they can severely complicate and increase the burden of disease resulting from pre-existing (comorbid) health conditions; especially where individuals have limited social support and other adverse life situations (Clarke, 2009; Clarke & Currie, 2009).

The feelings of intense shame and rejection often experienced by those bereaved by suicide can also detrimentally impact an individual's ability to interact socially; thereby also significantly altering interpersonal relationships (sometimes to the point of family conflict and/or disintegration, for example) and relationships with surrounding social structures (Worden, 1991; Cvinar, 2005; Doka, 2002b).

This can lead to increased, or in some cases, complete, isolation of the bereaved during the period immediately following the suicide (including—where support mechanisms are offered—a resistance towards help-seeking and/or intervention). Similarly, suicide bereavement can result in complications other than the personal deterioration of mental and physical health. These can include financial problems, the prospect of unemployment, an increasing sense of hopelessness and, at worst, increased suicide risk (Worden, 1991; Cvinar, 2005; Mitchell et al., 2005; Krysinska, 2003; Szanto, Prigerson, & Reynolds, 2001).

Other studies show that individuals that witness a suicide or find the body of a loved one after death are more likely to experience enduring post-traumatic reactions (Rubel, 1999). The vicarious trauma and impact of suicide (particularly where the deceased was a patient or client) on first responders (including police and emergency services), clinicians, general practitioners and other health professionals (including coronial staff), and also volunteers, work colleagues and whole communities, should not be underestimated.

Undoubtedly, suicide can throw a whole community into confusion. "Bereaved families," writes Clark (2001a,p. 102), "face particular dilemmas, such as what to tell others, whether to hold a public funeral, and the intrusions by police and the legal processes surrounding 'sudden death'. To answer the question: "Why did he/she do it?" is a compelling quest", and the bereaved may harbour intense feelings of "guilt, rejection, and shame as well as questioning their value system".

Added to this, friends and neighbours may feel out of their depth and fail to support bereaved families ("I didn't know what to say" / "I didn't know what to do") and

inappropriate or insensitive media reports can cause further distress to those bereaved (Clark, 2001a; Australian Government Department of Health and Ageing, 2007).

Likewise, in the case of youth suicide, teachers may encounter mass grief within the school community, the dilemma of preventing heroism in tributes to the deceased young person, and the risk of imitative or copycat suicides (Clark, 2001a). Clinicians, and other professionals responsible for the care of the deceased prior to death, are also not immune from the effects of suicide bereavement (see Myers & Fine, 2007). However, it is only recently that the personal issues faced by professionals after the suicide of a client or patient have been recognised as an area requiring greater attention, research and response (Clark, 2001a; SANE Australia, 2009).

These individuals may well face the personal conflict of having to deal with their own emotions—including a sense of loss and personal and professional failure—while at the same time being required to provide "objective support for the bereaved family, patients contemporary with the suicide victim and fellow team members" (Clark, 2001a, p. 102). This is obviously further complicated in instances where a bereaved family feels aggrieved by a perceived failure of (mental) health care and treatment, which may increase a professional's fear for their reputation and of litigation (Hodgkinson, 1987; Michel et al., 1997).

Literature shows that suicide bereavement differs remarkably from most other forms of loss for many of the aforementioned reasons, but principally because of the stigma either *experienced* or *perceived* by the bereaved (Cvinar, 2005). Indeed, many individuals bereaved by suicide report feeling greater isolation and stigmatisation than other mourners, as a consequence of being 'tainted' or 'marked' with the real or perceived stigma associated with suicide, and the inability of others to "accept suicide as a legitimate death" (Jordan, 2001; Dunn & Morrish-Videners, 1987). This is further complicated, particularly for some older and terminally ill people, by the parameters and perceptions around legal versus non-legal intervention and physician-assisted suicide.

Real or perceived stigma in suicide bereavement can significantly complicate the grief process, as it can lead to experiences of 'disenfranchised grief', withdrawal, isolation and loneliness, due to reduced understanding and lack of social support. This, in turn, can reduce help-seeking behaviours and increase self-blame, lower self-esteem and increase vulnerability to depression (Sands, 2008; Doka, 2002a). In extreme cases, stigma has resulted in bereaved individuals disconnecting themselves from their existing homes and employment to relocate to new environments in an effort to distance themselves from the suicide event, find relief from the pressures of stigmatisation, and progress with the healing process (Demi & Howell, 1991). Police and coronial investigations following a possible suicide can often compound the pain of those bereaved by the death, especially in cases where bereaved individuals and/or families have had previously traumatic experiences within the criminal justice system. For these individuals and families, police and coronial investigations can contribute to a heightened sense of anxiety.

Empirical and clinical evidence suggests that individuals bereaved by suicide are more likely to experience suicidal ideation and behaviours than others not exposed to loss by suicide (Crosby & Sacks, 2002; Cleiren & Diekstra, 1995). Imitative suicides have

previously been noted in the literature on suicide bereavement, particularly among adolescents and young adults (Krysinska, 2003; Stack, 2000; Velting & Gould, 1997).

In Australia, these concerns have previously been reflected in a NSW Centre for Mental Health Report (1999), which noted that those bereaved through a suicide death of a significant other had a fivefold increased suicide risk compared to the rest of the population (Sands, 2008). Suicide deaths can also spark clusters of suicides or a 'contagion effect', wherein the suicide or attempted suicide of one person may trigger suicidal behaviours in those associated with that person or in vulnerable individuals who become aware of the suicide (see, for example, Chen et al., 2007; Malchy, 1997; Gould et al., 1994; Davies & Wilkes, 1993; Ward & Fox, 1977). These 'triggers' for increased risk of suicide can manifest in many different ways, according to the Commission for Children and Young People and Child Guardian (2009), including:

- Seeing the person who completed suicide and being involved in the aftermath
- Having talked with or seen the person on the day of the suicide
- Belonging to the family of the person
- Being a close friend of the person or of the family
- Being in the same class or peer group
- Learning of the attempted suicide or suicide of a role model
- Reading or hearing about the death in the media.

This demonstrates the need for grief support services that not only meet the specific needs of individuals and communities, but for those that also work from culturally sensitive understandings of and responses to loss, including the provision of tailored postvention strategies for highly vulnerable population groups; most notably, and as previously highlighted, Australia's Indigenous populations, but also bereaved children and youth, males, people with mental illness and their families and friends, and gay and lesbian, immigrant and rural and remote communities.

People from culturally and linguistically diverse backgrounds

While suicide occurs in almost every culture, the phenomenon of suicide and suicidal thinking among people who move from one culture to another varies from country to country. However, suicide rates among immigrants to Western countries appear (overall) to be higher than that found in the country of birth. When compared to country of birth, migrant suicide rates in Australia are reportedly higher, but it is unclear to what extent pre and post migration factors play a part in suicide rates and mental health problems (Burvill, 1998).

Mental health problems are considered a significant risk factor for suicide among people of culturally and linguistically diverse backgrounds. While the research does not provide consistent rates for mental health problems affecting immigrants and refugees, overall rates of mental disorders are widely believed to be substantially higher than in the general Australian population (Hunt et al, 2003). Post-traumatic stress disorder, depression and anxiety disorders are the most commonly diagnosed mental health disorders, although a range of other mental illnesses and social and behavioural problems have also been widely reported (Hodes, 2005).

Post-traumatic stress disorder (PTSD) has attracted the most research attention. Past trauma may take the form of events experienced or witnessed, where lives have been

threatened or people have been killed. Also significant is the loss of family, friends, relatives, personal belongings and possessions, livelihood, country and social status. PTSD is also likely to occur concurrently with depression or anxiety disorders, although PTSD on its own is more likely to persist over time.

Refugees have often been exposed to significant levels of conflict, violence and trauma, which are known risk factors for suicide for people from CALD backgrounds. Other potential risk factors for refugees include a lack of family support, living with a mentally ill family member, family stress, being alone or unaccompanied, prolonged (i.e. more than six months) incarceration in immigration detention centres, poor coping skills and resettlement stress. Poverty, discrimination and acculturation stress are all linked to mental health problems, such as depression, and may also increase the risk of suicidality.

There is also some evidence to suggest that second generation migrants (i.e. people whose parents immigrated to Australia, but who were themselves born in Australia) have a higher risk of suicide than other migrants (Hjern & Allebeck, 2002), perhaps due to difficulties in successfully integrating the cultures from their parental country of birth and their country of residence.

People from culturally and linguistically diverse backgrounds typically have difficulty accessing mainstream support services, due to language difficulties and/or culturally inappropriate resources. In addition, many cultures have a different understanding and meanings associated with suicide (both completed and attempted), bereavement and mental health, which are often poorly understood by mainstream health professionals.

Other higher risk groups

A number of other groups within the Australian community have been found to exhibit a higher risk of suicide than the general population. Some of these groups include people who have been recently discharged from psychiatric or hospital care, prisoners and those involved with the criminal justice system.

There is strong evidence to suggest that failures within the health care system tend to occur most at points of transition, such as when people are discharged from care or move from one type of service to another. People who have recently been discharged from psychiatric care are known to have extremely high levels of suicidality, particularly in the first day, week and month following discharge. In addition, prisoners and other people who are involved with the criminal justice system have also been found to have higher rates of completed and attempted suicide. In addition, certain occupational groups are known to have higher rates of suicidal behaviour, including the construction, farming and agricultural industries.

Although these groups typically only comprise a small proportion of the general population, their rates of suicide are known to be substantially higher than that of the general population. Furthermore, they are arguably easier to identify and, thus assist through targeted suicide prevention programs.

Chapter 4 - What Works – The Evidence Supporting Health and Social Interventions

Despite numerous nations across the world having specific suicide prevention strategies (including Australia) and many decades of research and investigation into the complex range of causes of suicidal behaviour, there is still limited high-quality, defensible evidence regarding the most effective and efficient approaches for preventing suicide. Globally, there are few wide-scale, longitudinal or cross-cultural studies that have clearly demonstrated the efficacy or positive impact of suicide prevention approaches (Leitner et al, 2008; Mann et al, 2004; Beautrais et al, 2007; De Leo, 2002; Headey et al, 2006). Indeed, regular, independent evaluation of existing government-funded programs and activities has only recently become mandatory in Australia. Nonetheless, there are many promising approaches, both internationally and within Australia.

Reducing access to lethal means of suicide

Arguably, the approach that has been scientifically shown to be the most effective for reducing suicide rates to date is removing the availability or regulating the access to lethal means of suicide. Reform to Australia's gun laws in the 1990s has had a significant impact on the number of suicides involving firearms. In addition, there has been no evidence of means substitution (i.e. a decrease in the number of suicides using firearms is accompanied by an increase in the number of suicides using other means). Restriction of access to barbiturates in Australian in the 1960s was also associated with a 23% drop in suicide using this method, without increasing the rate through other means. Despite these positive findings, restriction of suicide means can be costly (i.e. through consistent monitoring of suicide methods and compliance with legislation) and the potential for means substitution must be taken into consideration. Additionally, the most common method of suicide in Australia currently is hanging, making up almost half of all suicide deaths. Hanging is a particularly difficult method of suicide to prevent, as means for hanging are readily available and it is infeasible to restrict access to all the materials that could be used.

Key Points from this Chapter

There is limited high quality evidence regarding the most effective and efficient approaches for preventing suicide.

Arguably the most effective approach to date has been the removal of access to lethal means of suicide such as firearms control, access to certain drugs, protective barriers at known suicide sites, etc.

Training of frontline workers, such as Police, Emergency Services, health care providers, GPs and teachers – known as "gatekeepers" – also has strong evidential support.

Access to evidence-based mental health services and strategies for continuity of care following discharge from an acute psychiatric unit are also sound strategies.

Social networks and caregiving to counter social isolation and creating a safe and empathetic environment for those who have a mental illness or are experiencing suicidal thoughts can be beneficial .

Developing and applying media guidelines for reporting on suicide is thought to be an effective strategy.

Bereavement services for those directly affected by a suicide or suicide attempt is beginning to demonstrate positive results.

Crisis centres, telephone counselling and new online services are among the most cost effective strategies.

Much more research is needed to identify the most effective and sustainable strategies for suicide prevention.

'Gatekeeper' training

Another approach that has been shown to reduce suicide rates is suicide prevention and intervention training and education for frontline workers or "gatekeepers" (e.g. emergency workers, health care workers, GPs, etc.). "Gatekeepers" are those individuals who respond to, deal with or witness suicide incidents or attempts or who deal with people who are suicidal and who may have the potential to prevent suicide.

One of the most effective gatekeeper training programs was a suicide prevention program initiated within the US Air Force in 1996. The program aimed at reducing suicide risk factors and enhancing protective factors, including changing policies and social norms, reducing the stigma of help-seeking for mental health problems and improving awareness of mental health issues. The program resulted in a 33% decline in suicide rate, as well as reductions in levels of other related problems, such as accidental deaths, homicide and incidents of domestic violence among the Air Force personnel.

It is important to bear in mind that this program was implemented in a highly structured military environment, with formalised gatekeeper roles and referral pathways, and similar programs carried out in other settings (e.g. schools, workplaces) have had less impressive results. Nonetheless, the US Air Force program prompted the initiation of strategies and policies across various US states and has had an enormous positive impact on our understanding of the potential benefits and positive outcomes of effective gatekeeper training and changes in societal norms relating to help-seeking.

Effective treatment and care for people with mental illness

Because of the strong association between mental illness and suicide risk, there is substantial evidence that suggests that the effective treatment of mental health conditions (particularly major depression) reduces the risk of suicide and may decrease suicide rates. This includes both pharmaceutical treatments for mental illness and other forms of treatment, such as cognitive behavioural therapy, dialectical behaviour therapy and family therapy, which have been shown to be effective in both reducing the symptoms of mental illness and the risk of suicidality.

Pathways to care

Internationally, up to 83 percent of individuals who suicide have had contact with a primary care physician within a year of their death and up to 66 percent within a month (Mann et al., 2005; Luoma, Martin, & Pearson, 2002; Andersen, Andersen, Rosholm, & Gram, 2000). Yet, depression and other mental illnesses are often under-recognised and under-treated in primary care settings (Mann et al., 2005).

As Goldney (2008) points out, by way of example, a common theme among a number of studies maintains that mood disorders have often not been diagnosed in many of the individuals who have died by suicide. In instances where they had been, those people had often not received "adequate treatment for their depressive conditions" (Goldney, 2008, p. 28). Thus, writes Mann and colleagues (2005, p. 2065), a key prevention strategy could well be the "improved screening of depressed patients by primary care physicians and better treatment of major depression".

An example of this includes a previous Australian program that provided training to primary care physicians to assist in the recognition and response to psychological distress and suicidal ideation in youth. The training increased identification of suicidal patients by 130 per cent, "without changes in treatment or management strategies"

(Mann et al., 2005, p. 2067; Pfaff, Acres, & McKelvey, 2001). Primary care has also previously been identified as an ideal setting in which to address the high comorbidity between mental and physical illnesses and disorders (Whiteford, 2008; Andrews, Slade, & Issakidis, 2002). However, international studies (for example, Hunt et al., 2006) show that:

> *"Cases of suicide with drug dependence, alcohol dependence or personality disorder showed marked recent disengagement from services (e.g. missed appointments and self-discharge). Services were less likely to arrange follow-up appointments or attempt re-engagement with these patients. Services more often viewed suicide as preventable in schizophrenia, depression and bipolar disorder" (p. 141).*

The role of primary care as one of the most effective and proven early interventions to major mental illness and suicide should not be underestimated. Government reforms towards a more multidisciplinary approach to the diagnosis and treatment of mental illness suggest that greater value is being invested in the primacy of primary care. However, this recognition requires increased support of primary care physicians and general practitioners in the form of additional education, training and resourcing to assist in the development of improved risk assessment and diagnosis times (which, at present, can be anywhere up to 10 years for bipolar disorder, for example).

Reports such as *Tracking Tragedy: A systemic look at homicide by mental health patients and suicide death of patients in community mental health settings* have previously shown that constraints on the availability and capacity of Australia's mental health care services may contribute to deaths by suicide (NSW Mental Health Sentinel Events Review Committee, 2007). In fact, systemic reviews of suicide estimate that "around a third of suicides may realistically have been preventable with more optimal care" (NSW Mental Health Sentinel Events Review Committee, 2007, p. vi).

Specific concerns raised by the *Tracking Tragedy* report highlighted gaps in assessment documentation, deficient duration and continuity of care, and poor ongoing risk monitoring (NSW Mental Health Sentinel Events Review Committee, 2007; see also Burgess et al., 2000). The implication arising from such findings is that improved integration at critical transitions of inpatient and community-based care may well reduce the risk of suicide among mentally ill individuals. However, Australia's public mental health services require long-term remedies, not just band-aid solutions, and the building of capacity for the effective treatment of mental illness and suicidality.

It is equally important to remember that pathways to care for mentally ill and suicidal individuals are not (and should not be) restricted to those of a clinical context alone. For instance, mental health professionals may bear a greater chance of intervening in the progression of suicidal ideation into suicidal attempt if they identify other recent instances of social, situational, emotional or interpersonal precipitating risk factors, such as "upsetting social interactions, diagnosis of a disabling physical illness or recent job losses" (Fairweather et al., 2006, p. 1243). Similarly, the identification of social support networks and peers as a protective factor towards suicide risk is also essential.

Treatment options for mental illness and suicide prevention

It is important to note that mental illness affects each person differently. As such, appropriate and effective treatments will vary accordingly. Notwithstanding, the contribution of pharmacological treatments (particularly lithium and clozapine) and the

use of health services (often as one of the first points of clinical contact) are well regarded in the identification, assessment, and treatment of mental illness and suicide risk. There has also been some authentication given to the effectiveness of self-management strategies, including use of the internet, telephone counselling, and self-help groups, particularly for young people, people living in rural and remote areas and minority groups (e.g. LGBT populations, CALD populations).

More formally, studies have shown that therapies such as cognitive behaviour therapy (CBT) and dialectical behaviour therapy (DBT), as well as family therapy and problem-solving therapy, are often directly effective in reducing rates of suicidal ideation and suicidal behaviours; particularly through their management of depression and anxiety (see Burns et al., 2005).

Additional treatment options and crises services such as outreach interventions, which typically include regular telephone contact (e.g. Tele-Help/Tele-Check – see Fleischmann et al., 2008; De Leo et al., 1995; Termansen & Bywater, 1975) and home visiting, have also been highlighted as effective strategies for reducing social isolation and preventing suicide. Telephone contact, in particular, enables the detection of people at high risk of further suicide attempts, as well as timely referral for emergency care, and has been shown to help reduce the proportion of suicide reattempts among individuals recently discharged from hospital emergency departments (Vaiva et al., 2006, p. 1244).

Studies have also demonstrated that long-term letter or postcard interventions can be similarly effective in reducing repeat episodes of self-harm and also death by suicide among psychiatric inpatients following discharge from hospital (see Carter, 2005; Motto & Bostrom, 2001; Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-Harm, 2004).

The value of psychiatric hospitalisation as a suicide prevention strategy is unclear, though some research supports psychoanalytically-oriented partial hospitalisation (Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Deliberate Self-Harm, 2004). Quite often, however, when individuals present with one or more mental disorders (in particular) the tendency among many (mental) health care professionals is to treat the illness rather than the person, and the social circumstances and life events that typically give manifestation to the development of such mental disorders remain unaddressed.

Although the importance of effective clinical treatments (including antidepressant medications) should not be underestimated, suicide prevention strategies should equally take account of interventions that aim to diminish and counteract life stress by addressing the range of social, situational, genetic, emotional and interpersonal factors that can give rise to the development of mental illness and/or suicide and suicidal behaviours. As Goldney (2005, p. 130) points out, risk factors such as sexual abuse, parental domestic violence, and unemployment (often developed in childhood and adolescence and associated with adult mental disorders), among other social and situational risk factors (including, for example, the breakdown of relationships), should "demand the attention not only of health professionals, but of the community as a whole".

This rationale has been evident in a number of 'best practice' community intervention and outreach programs, such as (but not limited to) the following 'partnerships in action':

- The joint National Rugby League (NRL) *One Community* and Lifeline *Help a mate stay in the game* campaign, which aims to reduce the incidence of suicide while increasing awareness of depression;
- The Prevention and Recovery Care (PARC) program in Victoria, designed to divert vulnerable mental health consumers from hospital ('step-up care') and provide support following discharge from hospital to promote recovery ('step-down care') and vocational rehabilitation outcomes; and
- The Mentally Healthy WA program, *ACT-BELONG-COMMIT*, aimed at promoting better mental health through the building of resilience, connectedness and wellbeing in a number of rural communities.

At present, while drug and alcohol disorders are included in the formal definition of 'mental illness', as prescribed by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV-TR) and the *International Classification of Diseases, Tenth Edition* (ICD-10), they are typically excluded from Australian health care planning. This leads to a situation where barriers often exist "between services provided for different illnesses and different population groups" (Senate Select Committee on Mental Health, 2006, p. 7). This predicament is exacerbated for those experiencing comorbidity, in that the separation of (or barriers between) alcohol and other drug services and mental health services negates the prospect of holistic health treatment. Subsequently, people with dual diagnosis are often "shuffled between services [that are] unable and sometimes unwilling to treat both conditions" (Senate Select Committee on Mental Health, 2006, p. 18).

To this end, greater attention should also be provided to the treatment of comorbid conditions and the development of suicide prevention strategies that target mental illness and suicidality holistically, rather than simply as a medical issue. One way to address these issues might be to place less emphasis on at-risk populations and more emphasis on *why* certain populations are at risk. Likewise, it may be beneficial to question, evaluate and more prominently promote those treatment options known to be effective in addressing mental illness and suicidal ideation.

The debate over antidepressants

The prescription of antidepressants, particularly to children and adolescents, remains a controversial issue, with recent expert and public debate dominated by concerns over the efficacy and safety of new generation antidepressants (NGAs) (Dudley et al., 2008), and those medications that influence serotonin levels in the brain (Australian Government Department of Health and Ageing, 2007a).

Indeed, available research confirms that individuals may experience an increased risk of suicidal behaviour in the early stages of starting antidepressant medication, given that this treatment may not be immediately effective (Jick et al., 2004). However, a recent study, published in the *Canadian Medical Association Journal*, shows that selective serotonin reuptake inhibitors (SSRIs) can decrease the risk of suicide by over 40 percent among adults and by over 50 percent among elderly people (Barbui et al.,

2009). The enduring association of antidepressants with suicidal behaviour may well then simply suggest that antidepressant medications "are being prescribed for the right indication, and that they do not immediately eliminate suicide risk" (Wessely & Kerwin, 2004, p. 380).

Despite contrasting findings, the debate to date has largely considered the risks of treatment. Evidence regarding the risks of no treatment is discussed less often, or has only newly emerged (Dudley et al., 2008). Only 1.7 percent of adolescents dying by suicide are taking SSRIs (Dudley et al., 2009). As such, concern about the risks of prescribing NGAs and other antidepressants, such as SSRIs, to depressed children and adolescents (and adults) "must be balanced against risks of non-treatment", especially given that evidence predominantly suggests that in "moderate-severe depression the risk of suicide if NGAs are not used may outweigh any risk of self-harm associated with them" (Dudley et al., 2008).

More recently, research in this area has debated the impacts of 'black-box' warning labels on antidepressant medication, such as SSRIs and NGAs (Dudley et al., 2008; Gibbons et al., 2007a; Wheeler et al., 2008). Whether black-box warnings may decrease antidepressant treatment and increase suicidality in individuals with depression remains open to question.

Above all, however, it is important to remember that antidepressants do not (and are not expected to) address the variety of psychosocial factors that are strongly related to suicide and depression (see De Leo, 2004). As such, suicide must always be approached and treated as not only a psychiatric problem, but also as a social, emotional and cultural issue.

Social networks and caregiving

The building of strong partnerships and social support networks (inclusive of families, friends, carers, colleagues, governments, peak and professional bodies and non-government organisations), as well as capacity-building among Australian communities, more generally, may function as protective factors to mentally ill individuals at risk of self-harm or suicide. For example, writes Hunt et al (2006, p. 141): "Many young patients live with their families prior to suicide and improved communication between services and families may help to detect warning signs."

Yet, there is evidence to suggest that communication between families and general practitioners is often poor in the treatment of individuals with mental illness (NSW Mental Health Sentinel Events Review Committee, 2007). This should be cause for concern, considering clinical experience suggests that "family involvement in the aftercare of young people who have attempted suicide can play a major role in facilitating recovery" (Burns et al., 2005, p. 125).

More to the point, there is also evidence to suggest that "providing a sense of caring, better social connectedness and creating a secure, safe and empathetic environment for those who have a mental illness or are feeling suicidal can reduce suicidal behaviours" (Australian Government Department of Health and Ageing, 2007a). There is great benefit, therefore, in fostering social, clinical, workplace and familial environments that encourage and support not only social inclusion more generally, but more specifically, help-seeking by mentally ill and suicidal individuals. This requires a multidisciplinary approach that encompasses long-term planning for Australia's health system and the

capacity to service at-risk individuals and those in need; ranging from better screening and risk assessment through to evidence-based treatment options and follow-up care and support.

This also incorporates workplace education on how to positively contribute to the mental wellbeing of staff and colleagues, as well as the development of individual protective factors through activities that aim to build self-esteem, psychological strength and resilience; particularly among younger people and other at-risk population groups (Australian Government Department of Health and Ageing, 2007b).

Intensive and early community follow-up, in addition to generally enhanced levels of aftercare, have also been shown to significantly reduce suicide risk, particularly in recently discharged psychiatric patients (Hunt et al., 2008). Therefore, greater capacity for community care is essential. This includes reducing exposure to potential social and contextual risks through, for example, greater access to affordable housing, improved employment prospects and social support networks (Australian Government Department of Health and Ageing, 2007b).

However, for some, strong connections to family, community, culture and religion can actually be a negative experience and can result in negative (mental) health consequences (Costello et al., 2006). Therefore, it should be emphasised that it is the *quality* of relationships that matters, and that participation alone does not necessarily translate into acceptance, trust or reciprocity (Kushner & Sterk, 2005).

It is also important to recognise the profound effect suicide can have on others, especially where mental illness is involved. Research suggests that family, friends and carers bereaved in this way experience an added intensity of grief and are also two to five times more likely to die by suicide themselves (SANE Australia, n.d). There is, therefore, a requisite need to provide easier access to appropriate care, non-judgmental support and interventions for those individuals and

The Use of "Postcards"

There is emerging evidence that the use of 'postcards' mailed from services to persons discharged from an acute care mental health unit may be effective in reducing the risk of suicide. Some of this evidence points to effective strategies that could have universal application. As one striking example, two randomised controlled trials now indicate that continuing support after hospitalisation can prevent suicide.

One is from the US (Motto and Bostrom, 2001), which studied psychiatric in-patients who refused follow-up and used postcards inviting them to stay in touch at regular intervals. The other was a WHO multi-country study (Fleischmann et al, 2008) of suicide attempters, which used regular phone calls or visits to do the same. Carter et al demonstrated something similar for self-harm.

These are relatively inexpensive approaches and apparently work through enhancing social connection and a sense of personal value. Allowing for appropriate cultural adaptations, these could be costed and considered for adaptation to casualty departments and psychiatric wards post-discharge.

families bereaved by suicide (DOHA 2007b).

Psychiatric and emergency department services and risk of suicide

Research suggests that people who have recently been discharged from hospital after treatment for mental illness may be at higher risk of suicide. According to a number of international studies (see Meehan et al., 2006; Goldacre et al., 1993; Geddes & Juszczak, 1995; Appleby et al., 2001; Yim et al., 2004), for those in contact with psychiatric services, the risk of suicide is at its highest during inpatient psychiatric care and the post-discharge period.

International studies have calculated rates of suicide death within 28 days of discharge as being between 2.9 and 4.3 suicide deaths per 1,000 discharges (NSW Mental Health Sentinel Events Review Committee, 2005; Appleby, 2000). For cases of post-discharge, suicide death has previously been estimated as being most frequent in the first two weeks after leaving hospital (Meehan et al, 2006). Others, such as Hunt et al (2008), have suggested that the first week and the first day after discharge represent particularly high risk periods. Writes Mann and colleagues (2005, p. 2070): "Many depressed patients who survive a suicide attempt will make further suicide attempts, particularly in the period shortly following psychiatric hospitalisation or during future major depressive episodes."

Research shows that follow-up services to an emergency intervention around suicide can be effective in preventing further attempts of suicide, and in encouraging safety planning and utilisation of treatment services. For example, higher rates of treatment have previously been reported after discharge when health providers call the referral to set up an appointment for the client and then make a follow-up call to see if the client kept the appointment (Sudak et al, 1977).

More recently, research has shown that when a trained psychiatrist contacted patients one month after discharge from the emergency department for a suicide attempt, the rate of re-attempt was lower compared to controls (Vaiva et al., 2006). Where suicide does occur, there is a need to address the responses and needs of bereaved friends and families, including those aggrieved by a perceived failure of (mental) health care and treatment. Similarly, it should not be forgotten that the impact of patient suicide can also be significant for mental health services staff (particularly clinicians) and general practitioners (Queensland Health, 2005). As the *Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events* points out, it is important to note that not every case of suicide necessarily represents a failure of clinical care or the mental health system (Queensland Health, 2005).

Media guidelines and reporting

Media reporting of suicide and its fictionalised portrayals on television are "known to influence suicidal behaviour, particularly the choice of method used" (Biddle et al., 2008; Pirkis & Blood, 2001). Also of increasing concern is the prevalence of information relating to instructions in methods of suicide; made all the more readily accessible via the internet and online social mediums, such as suicide chat rooms and web forums. Further concern has recently been expressed as to the increasing emergence of cases of 'cybersuicide'—attempted or completed suicide influenced by the internet (Biddle et al., 2008).

The "toning down" of media reports of suicide has previously been highlighted by the World Health Organisation as being one of six elementary steps for suicide prevention (Goldney, 2005, p. 128). While some styles of reporting have been linked to increased rates of actual suicide, appropriate reporting can also help reduce rates (Pirkis & Blood, 2001). There is also evidence that "the way suicide is reported can *reduce* suicide rates. Reporting that positions suicide as a tragic waste and an avoidable loss, and focuses on the devastating impact of the act on others, has been linked to *reduced* rates of suicide" (Australian Government Mindframe National Media Initiative, 2006). Similarly, online technologies can also have a positive impact; enabling individuals to access information and resources at their convenience, with the added comfort of anonymity.

As Mann and colleagues (2005, p. 2070) point out, the media can "help or hinder suicide prevention efforts" by being an avenue for public education or by exacerbating suicide risk by glamorising suicide or promoting it as "a solution to life's problems". Similarly, there is strong evidence to suggest that the media may be an important influencer of community attitudes towards mental illness. In particular, negative media images can result in the development of further negative beliefs about mental illness, which may in turn lead to stigma and discrimination (Francis et al., 2001). As such, people involved in mental health and mental health care "have an important role to play in supporting appropriate media coverage of suicide, mental health and mental illness" (Australian Government Mindframe National Media Initiative, 2006).

Postvention care for people bereaved by suicide

For those bereaved by suicide, grieving is an intensely personal and individual process, which will likely be influenced by factors, such as the age of the deceased (and bereaved); the quality of the relationships with the deceased; the attitude of the bereaved towards the loss; ethnicity; and cultural beliefs (Hawton & Simkin, 2003). Fears for personal safety (as a result of concerns of hereditary susceptibility) may also be a feature for some individuals, especially where there is a family history of mental illness and suicide (Hawton & Simkin, 2003).

For others, the need for support services will be minimal, given individual resilience and coping skills. Different people, therefore, require different responses to their loss. For this reason, it is vital that suicide postvention strategies, health care providers and other caregivers recognise the importance of no longer treating those bereaved through suicide as a homogeneous group (Clark, 2001a).

For instance, studies show that, although helpful for many, for some individuals, bereavement programs and support may not always be a positive experience or indeed beneficial (McMenamy, Jordan, & Mitchell, 2008; Murphy et al., 1998; Lehman, Ellard, & Wortman, 1986). For others, the ideal time for professional support may not always be immediately following a suicide and many more may not feel ready to seek help at the time that it is offered (Provini et al., 2000).

Individuals may also be impacted by the intergenerational post-traumatic effects of suicide a number of years after the death of a loved one or an associate. Recommendations emerging from both bereaved individuals and professionals attending the SPA National Conference in 2000 supported this with calls made for greater flexibility in the delivery of existing services, including follow-up with bereaved

individuals immediately after the suicide as well as into the longer-term, and even possibly throughout an individual's lifetime (Clark, 2001b; Grad et al., 2004).

For most individuals, the bereavement journey is undoubtedly prolonged, and while support is often provided soon after a suicide (generally recognised as a time of significant crisis for those bereaved by suicide), as time wears on, bereaved individuals can often become increasingly isolated and at-risk. Some studies show that, as a consequence of sociocultural taboos and stigma, those bereaved by suicide are often, and frequently, avoided at the very time in which they may be at their most vulnerable and in greatest need of support (Cvinar, 2005).

As Hoff (2001) points out, it is also usually at this time that suicide bereaved individuals become their most withdrawn as they try to deal with their own 'disenfranchised grief' and internal emotions of grief, anger, loss and confusion. Further compounding the problem is the general absence (or, where these exist, general lack of awareness or accessibility) of targeted outreach programs "able to provide support and meet their needs" (Cvinar, 2005, p. 19). Research conducted as part of SANE Australia's *Mental Illness and Bereavement Project* (2009) shows, for instance, that many mental health services do not have policies around supporting families after a client dies by suicide. In fact, a number of families participating in the study indicated that they had received no contact at all from the treating service after their family member had died (SANE Australia, 2009).

As such, greater emphasis must be placed on continuity of care and 'safety nets' for those bereaved by suicide—that is, the transfer of professional responsibility and accountability for some or all aspects of care for individuals throughout the trajectory (which is not always linear) of health care provision and social support.

Over time, an individual's needs may change. As such, they must feel assured that a breadth of services will be both available and accessible to them as required, and that these services can be accessed again later, if necessary. Timely intervention and the offer of ongoing support can alleviate much distress. Of particular importance is the provision of support mechanisms by which to enable affected individuals to not only address their own perceptions of stigma, but also restore internal social structures and communications to assist in finding meaning in the circumstances surrounding their loss (see Cvinar, 2005; Worden, 1999).

As Wilson & Clark (2004, p. 10) suggest, "suicide postvention represents an opportunity for mental health services, social services and other health services to collaborate to enhance the quality of care provided to those persons who become bereaved due to the suicide of someone they know." While there is no universal principle or model for responding to a suicide death, a number of guidelines have been published in the Australian context to assist specific population groups (e.g. school students) and communities, more broadly, in the development and delivery of suicide postvention strategies and support (see, for example, Department of Communities, 2008; Department of Education and Children's Services et al., n.d; SANE Australia, 2009).

The principles of postvention developed under the *Queensland Government Suicide Prevention Strategy 2003–2008*, for example, recommend some of the following points as a general 'rule of thumb' or guide to 'good practice' responses following a suicide death (see Department of Communities, 2008, p. 3):

- The ethical principle 'do no harm' should remain central to the provision of all postvention responses.
- Postvention involves responding to need at a range of levels, including the needs of individuals, families, groups, communities and service providers.
- Postvention responses should aim to avoid glorification or indications of judgment or criticism of the deceased person and the act of suicide and minimise sensationalism (particularly through media channels).
- Postvention responses should facilitate the early identification of other individuals who may be at-risk of harming themselves (including those experiencing anniversaries or dates of special significance).
- Close consultation with known and available 'experts' in the suicide prevention and postvention fields is critical throughout the development and implementation of postvention responses.
- Postvention responses are most effective when they are coordinated across communities and involve a broad range of stakeholders in development, implementation and review and evaluation.
- Postvention responses should ideally be planned by organisations and communities before suicide deaths occur to ensure timely and well-informed implementation in the event of a suicide.

Bearing this in mind, it goes without saying that those bereaved by suicide undoubtedly experience a wide range of emotional, spiritual and cognitive responses, reactions and behaviours. Therefore, in response to a suicide death, it is important that these individuals and communities are, first and foremost, "reminded and reassured that they are not alone" (Australian Government Department of Health and Ageing, 2007). In this respect, Hawton & Simkin (2003, p. 178) point out that general practitioners may be an important source of care in some cases; "particularly where they have known both the deceased and bereaved persons". For others, however, specialised suicide postvention or clinical care may be necessary.

While there have been few methodologically sound evaluations of treatment options for those bereaved by suicide, the literature does suggest that individual, group or family counselling and psychotherapy may be of some benefit (Jaques, 2000). For example, one controlled clinical trial in children who had lost parents or siblings through suicide indicated "greater improvements in depression and anxiety in those who entered group treatment than in those who did not" (Hawton & Simkin, 2003, p. 178; see also Pfeffer et al., 2002). Treatment included education about death, suicide and grief experiences, enhancement of coping skills, facilitation of expressions of grief and encouragement to develop new relationships. Bereaved parents were offered similar help and advised on how to support their children in dealing with the loss (Hawton & Simkin, 2003).

Furthermore, there is growing evidence to suggest that community-based, active postvention services that provide support services for people bereaved by suicide and offer capacity building for the communities in which they are established can have wide-ranging positive benefits and outcomes for both the bereaved and the communities as a whole, including reducing the incidence of suicide ideation amongst the bereaved.

Given the significant proportion of suicides among individuals in current or recent psychiatric care, Hawton & Simkin (2003) suggest that psychiatric services may also be an appropriate source of assistance for bereaved individuals. However, they caution that this may be impeded where the bereaved consider care for the deceased to have been inadequate (Hawton & Simkin, 2003).

In light of this, other factors "that might help reduce stress include specialised training for professionals who have contact with people bereaved by suicide, modifications to those aspects of coroners' inquest procedures that the bereaved report finding most stressful, and more sensitive media coverage of suicides" (Hawton & Simkin, 2003, p. 178). Hawton & Simkin (2003) and Clark (2001a) also cite bereavement organisations and self-help groups, as well as books written by bereaved individuals as other sources of information and practical support. Telephone counselling 'hotlines' may also be helpful for suicide bereaved individuals seeking emotional support.

Similarly, greater understandings of the psychodynamics of suicide grief can lead to strategies that may help the bereaved through their individual grieving processes (Clark & Goldney, 2000). For example, Clark (2001a, p. 103) suggests that viewing the body, or at least being with the covered body of the deceased, may assist in acknowledging the reality of the death and "may prevent fantasies about its condition and possible trauma in the dying process".

An increased reliance on the internet and online networks for informational support and links to sources of practical and emotional support has also been cited in the literature. This may be particularly useful to bereaved individuals who are geographically isolated or are seeking anonymity and privacy or 24-hour availability, and a non-confrontational means of support (Clark, 2001a; Hawton & Simkin, 2003). Web-based services such as *Reach Out* have also been noted for helping to improve the mental health and wellbeing of young Australians by providing online support information and referrals, including those related to loss and grief, in a format that appeals to young people. However, the risks and benefits inherent in the use of the internet and online social mediums as a means of support and practical information should be equally noted.

In Australia, enhanced support and practical resources for suicide bereaved individuals have only recently started to gain greater prominence. Newly commencing work in this area includes, among others:

- The development of activities targeted towards suicide bereavement under the *National Suicide Prevention Strategy*;
- Circulation of bereavement support and resource kits;
- Lifeline Australia's *Suicide Bereavement Support Group Standards & Practice Project* (a workforce development project);
- SANE Australia's *Mental Illness and Bereavement Project*, including the *SANE Bereavement Guidelines* and DVD exploring real-life experiences of families bereaved by suicide;
- Outreach support and response services such as the community-based *StandBy Response Service*, Jesuit Social Services' *Support After Suicide*, the Salvation Army's *Living Hope* bereavement support program, Curtin University of

Technology and the Telethon Institute for Child Research's 'Active Response Bereavement Outreach' Program (ARBOR) and Anglicare's *Living Beyond Suicide*; and

- Various other state-based suicide bereavement, grief and loss programs and postvention initiatives and guidelines.

However, the need for improved and ongoing support of those bereaved by suicide in Australia is such that there remains a requisite need for the introduction of additional pragmatic *evidence-based interventions* and suicide postvention initiatives.

Crisis centres and telephone counselling services

Many phone-based crisis and counselling services worldwide have been operational for decades and data shows that both individuals in crisis and third parties concerned about somebody else's wellbeing frequently use these services. Positive results are reported in anecdotal evidence, as well as studies examining clients' and counsellors' satisfaction with the services provided, repeat use of services and referral outcomes. However, studies assessing the services' impact on actual suicide rates have yielded conflicting results. Some studies show that suicide hotlines may help to reduce suicide rates among particular groups (e.g. young white females).

A study conducted in 2007 (Gould et al., 2007) found that crisis hotline services were effective in reaching suicidal individuals (including those people who demonstrated severe suicidality) and that those individuals were satisfied with the service they received from the service. In particular, young, white females expressing suicidal intentions were the most likely demographic group to contact the service. However, although the service was effective in reducing feelings of hopelessness and psychological pain, there was no significant reduction in callers' intent to die in the time between the end of the call and a follow-up call conducted 1-2 weeks later. Indeed, only 12% of callers' indicated that the call prevented them from killing or harming themselves. This outcome may at least partially explain why suicide rates were not reduced.

Interestingly, the reasons cited by callers' as the cause of their suicidality were wide-ranging, including prior suicide attempts, mental health problems, interpersonal problems, inability to meet their base needs (i.e. shelter, food), addictions and substance abuse disorders, physical health problems, work problems and abuse/violence. Often, individuals had experienced more than one of these risk factors. This study also found that of those callers' who were referred to other services (including mental health resources), only 35 percent kept or made their appointment during the follow-up period.

Nonetheless, this study shows that crisis hotlines and counselling services have a significant part to play in suicide prevention and intervention and that they can be effective in reducing the risk of suicide for a percentage of suicidal individuals. There have also been other examples of telephone support services that have demonstrated positive effects of suicide rates. For example, a community-based phone support program for the elderly established in Italy produced promising results (De Leo et al, 1995). Longitudinal evaluation of this service showed that ten years after the introduction of the service, suicide rates amongst people over 65 years of age were significantly lower than the general population (De Leo et al., 2002).

Other strategies and activities

A number of others suicide prevention, intervention and postvention activities and strategies have provided some evidence of being effective in reducing suicide ideation and/or behaviours. However, further investigation and evaluation of these activities is needed to confirm their efficacy and effectiveness in reducing suicide rates. Some of these activities include:

- Screening for depression and suicide risk in educational, employment and workplace settings – regular screening programs for students and/or employees to identify mental health conditions (e.g. depression) and/or suicide risk.
- Public awareness, education and mental health literacy programs – broad-scale awareness-raising and educational programs aimed at increasing the public's awareness of the issues related to suicide, suicide prevention and mental illness, encouraging help-seeking by at-risk individuals and reducing stigma and discrimination.
- School-based resilience, competency and skill enhancement programs – activities and programs that are delivered in a school setting that aim to increase protective factors, such as resiliency, and encourage a culture of help-seeking (the Mind Matters resources are a good example of school-based resources and programs offered in Australia – see website for examples www.mindmatters.edu.au).

Interventions that have been shown to be ineffective and/or potentially do harm

As suicide is a sensitive and complex issue, there is a critical need to ensure that all available suicide prevention activities and strategies abide by the principle of "do no harm". Individuals at risk of suicide can be easily influenced by certain displays or discussions relating to the issue. For example, inappropriate portrayals of suicide in the media can precipitate suicide amongst at-risk individuals. Other activities that have had mixed results and may potentially cause harm are some suicide-related public health messages, therapies involving recovered or repressed memories, no-harm and no-suicide contracts and some school-based suicide awareness programs (see Beautrais et al, 2007). Thus, it is essential that any new or innovative suicide prevention activities are based on existing evidence and best practice and carefully monitor for potentially harmful outcomes.

Challenges in evaluating the effectiveness of suicide prevention programs and activities

Demonstrating the effectiveness of suicide prevention programs and activities is a challenging exercise, for a number of reasons. Some of the reasons it is difficult to scientifically demonstrate the efficacy of suicide prevention activities are:

- Many suicide prevention programs are not able to be properly or longitudinally evaluated due to their short duration and/or inadequate funding and resources.
- Many suicide prevention programs target multiple risk groups and populations, making it difficult to establish causality amongst a range of other intervening and potentially confounding variables.

- Evaluations often suffer from methodological difficulties, such as small sample sizes, a lack of adequate control groups and the use of retrospective evaluation techniques.
- Often the effects of suicide prevention activities may not be observed for many years after the activity has been offered, making it difficult to detect the program's effects in the short-term.
- Official suicide statistics typically take a number of years to be released and there is evidence to suggest that national statistics are inaccurate. In addition, suicide rates for specific geographic areas or sub-groups are often very difficult to obtain and may not be accurate due to small sample sizes.

In addition, although suicide rates and numbers are unacceptably high, from a statistical point of view, death through suicide is still a relatively rare event. This makes it very difficult to detect changes in suicide rates within small samples. For example, in Australia, approximately 0.01% of the population dies by suicide each year. Thus, in order to prove that a suicide prevention program reduces suicide rates by 15%, an evaluation study would need a sample of over 13 million people, which is obviously not feasible for the vast majority of program evaluation studies. As such, many program evaluations use alternative measures of suicidality, including suicide ideation, suicide attempts, rates of mental illness and/or other risk factors for suicide (e.g. hopelessness) and increases in protective factors (e.g. coping skills, help-seeking behaviours, compliance with treatment for mental health problems, social connectedness, mental health literacy, etc.) (Silverman & Maris, 1995; De Leo, 2002). These proxy measures may not accurately predict actual suicides and studies using these methods should be interpreted with caution.

Nonetheless, suicide prevention activities that demonstrate significant reductions in the incidence of suicide ideation, suicide attempts and mental illness and increases in protective factors are still having positive benefits within the community and should be further investigated and evaluated longitudinally to determine their ongoing impact on actual suicide rates.

There are also few studies that evaluate the cost-effectiveness or economic impact of suicide prevention, intervention and postvention activities and strategies. These types of evaluations (e.g. cost-effectiveness analysis, cost-benefit analysis) are often difficult and sometimes controversial, due to the need to "quantify" various immeasurable variables, such as calculating the value of a human life and the emotional and social costs associated with suicide attempts and suicide bereavement. However, economic evaluations of suicide prevention activities are essential for providing evidence to government, other funding bodies and the community of the expected return on investment for suicide prevention activities, as well as highlighting the substantial costs attributable to suicide and its effects.

What is required? – Future research and evaluation needs

Although there has been considerable research into the potential risk factors for suicide and, more recently, the factors that may help to protect individuals from suicidality, there is still a limited understanding of how to use the existing knowledge to effectively reduce suicide rates. The range of risk and protective factors is extremely diverse and complex. Many people who could be classified as "high risk" never exhibit any suicidal

thoughts or behaviours, while other people who apparently have had limited exposure to risk factors and many protective factors may, in fact, experience intense suicidal thoughts or behaviours. Further investigation is needed to increase the ability to accurately identify high risk groups and to determine the specific constellations of risk factors that, when combined, are most likely to lead to suicide.

Suicide prevention efforts to date have typically been based on the USI model – Universal, Selective and Indicated. *Universal* suicide prevention activities are those that are applied to the whole population, *selective* measures are those applied to groups at an increased risk and *indicated* interventions apply to individuals at imminent risk. Universal suicide prevention activities may include awareness-building and educational messages for the public; selective activities may include culturally-appropriate programs designed for Indigenous populations or programs that encourage help-seeking behaviours amongst men; while indicative activities may include individualised support and treatment for people who have previously attempted suicide.

Although the USI model is widely recognised and used in suicide prevention strategies across the world, there is still a need to ascertain the most effective ratio of suicide prevention activities across the three types of interventions to have the greatest impact on suicide rates within the Australian community and how the three types of interventions relate to suicide risk and protective factors, warning signs, precipitating events and imminent risk. In addition, it is also important to attempt to identify the critical point for action – i.e. at what point in the path to suicidality will suicide prevention activities be most effective in reducing the loss of life?

It is well-known that across many different types of systems (e.g. health care systems, manufacturing systems, etc), it is the points of transition that typically experience the highest level of failures. For example, people who have recently been discharged from psychiatric care and are transitioning back into the general community have a much higher risk of suicide than the general population (up to 200 times more likely than the general population) . Accurately identifying the points within our health care, government and other systems that deal with suicide incidents may assist in determining the most effective times and places for "safety net" activities to occur.

In order to more effectively and appropriately respond to suicide risk factors, warning signs and times of imminent risk and reduce the incidence of suicide, it is imperative that programs that build greater awareness of the issues surrounding suicide and how to respond appropriately and sensitively, both generally within the broader community and for recognised "gatekeepers" (i.e. people who regularly deal with people who are suicidal or suicide incidents – e.g. police officer, paramedics, hospital emergency staff, GPs, prison officers, teachers, etc), are developed and implemented. Unfortunately, in much of Australia, suicide is still considered a taboo topic and there are many myths and misconceptions about the potential causes of suicide and how best to support and assist people who are experiencing suicidal thoughts, exhibiting suicidal behaviours or who have previously attempted suicide. For example, common myths, such as that asking someone about suicide can cause suicidal behaviour, that people who talk about suicide or attempt (but do not complete) suicide are simply "attention-seeking" and that people who attempt or complete suicide are "selfish" and are "wasting scarce health resources", are still very common in Australian society today.

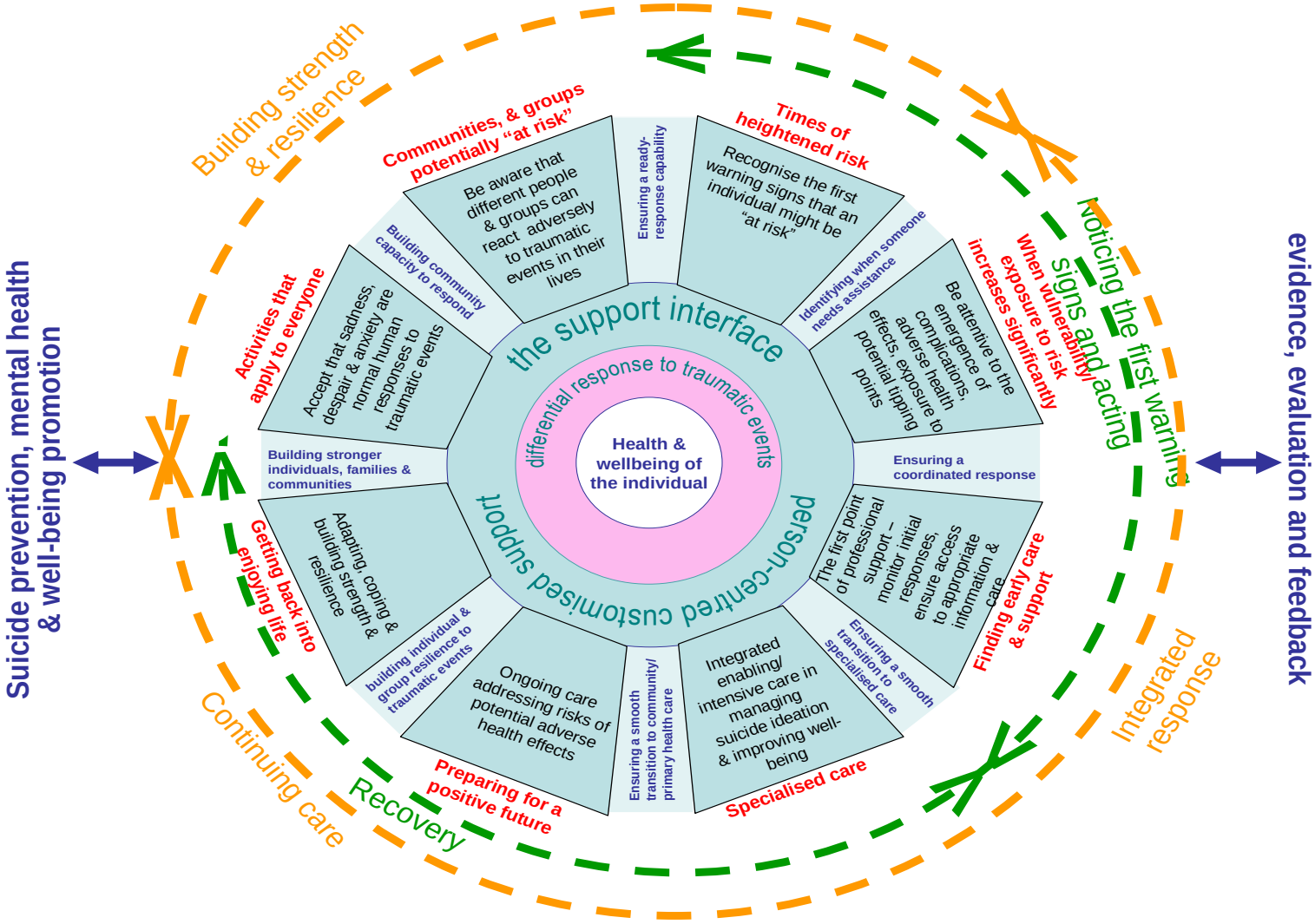
The appropriate responses to suicide risk factors, warning signs, precipitating events and imminent risk vary according to the assessment of risk. There are a range of guidelines that currently exist that describe how to assess the level of suicide risk and identify appropriate ways to respond to suicide warning signs and the point of imminent risk (e.g. LIFE Framework Factsheets, Lifeline toolkit for suicide prevention). However, there is still much that needs to be done to ensure that there is better awareness and understanding across the entire community of suicide and suicide prevention. A better understanding of protective factors and how these can be enhanced amongst high-risk individuals and groups, is also a priority for future research and for inclusion in the evaluation of existing suicide prevention, intervention and postvention programs.

There is an urgent need for continued development of well-planned, evidence-based programs and research evaluating their effectiveness in Australia (Mann et al, 2005; Beautrais et al, 2007; Gunnell & Frankel, 1994). All suicide prevention initiatives should be guided by current research and include an evaluation component based on meaningful and measurable outcome measures. This will allow the critical components of effective suicide prevention programs to be identified and refined, and to guide future efforts to prevent suicide.

Suicide prevention initiatives should be multi-modal and complementary, targeting a wide range of high risk groups. The diverse approach to suicide prevention is essential, because there is no single, readily identifiable, high risk population that constitutes a sizeable proportion of overall suicides and yet is small enough to easily target and have an effect (Gunnell & Frankel, 1994). There is also a need to strike a balance between universal, selective and indicated suicide prevention activities, as initiatives in Australia have typically focussed on broad, population-based methods and have somewhat neglected more targeted approaches that are specifically designed for known high-risk groups (e.g. people who have previously attempted suicide, Indigenous populations, rural/remote communities). It is, therefore, important that resources be allocated to a variety of suicide prevention activities across Australia.

There needs to be a coordinated and standardised approach for evaluating the effectiveness, efficiency, cost-effectiveness and sustainability of suicide prevention activities. This includes the development of easy-to-understand guidelines for developing and implementing evaluation frameworks, outlining standardised outcome measures that are dependent upon the program's goals and objectives (e.g. actual suicide rates/numbers, suicide ideation, suicide attempts, incidence of mental illness, protective factors) and methods of measurement and assessment. There also needs to be adequate funding and resources to conduct high-quality, independent evaluations of suicide prevention activities, so that our understanding and knowledge of effective methods is enhanced and builds upon existing knowledge. Evidence-based evaluations are the key to developing and implementing suicide prevention activities that result in a demonstrable reduction in suicide rates and effectively decreasing the incidence of this tragic, and yet preventable, loss of life.

Figure 13: The Continuum of Care for Suicide Prevention



Source: Draft Life is for Living Strategy, 2007

Chapter 5 - Australia's Response to Date

Key Points in this Chapter

Australia was one of the first countries to develop national suicide prevention strategies.

From 1995-2006, funding for suicide prevention at Commonwealth level remained at approximately $10/annum.

The Youth SPS and later NSPS remained related to the National Mental Health Strategy.

2005 Evaluation of NSPS showed some gains in terms of networking and community capacity building, but few sustainable or measurable impacts.

Specific targets for reducing the number of suicides have not been included in either NMHPs or the NSPS.

Monitoring, evaluation and research have been patchy, at best.

While bereavement programs have grown, a national strategy has never been rolled out.

A Newspoll survey showed a significant segment of the community are unable to talk about suicide or suicidality and beliefs remain a block to progress.

Continual commitments by health Ministers to mental health reform fall well short of intentions and compromise suicide prevention efforts.

Early efforts

The first national efforts by government on suicide prevention in Australia commenced under the (First) National Mental Health Plan 1993-1998. Promotion and prevention was one of the overarching aims of the Plan. A number of measures were advocated, designed to "…promote the mental health of the Australian community and, where possible, prevent the development of mental health problems and mental disorders."

At the same time as the NMHP, the Commonwealth Government from 1995-6 made available $31 million targeted at reducing suicide among youth.

The evaluation of the Plan showed that prevention efforts, including tackling stigma in the community suggest that only marginal gains have been made in promoting mental health issues in the community. The Evaluation Committee in their final report to the Australian Health Ministers' Conference wrote:

"The theme of 'unfinished business' is the essence of the committee's final report to AHMAC. We urge the Commonwealth, State and Territory policy makers to recognise that what has been started will need continued policy attention. Many initiatives taken, particularly those focusing on service quality and outcomes, will not deliver results for several years and will need the momentum maintained. In a number of critical areas (e.g. workforce training), action is yet to commence."

The Second National Mental Health Plan, agreed to by all Australian Governments in July 1998, also included a focus on promotion and prevention. In the Plan, a reduction in the number of suicides was included as a specific outcome measure.

A commitment was included in the 2nd NMHP to evaluate promotion and prevention initiatives, to inform the development of future initiatives. The strategies included:

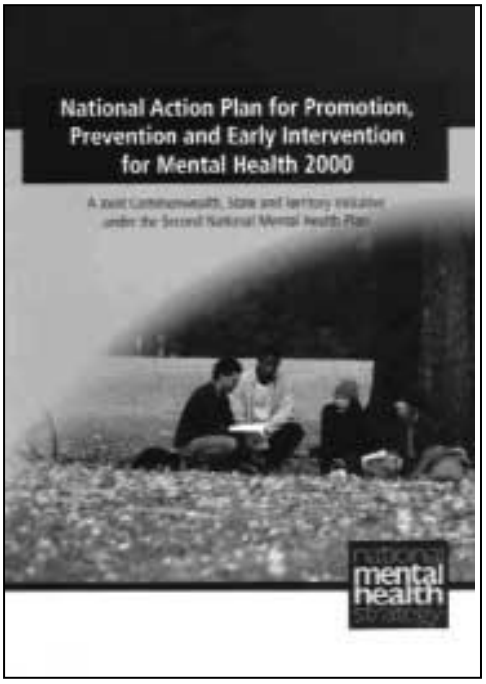
- Development of a national mental health promotion and prevention work program through the National Public Health Partnerships.
- Completion and evaluation of programs to reduce suicidal behaviour amongst groups with high rates of attempted and completed suicide, including those

identified in the National Youth Suicide Prevention Strategy.

- Development and evaluation of risk-reduction programs for groups identified as vulnerable to the development of mental illnesses.
- Development and evaluation of programs with demonstrated efficacy in the prevention of mental health problems in infancy, childhood and adolescence, including programs targeting children vulnerable through parenting difficulties, family discord, family disruption, loss, trauma, maltreatment and abuse.
- Development of research programs that contribute to the compilation of an evidence base for population health approaches to mental illness prevention.

The Evaluation of the 2nd Plan showed that assessing the reduction in suicides was omitted. No explanation was given for this decision.

Figure 14: The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health



The Evaluation refers to the ***National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*** as demonstrating a significant commitment to promotion and prevention efforts under the 2nd Plan. The report highlights a range of initiatives commenced during the period of the 2nd NMHP addressing promotion and prevention, including *Mindframe*, *beyondblue, Stigma Watch*, the Rotary Community Awareness Program and *MindMatters*.

In the conclusions, the report is consistent with the evaluation of the 1st NMHP, where it stresses the need to "build the evidence base" for promotion and prevention and that "much more needs to be done to eliminate stigma".

The 3rd National Mental Health Plan was signed off by all Australian Governments in July 2003. Like the earlier plans, it included a focus on "preventing mental health problems,

mental illness and suicide". Among the 34 outcomes defined in the 3rd Plan were two related to suicide, namely:

- Outcome 5: Increased capacity of communities to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk; and
- Outcome 6: Reduction in suicidal behaviours, reduction in risk factors for suicidal behaviours, and enhancement of protective factors for suicidal behaviours.

Despite the recommendations from both the earlier evaluations, actions were not taken during the life of the 3rd Plan to put in place effective monitoring, research (to build the evidence base) and evaluation. This was highlighted in the subsequent evaluation of the Plan, which has not been made available through the Department, but is accessible on the Crikey.com website (Thornicroft and Currie, 2007).

The NSPS from 1999-2005

The National Suicide Prevention Strategy (NSPS) was established by the Australian Government in 1999. Under the NSPS, some $63 million was allocated for the development of national and community-based initiatives for suicide prevention. The NSPS intended to build upon the outcomes of the National Youth Suicide Prevention Strategy (NYSPS) and expand the focus on suicide prevention activities across the lifespan and for specific at-risk groups. The NSPS also aimed to develop and enhance existing links between governments, business, non-government and community organisations that support people at risk of suicide and self-harm.

In comparison with the preceding Strategy, the NSPS aimed to:

- widen the focus from youth to suicide prevention across the age range, recognising that a range of age-specific groups have experienced increased or significant rates of suicide
- maintain a youth focus and incorporate a specific focus on Aboriginal and Torres Strait Islander communities
- focus on resilience and protective factors, rather than solely suicide prevention
- focus on community capacity building, to make existing structures more responsive to suicidal, self-harming and at risk behaviours from increased awareness, knowledge and skills
- strike a balance between primary or universal/selective prevention strategies ('upstream' strategies) and early intervention and crisis intervention strategies ('downstream' strategies)
- foster meaningful and effective partnerships between service providers and governments
- establish appropriate structures to ensure effective and timely implementation.

The NSPS is guided by the Living Is For Everyone (LIFE) Framework, which sets out national priorities for suicide prevention and mental health promotion. A National

Advisory Council on Suicide Prevention (NACSP) was established in 2000 to provide strategic advice to the Australian Government on suicide prevention and related issues.

Under the NSPS, over 150 community-based suicide prevention projects were funded in States and Territories, as well as 27 national projects of various kinds. A total of $63,454,000 was allocated to the NSPS between 1999 and 2006.

The details on the goals, philosophy and governance structures for the NSPS during the period to 2008 are contained in Appendix 3.

Evaluation and re-development of the NSPS 2005-8

It is also worthy to note broader policy developments that occurred during the period of the evaluation and re-development of the NSPS. Firstly, the Australian landscape in mental health dramatically altered. This followed the release of the report *Not For Service: experiences of injustice and despair in mental health care in Australia* in October 2005 from the MHCA and the Human Rights and Equal Opportunity Commission (HREOC) and then the Senate Select Committee Report, *From Crisis to Community*, in March 2006. In response to these reports, the Council of Australian Governments (CoAG) agreed in July 2006 to inject an additional $4b into mental health services over the next five years. The Commonwealth, in its contribution to the COAG National Action Plan on Mental Health, substantially increased its contribution to suicide prevention by an additional $62.4m over the five years.

Secondly, the Commonwealth undertook an evaluation of the National Suicide Prevention Strategy (Urbis Keys, 2006) and commenced a major revision of the LIFE Framework.

The draft materials from that review were provided to DOHA in July 2007 and the Parliamentary Secretary, the Hon. Senator Brett Mason released a revised LIFE Framework document on 17 October 2007. Senator Mason stated in his press release that "the framework defines the vision and purpose of suicide prevention in Australia, as well as clearly stating the action areas that need to be addressed and the outcomes we are working towards". The status of the document was unclear until all LIFE Framework documents (viz. *Research and Evidence in Suicide Prevention* and *Practical Resources for Suicide Prevention*) were released by the Federal Minister for Health, The Hon. Nicola Roxon MP, on 2 July 2008.

Key Findings for the NSPS evaluation

- Over 150 community-based projects have been funded across the States and Territories, and 27 projects have been funded at the national level.
- Analysis of the community-based projects reveals that:
  - most targeted a specific age group; 40% of projects identified young people up to the age of 25 as a primary target
  - most did not target a specific gender; about 25% identified males as a primary target
  - a significant minority (29%) identified Aboriginal and Torres Strait Islander peoples as a primary target, with a smaller number targeting people from culturally and linguistically diverse communities (9%), people with a mental illness (9%) and people who have attempted suicide (9%)
  - there was a considerable focus on regional, rural and remote communities, with 43% of NSPS community-based projects aimed exclusively at these populations.
- Analysis revealed most of the national projects utilised population-based approaches that aim to address risk and protective factors for suicide. Some have been jointly funded with the National Mental Health Strategy to better integrate mental health promotion and prevention with suicide prevention.
- Both national and community-based NSPS projects have supported a wide range of approaches to suicide prevention. However, the bulk of the projects have been *universal* (i.e. population based) or targeted at *selective* groups (i.e. groups at particular risk of suicide), with fewer *indicated* projects (i.e. projects focusing on individuals who have a risk factor or condition that places them at very high risk of suicide).
- NSPS funding has been allocated in accordance with the broad aims to widen the focus from youth to all age groups; to incorporate a specific focus on Indigenous communities, resilience and protective factors, community capacity building and partnerships; and to establish structures to assist with development and implementation of the NSPS.
- The goals of the NSPS were viewed as too broad and the Strategy needed to be more strategic and focussed on clearly defined objectives and outcomes
- The complexity and structure of the NASCP governance as a barrier
- The level of funding allocated needs to be reviewed based on suicide rates and local issues.

Source: Urbis Keys Young, Evaluation of the National Suicide Prevention Strategy – final report. April 2006.

Issues Arising from the 2008 Suicide Prevention Australia Strategic Review

In early 2008, Suicide Prevention Australia commissioned a comprehensive review of the organisation against the 2005-8 Strategic Plan. The review endeavoured to establish the effectiveness of SPA as a national peak body and, in particular, its ability advocate on behalf of members and other stakeholders.

A large number of stakeholders and members were engaged through a range of evaluation techniques during the early months of 2008. The review addressed SPA's role within the revised LIFE Framework. The key themes and some representative comments from this question were:

▪ Advocating for and building the evidence base and diffusion of innovation	*"SPA must advocate for and facilitate the take up of evidence based interventions"* *"Lots of money into non-evidence based activities"*
▪ SPA must be independent and NOT an arm of Government	*"DOHA's strategy is divide and conquer – keep people scratching around for dollars"*
▪ SPA as the community voice.	*"... fight against the current policy"*
▪ Coordination	
▪ Building awareness (on critical issues)	
▪ Building alliances (across action areas)	*"There is a broader policy agenda – SPA should focus on housing, employment, education, etc"*
▪ Concerns regarding the LIFE Framework	*"SPA's role right now is to get this document revised"* *" ... complete disregard of the evaluation".*
▪ LIFE Framework does not provide a role for SPA	*" LIFE Framework provides no direction (generally) and no role for SPA".*

The policy framework, the level and allocation of funding and the approach to suicide prevention generally by DOHA was sharply criticised in these discussions. DOHA was seen as "controlling the entire agenda", arbitrarily taking decisions while disregarding the informed advice of experts and views of the sector, and generally marginalising the issue of suicide prevention (ConNetica Consulting, 2008).

DOHA was seen as treating expert groups like the National Advisory Committee on Suicide Prevention (NACSP) with indifference. For example, DOHA refused requests to provide the NACSP with the independent evaluation report on the National Suicide Prevention Strategy and the LiFE Framework (Urbis 2006), while expecting the NACSP members to be able to provide advice on the directions for policy and program interventions, was seen as dismissive and disrespectful by stakeholders and members of the Council.

The Federal Department of Health is part of the problem with why suicide prevention remains a topic of interest and not one of central concern. Many more Australians die and are affected from completed suicides and self harm than road trauma yet the effort to address it is a joke. We need to decouple from the Health bureaucracy to get anywhere with this issue
Response to SPA, Online Survey, March 2008.

Since 2000, the policy of funding numerous small scale and unsustainable community projects and failing to build a sound body of evidence through research and baseline data were commonly

expressed concerns and frustrations. As one key informant pointed out, that *"despite more investment on a per capita basis in suicide prevention than any other nation, we have little or nothing to show"*.

The National Bereavement Strategy[5]

In 1999, it was estimated that around 8% of youth suicide prevention activities in Australia specifically targeted postvention and that around 14% of youth suicide prevention activities used postvention as the main prevention activity. The youth suicide postvention interventions were primarily self-help support groups (Mitchell, 1999). In 2006, it was estimated that there were around 60 self-help suicide bereavement support groups in Australia under the auspices of a range of agencies – NGOs, religious, cultural, and local government (Corporate Diagnostics, 2006).

Between the mid-1990s and 2006, a number of initiatives were taken at local, state and federal government levels to assist Australians bereaved by suicide. These included:

1. One-off initiatives (brochures, targeted counselling services, referrals to professional support) by specific medical practitioners, service providers, mental health and health agencies
2. Information or support kits distributed by the Coroner's office or by NGOs, such as Lifeline Australia or the Salvation Army
3. Telephone crisis and counselling services
4. Community-based professional response services for people bereaved by suicide
5. Community-based self-help support groups for people bereaved by suicide.

In 2006, the Australian Government commissioned a study entitled "National Activities on Suicide Bereavement" (Corporate Diagnostics, 2006). That study, delivered to the Australian Government in August 2006, included a scoping of suicide bereavement literature, a mapping of suicide bereavement activities across Australia, the identification of gaps in suicide bereavement research and activities and a recommended framework and ongoing strategy for suicide bereavement activities in Australia. The 2006 study also undertook a major analysis of the role and effectiveness of the most widely used suicide bereavement support kit – an Australian adaptation of a 1997 United Kingdom initiative entitled *"The Information and Support Pack for those bereaved by suicide and other sudden death"* (DOHA, 2003).

In the light of this research, the 2006 round of Australian government NSPS funding included an allocation of $23.5 million for 46 community-based projects. Thirteen of the 46 community-based projects (approx $8.5 million over three years) focused on building community capacity to respond to people bereaved by suicide (e.g. suicide response services, bereavement response services, enhanced training of service providers, grief and loss counselling). The 2006 round of Australian Government funding also included a requirement that all projects be independently evaluated and, in most cases, the funding was made available for a three year period to allow effective longitudinal measurement of project impact, effectiveness and success.

5 This section is largely based on an unpublished paper by Bycroft and Fisher (2008) *International Perspectives on Suicide Bereavement – the Australian experience.*

Figure 15: Establishing a systemic response capability for those bereaved by suicide

While the increase in Australian Government funding to projects which focus on people bereaved by suicide is welcome, it is regrettable that the National Suicide Bereavement Strategy Strategic Plan (2006-9) has never been released by the DOHA. The reasons for this are not known.

However, there are many projects currently underway that are being independently evaluated so that the lessons learnt can be translated to service providers nationally. There is also a wide network of suicide support groups that are now in regular contact. Standard guidelines and principles for these support groups are currently being finalised, accompanied by evidence-based, accredited facilitator training. These are all positive developments which can be strengthened through a clearer national policy framework.

Previous head of UK Govt's Delivery Unit, Sir Michael Barber:
"Leaders need excellent strategy functions and strong performance management systems, enabling them to steer well, identify flaws in implementation and intervene where necessary... The government departments responsible for major strategic reforms also need to develop this kind of capacity for themselves – and where they do not have the necessary real-time data or the skill and will to intervene where there are problems, inevitably reforms falter."
Quoted in Shergold, Oct 2006, Implementation Matters

The Collection of Suicide Data

The problem of underreporting of suicide has been debated for some time in Australia. Whilst it has been generally accepted that due to cultural (including religious, moral and ethical), financial and historical factors, the actual number of suicides has exceeded the publicly reported number, it has become clear that, in the past decade, a decline in the publicly reported suicides may be due to other factors. This underreporting of suicides in the past ten years may have given false hope that suicides were in decline when in fact, no substantial change had occurred (De Leo, 2007; De Leo et al, in press).

The underreporting of suicides presents two major problems for policy makers.

First, it means we have no way of monitoring with any confidence, that policy and program initiatives are having the intended effect.

Second, it is highly unlikely that underreporting is really an issue across all population sub-groups. This means that we may be directing the already meagre resources for suicide prevention away from high risk groups in the community. It is the first principle of any sound public policy that we can establish a 'baseline' on the scale and nature of a problem or issue and then monitor changes.

In an attempt to address the problem of under-reporting, the ABS will begin progressive, restorative work on 2007, 2006 and 2005 suicide data with the first planned re-release of 2007 data in March 2010. However, delayed case closure from Coroners is expected to prevent final counts (and full benefit) for several years. Newly-adopted ABS coding practices may also require evaluation.

In addition to the major problem of undercounting of deaths by suicide, another potentially and significant contributor to poor policy and program design is the lack of information in death records on some characteristics of people dying by suicide (De Leo et al. 2009, National Committee for the Standardised Reporting on Suicide). For example, evidence shows that Indigenous Australians aged 12 to 24 years have suicide rates four times higher than comparable non-Indigenous urban Australians. However, frequent under-identification of Indigenous status at death hampers measurement and analysis in this area. Similarly, gay, lesbian, bisexual and transgender status is also seldom recorded, despite the over-representation of these groups in suicide and self-harm statistics (SPA, 2009).

More comprehensive primary data on the risk/demographic indicators of suicide – not just a determination of suicide – from a range of sources (e.g. police reports, forensic pathologists, coronial findings, general practitioners, psychological autopsies) may, in fact, prove beneficial to strengthening the consistency and accuracy of suicide statistics and the subsequent analysis of this data for research purposes and preventive strategies.

Part of the current problem is attributable to the fact that, in Australia, suicide statistics depend on a complex process of information capture, distribution and processing that involves numerous organisations and individuals. No one body or portfolio is responsible for producing mortality data. Multiple parties collect data for different, sometimes disparate, purposes (e.g. legal, statistical, research-oriented) with different standards of proof and reporting timelines (Harrison, Pointer, & Elnour, 2009; De Leo et

al. in press, National Committee for the Standardised Reporting on Suicide). The terminology related to suicide and self-harm also varies greatly across jurisdictions and among coroners, who are ultimately responsible for the determination of death (and intent).

It is acknowledged that, in recent years, reforms have occurred within the coronial system in Australia and, similarly, that – despite their disparities in approach – organisations responsible for data collection and coding practices, such as that conducted through the NCIS, have in place their own internal quality assurance procedures and systems (Harrison, Pointer, & Elnour, 2009). A number of remaining inherent barriers (e.g. political, legal/jurisdictional, philosophical, and practical) must be addressed if progress on the integrity and timeliness of suicide and suicide-related data in Australia is to be made.

The literature shows these impediments include, but are by no means limited to:

- Absence of a central authority for mortality data production;
- Lack of standardised reporting, collection and capture, classification and coding procedures across Australian jurisdictions;
- Lack of systemic resourcing, training and shared expertise;
- Concerns over validation of data and the impact of legacy issues associated with data collection processes and reporting procedures that have since been superseded;
- Burden of proof for coroners making a positive finding of suicide differs from the statistical requirements for research/policy purposes;
- Retrospectively-commissioned research to revise suicide numbers (which, while commendable in principle, will delay final counts and full benefit by several years);
- Deficiencies in the standardised identification of characteristics on death records related to Indigenous status and gay, lesbian, bisexual and transgender people;
- Life insurance 13-month exemptions for suicide, which are currently commonplace, and require industry reform;
- Traditional lack of coordination and collaboration between coroners, forensic counselling services and those bereaved by suicide to identify, understand and respond to situations where suicide determinations are at variance with a family's wishes; and
- Social stigma associated with suicide and mental illness is a constant deterrent to accurate reporting.

Statistics also show that, in Australia, the rate of completed suicide is higher for men than women, although more women than men attempt suicide (Australian Bureau of Statistics, 2009). The higher likelihood in men to choose more lethal means of death or methods of suicide that result in instant death (e.g. use of firearms) relative to women may well complicate coronial determinations of suicide as cause of death among women, and impact on the accuracy of statistics underpinning the reported prevalence of female suicide in Australia. This is because, for some mechanisms of death where it may be very difficult to determine suicidal intent (e.g. drowning, poisoning by drugs),

the burden of proof required for the coroner to establish that the death was suicide, may make a finding of suicide less likely (Australian Bureau of Statistics, 2009).

Public Attitudes towards Suicide

In November 2009, Lifeline Australia commissioned a national *Newspoll* Omnibus Survey to gain some further insights regarding public attitudes towards suicide and strategies for prevention. The *Newspoll* Omnibus surveyed 1,203 respondents aged 18 years and over, from across Australia. Only preliminary data was available at the time of preparing this Submission.

Preventability of suicide:

Just under two-thirds of respondents (64%) indicated that suicide in Australia is 'mostly preventable'. More alarmingly, one quarter (26%) indicated that suicide is 'mostly not preventable', with 10% undecided.

Lifeline's holds a strong belief that suicide is preventable. This is supported by a strong evidence base that access to crisis support, intervention and education contribute significantly to preventing suicide. This research demonstrates that one-quarter of the population are poorly informed, and that there is room for improvement with the use of community-wide education around suicide and suicide awareness campaigns.

Likelihood of talking about suicide

The *Newspoll* research shows that a low proportion of respondents believe that those who were suicidal would tell someone about it (23%). Seventy percentof respondents generally doubted that a person who had considered suicide would tell someone else about it. This finding was consistent across most demographic groups.

This again, shows the investment that needs to be made in suicide awareness education and campaigns within Australia. A significant segment of the community are unable to talk about suicide or suicidality. It could also be argued that many respondents are not empowered to 'read-the-signs' of someone who is suicidal and trying to communicate their sense of hopelessness.

Current response

National Suicide Prevention Strategy (NSPS) 2008

Appendix 3 contains the full, publicly available details on the NSPS from the Department of Health and Ageing. Some additional information has been included in COAG Progress reports issued by the Department as part of its obligations under the COAG National Action Plan on Mental Health. This is discussed in the following section.

On 10 September 2008, the Hon Nicola Roxon, Minister for Health and Ageing, announced the establishment of the Australian Suicide Prevention Advisory Council (ASPAC). ASPAC provides a forum for "expert service providers, researchers and clinicians to share expertise, contribute to national decision-making processes and to identify community needs and priorities for the National Suicide Prevention Strategy" (DOHA website, accessed 12 November 2009).

There are 13 national projects and 17 community projects currently listed on Life Communications website as receiving funding from the NSPS. Project funding is discussed below under the COAG National Action Plan on Mental Health.

With the exception of ABS suicide data and AIHW hospital separation data for self-harm, to date, no evaluation data is available on the NSPS. The Urbis Keys Young evaluation was published on an independent website in early 2009 (see www.crikey.com).

COAG National Action Plan on Mental Health 2006-11

In July 2006, following the release of the Senate Select Committee report on mental health in Australia, *From Crisis to Community,* and the MHCA's *Not for Service* report, the Council of Australian Governments (COAG) agreed to a National Action Plan on Mental Health (NAP).

The five year plan initially pledged $4b of additional expenditure toward significant reforms and new services to address the nation's mental health crisis. This has increased to nearly $5.5b over the five years. In the February 2006 COAG Press Conference, the then Premier of NSW, The Hon. Morris Iemma, acknowledged the consequences on mental health consumers and families for decades of neglect on mental health.

The COAG NAP nominated five key Action Areas:

- Promotion, prevention and early intervention
- Integrating and improving the care system
- Participation in the community and employment, including accommodation
- Increased workforce capacity
- Coordinating care

Total funding allocation to Action Area 1, Promotion, prevention and early intervention, now stands at $561m or 10.5% of the total COAG commitment. This includes the initiative *Expanding Suicide Prevention Programs* from the Commonwealth Government (see Table 9).

Table 9: Action plan funding commitments 2006-11 and allocations 2006-07 (millions)

	Funding commitments 2006-11			New funding allocated 2006-07 & 2007-8
	As reported in the Action Plan July 2006	Subsequent new funding commitments	Total funding commitments 2006-11	
Australian Government	1,855.1	138.3	1,993.4	757.3
New South Wales	938.9	41.4	980.3	361.1
Victoria	472.2	172.6	644.8	174.3
Queensland	366.4	617.4	983.8	277.9
Western Australia	252.5	231.4	483.9	135.6
South Australia	116.1	172.4	288.5	62.4
Tasmania	43.0	15.7	58.7	19.6
Australian Capital Territory	20.7	20.9	41.6	8.1
Northern Territory	14.5	0.6	15.1	6.7
Total	**4,079.3**	**1,410.7**	**5,490.1**	**1,803.0**

Under the COAG NAP, an additional $62.5m was committed over the five years and that brought total funding for suicide prevention to $127m to 2012. An additional $20.9m was announced for suicide prevention in 2008-09 in June. Most importantly, the COAG NAP committed all governments to reporting against twelve agreed outcomes measures – these covered population health, health service delivery and social and economic outcomes. These are listed in Table 10.

These funds were to be provided under the National Suicide Prevention Strategy for national and community-based projects and for national research and development to increase the understanding of suicide and its prevention.

There does not appear to be any progress on the Expansion of Suicide Prevention Programs, and nothing related to this program has been reported publicly by the DOHA since August 2008. Neither the Department's or LIFE Communication's websites contains a full list of funded programs (as accessed on 16 November 2009). To that date, $32.7m of these funds have been committed to 50 projects. This included $19.7m to 18 national projects (with $4.8m to *MindMatters* and $2.25m to *KidsMatter*) through 2008-09; $12.33m to 17 large community-based projects through June 2009; and $611,000 to 15 small community-based projects through June 2008. In addition, nearly $2m has been provided to Lifeline for telephone counselling services.

It appears than these funds include ten projects targeted at Indigenous communities (total funding $6.3m); eight projects targeted at children and youth (total funding $4.5m); and four projects targeted at people in rural and remote areas (total funding $4.96m).

Table 10: COAG Action plan outcome areas and progress indicators

Outcome	Progress Measures
Reducing the prevalence and severity of mental illness in Australia	The prevalence of mental illness in the community
	The rate of suicide in the community
Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery	Rates of use of illicit drugs that contribute to mental illness in young people
	Rates of substance abuse
Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention	Percentage of people with a mental illness who receive mental health care
	Mental health outcomes of people who receive treatment from State and Territory services and the private hospital system
	The rates of community follow up for people within the first seven days of discharge from hospital
	Readmissions to hospital within 28 days of discharge
Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation	Participation rates by people with mental illness of working age in employment
	Participation rates by young people aged 16-30 with mental illness in education and employment
	Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities
	Prevalence of mental illness among homeless populations

The March 2008 progress report from DOHA does not list any funded initiatives, but indicates that the current emphasis is on building the evidence base and development of measures around high-risk groups, consideration of options for more effective targeting of future suicide prevention activities, and ways of addressing the interface between suicide prevention and primary care.

The August 2008 progress report highlights changes in the work of the NSPS as a consequence of the Health Minister's announcement in June 2008. The aim is to better target high risk groups and people living in geographical areas with high rates of suicide by:

- Providing psychological services in primary care settings for people who have attempted suicide or self-harmed through funding to the Divisions of General Practice;

- Boosting the capacity of organisations in rural areas to provide allied and nursing mental health services for people with a mental illness who are at risk of suicide;
- Support for the development of bereavement response services for families and friends who have lost someone to suicide; and
- Building the capacity of Indigenous communities to provide culturally appropriate suicide prevention activities.

The August progress report points to the Health Minister's announcement of the new Australian Suicide Prevention Advisory Council, to be chaired by Professor Ian Webster.

It also highlights a national demonstration project (announced in March 2008) to provide additional support for patients at risk of suicide and self-harm through the *Access to Allied Psychological Services* (ATAPS). The project is jointly funded through ATAPS/Better Outcomes in Mental Health Care programs (BoMH) and the NSPS.

National Mental Health Policy and 4th Mental Health Plan

Background

Australia was the first nation in the world to recognise the need for a national effort to improve mental health services for people with mental illness. In 1992, the Australian Government, with the agreement of all States and Territories committed to the development and implementation of the first National Mental Health Strategy, based on an agreed national policy, an initial five year plan (2003-2008), the Mental Health Statement of Rights and Responsibilities and a funding agreement from the Commonwealth and states and territories.

As was briefly discussed earlier in this Chapter, in the seventeen years since, much has been achieved and much has changed about the way mental health services are delivered. However, the involvement of COAG, following the release of two major reports - The Senate's Report in March 2006 *From Crisis to Community* and the Mental Health Council of Australia's *Not for Service* Report in October 2005 – clearly signaled that the National Mental Health Strategy and the planning, implementation and monitoring processes were failing to address the needs of the Australian community.

Community concern regarding the state of mental health services, as reflected in the reporting of mental health issues in the media, official reports (such as those from the offices of state/territory Auditor Generals and Ombudsman) and the professional literature, reflects the reality that the admirable intentions and genuine commitments of governments to reform services have left many vulnerable Australians without access to mental health care when they need it. Furthermore, it is clear that the greater vision of bringing people with mental illness successfully out of the 'asylum' and achieving integration with the broader community has not been realised.

The evidence of the shortfall in policy intention and outcomes is there for all of us to see and for many to experience on a daily basis. Mental health, Indigenous health and dental health have been identified as the areas for urgent action in the recent National Health and Hospital Reform Commission's final report: *A Healthier Future for All Australians* . Each of these areas has the poorest health outcomes, the poorest resourcing and are the least functional in our national health system.

National Mental Health Policy 2008

In December 2008, all Australian Health Ministers endorsed a new National Mental Health Policy (Department of Health and Ageing, 2009).

> *"The revised National Mental Health Policy represents a renewed commitment by all Health Ministers and Ministers with responsibility for Mental Health to the continual improvement of Australia's mental health system"*
>
> The Hon Katy Gallagher MP, Chair Australian Health Minister's Conference, March 2009

The Policy states that it was updated to align with the whole-of-government approach articulated within the COAG National Action Plan on Mental Health.

> *"The Policy provides an overarching vision for a mental health system that enables recovery, prevents and detects mental illness early, and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community".*

The stated aims of the National Mental Health Policy are to:

- Promote the mental health and well-being of the Australian community and, where possible, prevent the development of mental health problems and mental illness;
- Reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community;
- Promote recovery from mental health problems and mental illness; and
- Assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.

The Policy sets out ten "policy directions"- one of these includes reference to "reducing suicide risk"[6]. The Policy is largely a discussion about the risks and general prevention strategies. It identifies mental illness as a risk factor for suicide along with "an array of social factors such as poverty and recent stressful life events". The Policy contains no strategies, funding commitments, nor any markers or mechanisms to measure progress.

National Mental Health Plan: an agenda for collaborative government action in mental health 2009-14

The Fourth National Mental Health Plan (4NMHP) was released by the Australian Health Minister's Conference on 13th November 2009, some four years since a working group was established to develop the 4th Plan. The Plan states that it will include actions which will:

- Maintain and build on existing effort
- Integrate recovery approaches within the mental health sector
- Address service system weaknesses and gaps identified through consultation processes
- Better measure how we do this and the outcomes achieved.

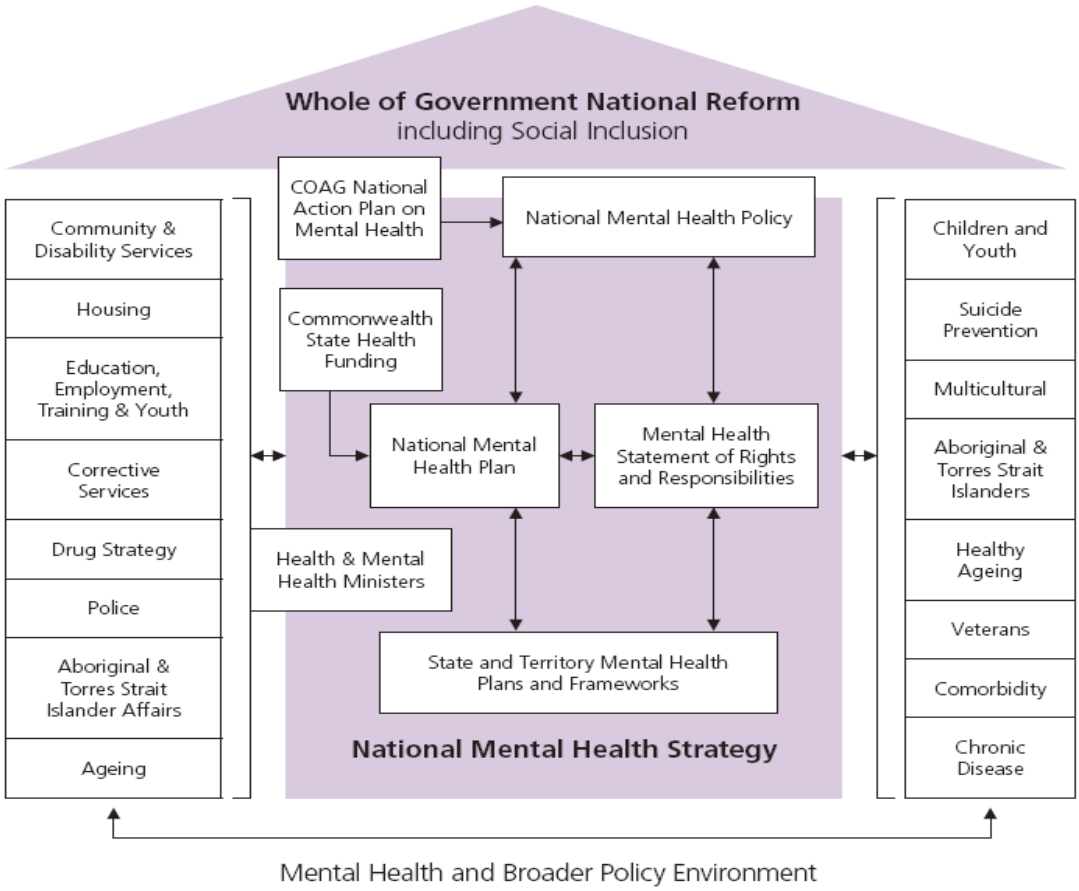
6 Policy direction 3 states: "Preventing mental health problems and mental illness, and reducing the risk of suicide" Page 14, National Mental Health Policy, 2009.

The Plan has five priority areas for government action in mental health:

1. Social inclusion and recovery;
2. Prevention and early intervention;
3. Service access, coordination and continuity of care;
4. Quality improvement and innovation; and
5. Accountability - measuring and reporting progress.

While led by health ministers, the Plan states that it takes "a whole of government approach" to acknowledge that the "best mental health outcomes are achieved through a partnership involving sectors other than just health". The diagram below is included in both the Policy and 4NMHP.

Figure 16: A whole-of-government approach to mental health



Source: NMH Policy 2008

Criticism of the 4NMHP

In the 4NMHP it states:

> *"Outlays by governments and health insurers to provide mental health services in 2006-07 totalled $4.7 billion, representing 7.3% of all government health spending. Mental health as a share of overall government spending on health has remained stable over the 15 year course of the Strategy."*

This is a revealing statement. While mental health has been declared as a national health priority since 1993, the proportion of health care funding has remained unchanged under the three National Mental Health Plans. It was only with the intervention of the COAG that a real boost in mental health expenditure occurred. This highlights a fundamental flaw in the planning for mental health reform. New services and new systems of care have only been possible when existing funds are diverted from existing services.

Despite the continuing high level of community concern, the results from the 2007 National Survey of Mental Health and Wellbeing, the numerous independent reports highlighting the continuing failure of services and care, the 4NMHP contains:

- No specific funding commitments by any Australian government
- It represents largely more of the same, as under previous plans 2 & 3 – an incremental approach to change when the evidence for transformation is clear
- It adopts a conservative approach, focused largely on specialist mental health services. Primary care is only briefly mentioned.
- There are no details on how the whole-of-government ambition of the Plan will be operationalised – that is, there is no detail on coordination mechanisms, governance or accountability across service systems.
- The Plan also appears divorced from the reforms flagged in the key reports (such as the National Health and Hospital Reform Commission) before the Australian Government.

Health Ministers have now established an "Implementation Working Group" to develop a third document – the Implementation Plan – due back to AHMC in one year with specific program and funding commitments. This process is no different to that undertaken under the 3rd National Mental Health Plan, except that the implementation plan took nearly three years to develop and be agreed to by all parties.

Despite the commitments made by successive Australian Health Ministers' Conferences toward mental health reform, progress is slow and persistent criticisms of the reform process are evident in the professional literature (Groom et al 2003; MHCA, 2005; Hickie et al, 2009; Rosen et al, 2009). In addition, there continue to be frequent independent assessments issued by public office holders across the nation highly critical of the quality, access and appropriateness of public mental health services. The most recent independent reviews have being issued by the NSW Ombudsman (Nov 2009), the WA Auditor General (Oct 2009) and the Victorian Auditor General (Nov 2009).

Mental Health Council of Australia. Not for Service: Experiences of injustice and despair in mental health care in Australia. Deakin, ACT, 2005.

The NSW Ombudsman's report on the Joint Guarantee of Service for People with Mental Health Problems and Disorders Living in Aboriginal, Community and Public Housing (JGOS) was developed in recognition that people with mental health problems frequently experience difficulties accessing housing, disruption to tenancies and reduced capacity to maintain housing. For these reasons, mental illness has been identified as one of the typical pathways into homelessness (ABS, Sept 2008).

The Ombudsman states the need to assess the implementation of key commitments by government agencies – such as those set out in the JGOS. The JGOS is intended to assist some of the most vulnerable people in the community: people with mental health problems needing assistance to access and sustain social housing. Mental illness has long been recognised as one of the major pathways into homelessness and homelessness is another risk factor suicide and self-harm (MHCA, 2009). Both the Federal and NSW governments have recently renewed their commitment to address homelessness (COAG, 2008) and ensure that no person was discharged from state care without adequate housing.

It would also appear that inadequate consideration was given at the outset to how the partners would demonstrate they were achieving the JGOS aims, that is, how an evidence base would be built. Our investigation found that neither Housing, nor Health, nor any of the other partners were systematically capturing information about what results were being achieved through the JGOS process or the nature of any impediments to achieving them.

NSW Ombudsman, Nov 2009

Gaps in service availability and access mean there are still too many people for whom the experience of care is not a good one, and who slip into crisis before getting help.

WA Auditor General, Nov 2009

Despite the priority given by First Ministers through COAG, the NSW Ombudsman and the WA and Vic Auditors General have found people with mental illness are continuing to be discharged from acute care hospitals into homelessness, are unable to access care and continue to experience poor quality of care across Australia. This places these Australians at considerably greater risk of suicide and self-harm.

Chapter 7 - International Comparisons

England

The UK released the National Suicide Prevention Strategy for England (NSPSE) in 2006 following a national consultation process. The strategy has a clear, time defined target to reduce the death rate from suicide by at least 20% by 2010. The strategy seeks to be comprehensive, evidence-based, specific and subject to evaluation, and will be delivered as one of the core programmes of the National Institute for Mental Health in England (NIMHE).

The NSPSE sets out six key goals, sub-objectives and key actions. Against each objective, the baseline data is provided along with the stated outcome measure, as illustrated in Table 11.

Table 11: UK NSPSE – Goal 1: To reduce risk in key high risk groups

Objective	Current situation	Illustrated impact of 20% reduction in suicides
Reduce the no. of suicides by people who are currently or have recently been in contact with MHS	1,200 deaths per year Latest 3 year average – 1238 Male – 826 Female - 412	240 fewer deaths
Reduce the no. of suicides in the year following deliberate self-harm	1,180 deaths per year Latest 3 year average – 1,176 Male – 672 Female - 504	236 fewer deaths
Reduce the no. of suicides by young men	1,300 deaths per year Latest 3 year average – 1,294	260 fewer deaths
Reduce the no. of suicides by prisoners	1,180 deaths per year Latest 3 year average – 1,176 Male – 672 Female – 504	17 fewer deaths
Reduce the no. of suicides by high risk occupational groups	Farmers & agri. workers: - 52 deaths per year Nurses – 27 per year Doctors – 172 per year	19 fewer deaths

Goal six under the NSPSE is "to improve monitoring of progress towards the *Saving Lives: Our Healthier Nation* target to reduce suicides". The strategy commits the Government to monitoring and reporting publicly on progress toward the relevant suicide statistical goals and targets (DOH, 2006).

California, USA

The Californian Strategic Plan on Suicide Prevention (*Every Californian is Part of the Solution)* was launched in 2008, following extensive community and expert consultations. The strategy is based on:

- Creating a system (infrastructure) to support suicide prevention

- Targeted approaches
- Multi-level or spectrum public health approaches
- Workforce training and development
- Public education
- Improving program effectiveness and system accountability.

An important learning from earlier suicide prevention efforts in California has been the Establishment of an Office of Suicide Prevention within the Office of the State Governor, to provide coordination and collaboration across the state and serve as an online clearinghouse of information about suicide data and related research findings, best practices and community planning.

Again, in recognising the need to engage the business and not-for-profit sectors in suicide prevention efforts, the Strategy commits to the development of a network of state-wide public and private organizations to develop and implement strategies to prevent suicide. The public and private partnerships include:

- Community-based and ethnic-based organizations
- Community leaders
- Client, family, youth and peer support advocacy groups
- Employers
- Health and mental health providers
- Insurance industry
- Local educational agencies and institutions of higher education
- Spiritual and faith-based organisations.

An additional noteworthy aspect of the Strategy is the commitment to improving data collection, surveillance, and program evaluation and a research agenda to design responsive policies and effective programs to reduce the impact of suicide in diverse populations.

(http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSPSP_V9.pdf)

Others

A number of other countries have developed and implemented and, in some cases, evaluated national suicide prevention strategies/programs. Summary data in relation to objectives (universal, selective or indicative interventions, media, research and evidence, access to means and other) for New Zealand, USA, Canada, Scotland and Ireland is contained in Table 12.

Details of these programs can be found in the following publications:

- Goldsmith, S.K., Pellmar, T.C., Kleinman, A.M. & Bunney, W.E. (Eds). (2002). Reducing suicide: A national imperative. Institute of Medicine, Washington DC: National Academies Press. [Book]. Chapter 8. - *In particular, the Finland and Norway strategies*

- deMartino, R.E., Crosby, A.E., Echohawk, M., Litts., D.O., Pearson, J, Reed, G., West, M (2003). A call to collaboration: The Federal Commitment to Suicide Prevention. Suicide and Life-Threatening Behavior, 33, (2), 101-110. – *USA strategy*
- US Public Health Service (1999). The Surgeon General's call to action to prevent suicide. Washington DC: Author. – *USA strategy*
- Choose Life website – www.chooselife.net – *Scotland strategy*

One additional program of note is that of the Samaritans in the UK – *Emotional health Promotion: changing our world.*
(see http://www.samaritans.org/your_emotional_health.aspx)

Table 12: A summary of international suicide prevention efforts

Objectives	New Zealand	England	Scotland	Northern Ireland
Universal (activities that apply to everyone)	• Promote mental health and wellbeing, and prevent mental health problems	• To promote mental wellbeing in the wider population	• Ensuring greater public awareness of positive mental health and wellbeing, suicidal behaviour, potential problems and risks amongst all age groups and encouraging people to seek help early	• To raise awareness of mental health and wellbeing issues
Selective (activities that apply to communities and groups "at risk")	• Improve the care of people who are experiencing mental disorders associated with suicidal behaviours	• To reduce risk in key high risk groups	• Providing earlier intervention and support to prevent problems and reduce the risks that might lead to suicidal behaviour • Providing on-going support and services to enable people to recover and deal with the issues that may be contributing to their suicidal behaviour	• To ensure early recognition of mental ill-health, and to provide appropriate follow-up action by support services • To provide appropriate training for people dealing with suicide and mental health issues • To develop co-ordinated, effective, accessible and timely response mechanisms for those seeking help • To enhance the support role currently carried out by the voluntary/community sectors, bereaved families and individuals who have made previous suicide attempts
Indicated (activities that apply to times of heightened risk)	• Improve the care of people who make non-fatal suicide attempts • Support families/ whanau, friends and others affected by a suicide or suicide attempt		• Providing support and services to people at risk and people in crisis, to provide an immediate crisis response and to help reduce the severity of any immediate problem • Providing effective support to those who are affected by suicidal behaviour or a completed suicide	
Research and Evidence (improving our understanding of the key issues in suicide prevention)	• Expand the evidence about rates, causes and effective interventions	• To promote research on suicide and suicide prevention	• Improving the quality, collection, availability and dissemination of information on issues relating to suicide and suicidal behaviour and on effective interventions to ensure the better design and implementation of responses and services and use of resources	• To provide support for research evaluation of relevant suicide and self-harm issues
Media	• Promote the safe reporting and portrayal of suicidal behaviour by the media	• To improve reporting of suicidal behaviour in the media	• Ensuring that any depiction or reporting by any section of the media of a completed suicide or suicidal behaviour is undertaken sensitively and appropriately and with due respect for confidentiality	• To support the media in the development and implementation guidelines for a suitable response to suicide related matters
Access to Means	• Reduce access to the means of suicide	• To reduce the availability and lethality of suicide methods		• To restrict access, where possible, to the means of carrying out suicide
Other		• To improve monitoring of progress towards the Saving Lives: Our Healthier Nation target to reduce suicides		

Objectives	Ireland	USA	Canada
Universal	• To promote positive mental health and wellbeing and bring about positive attitude change towards mental health, problem solving and coping in the general population	• Promote awareness that suicide is a public health problem that is preventable • Develop broad-based support for suicide prevention • Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention programs	• Promote awareness in every part of Canada that suicide is our problem and is preventable • Develop broad-based support for suicide prevention and intervention • Develop and implement a strategy to reduce stigma, to be associated with all suicide prevention, intervention and bereavement activities • Increase the number of primary prevention activities
Selective	• To reduce the risk of suicidal behaviour among high risk groups and vulnerable people	• Implement training for recognition of at-risk behaviour and delivery of effective treatment • Develop and promote effective clinical and professional practices • Increase access to and community linkages with mental health and substance abuse services • Develop and implement community-based suicide prevention programs	• Increase training for recognition of risk factors, warning signs and at-risk behaviours and for provision of effective intervention, targeting key gatekeepers, volunteers and professionals • Develop and promote effective clinical and professional practice (effective strategies, standards of care) to support clients, families and communities • Improve access and integration with strong linkages between the contiuum-of-care components/services/ families • Develop, implement and sustain community-based suicide prevention programs, respecting diversity and culture at local, regional, and provincial/territorial levels • Prioritise intervention and service delivery for high-risk groups while respecting local, regional and provincial/ territorial uniqueness
Indicated	• To minimise the distress felt among families, friends and in a community following a death by suicide and ensure that individuals are not isolated or left vulnerable so that the risk of any related suicidal behaviour is reduced		• Increase crisis intervention and support • Increase services and support to those bereaved by suicide
Research and Evidence	• To improve access to information relating to suicidal behaviour and on where and how to get help, and to encourage suicide research and improve access to research findings	• Promote and support research on suicide and suicide prevention • Improve and expand surveillance systems	• Promote and develop suicide-related research Improve and expand surveillance systems • Promote and support the development of effective evaluation tools • Increase opportunities for reporting
Media		• Improve reporting and portrayals of suicidal behaviour, mental illness and substance abuse in the entertainment and news media	• Increase media knowledge regarding suicide
Access to Means		• Promote efforts to reduce access to lethal means and methods of self-harm	• Reduce the availability and lethality of suicide methods
Other			• Increase funding and support for all activities connected with the CASP Blueprint for a Canadian National Suicide Prevention Strategy

Source: Draft Life is for Living Framework, 2007

Chapter 8 - What do we need to reduce the burden of suicide and self-harm

National leadership, coordination, strategy and infrastructure

Since its development in 2000-1, the LIFE Framework has served as a proxy for the National Suicide Prevention Strategy. This remains the case in 2009. The Commonwealth Department of Health and Ageing (DOHA) has had responsibility, and remains responsible, for the NSPS/LIFE Framework.

A new governance and accountability structure for suicide prevention in Australia is now necessary. The key reasons for this are:

- Engaging a wide coalition of stakeholders across the Australian community – not just a whole-of-government approach, but a whole-of-community approach is now possible, given where suicide prevention now sits in public policy and community terms.
- There is a need to broaden the funding base from non-government sources - that is, from community, philanthropic, unions and other collectives and business sources – to supplement the contributions made by governments. Funding must be significantly increased to have an impact on suicide rates and address the social and economic costs of suicide and self harm.
- There is a need and opportunity to provide greater ownership, engagement, transparency and accountability for and to the Australian community, as well as assisting the community to understand clearly where they need to go to get the services they need or to financially support this crucial social issue.

Currently, there are major reforms of the health system being canvassed in the Australian community. The Rudd Government is placing increased emphasis on the need to re-balance our health system with a greater focus on prevention and early intervention. New financing mechanisms, new structures and governance arrangements are being canvassed.

In relation to suicide prevention, the parties to this Submission believe new structures need to be developed or re-positioned for:

- Raising and distributing funding – from across the community from a wide variety of sources
- Structures for governance and accountability need to be established – potentially independent of government and

The field of suicidology, supported by the interrelated areas of health, diversity, social services etc., is a dynamic emergent area in the Australian health landscape. To continue this momentum, the need for a united, intersectoral and multidisciplinary collaboration is vital if a genuine coordinated national approach to suicide prevention is to be achieved. Response to SPA Online Survey, ConNetica Consulting, 2008

service agencies

- Service delivery, capacity building, community awareness and education and advocacy need to be appropriately resourced and not reliant on ad hoc funding arrangements.

There are a range of models from both Australia and overseas on suicide prevention, HIV prevention, road safety and breast cancer and that offer sound bases for a more effective national suicide prevention agenda.

A new national structure to implement a coordinated, multi-strategy approach to suicide and prevention is required. The rationale for this new approach is:

- Suicide and self harm remain unacceptably prevalent in the Australian community, with the number of suicide deaths significantly higher than the national road fatality rate. The damage to individuals, families and communities is immeasurable. Suicide remains, largely, "a hidden epidemic" in public health terms.
- Suicide, the prevention of suicide and support for the bereaved and attempt survivors, are becoming increasingly important to the Australian community. Media coverage of a number of high profile cases involving prominent and 'successful' Australians have highlighted the complexities and the need to find answers.
- The bureaucracy, specifically health, has been largely responsible for the efforts to date on suicide prevention and related issues. Ongoing changes in personnel, machinery of government and policy frameworks have impeded progress and outcomes. Historically, health bureaucracies have a poor track record in leading change in health outcomes (e.g. changes in health outcomes such as alcohol, tobacco, HIV / AIDS, road trauma, have all come from the community and community sector). Health Departments have limitations in being able to bring about the structural and broader societal changes necessary to tackle complex issues like suicide and they are limited in their ability to implement whole-of-community programs.
- Suicide is not (only) a health issue. It is a complex social problem, with many risk factors and triggers – some which are understood and many which are not. It requires a whole-of-government response from within government. Suicide prevention requires a policy response that is well beyond the remit of the health portfolio, beyond health plans and services and it is therefore unreasonable to expect the health portfolio to develop and support policy beyond its own boundaries. There are a number of sectors – private, public and community – with a stake in

A new national enterprise to effectively tackle suicide is required. The new enterprise must be a credible, independent, evidence-based body that can implement sustainable programs to address stigma, suicide awareness, prevention, intervention and postvention.

suicide and suicide prevention. These include large corporations with employee populations with higher than average rates of suicide; public sector agencies with an interest in sustaining rural and regional Australia, transport, community and education; Indigenous communities and community organisations providing housing and employment programs and so on. Presently these organisations are doing what they can or wondering what they can do – they are looking for leadership.

Possibilities for National Suicide Prevention Structure

A new national structure for suicide prevention could provide an opportunity to increase social impact, clarify roles and functions of various service providers and significantly increase the resources available for suicide prevention and related activities.

A clear learning from other sectors, such as HIV and breast cancer, is that clarity of roles and responsibilities ensures that scarce resources are well utilised and effectiveness is increased. A key benefit in Australia at present is that the suicide prevention sector is still in its infancy, which provides an opportunity to establish a clear structure to support effective advocacy, fundraising, service delivery and research that will support best practice. In addition key people in this sector are highly engaged and committed to working collaboratively to minimise duplication of effort and confusion for consumers.

The organisation would be established in such a way as to enable significant contributions from the state/territory governments, the business and community sectors and the Australian public.

The new National Preventative Health Agency, with a mandate to address mental health promotion and suicide prevention, is one possibility among many. Likewise, new governance options canvassed in the National Health and Hospital Reform Commission interim report also have application and implications for suicide prevention. Other options include a Federal Statutory Authority (as has been done in anti-doping, blood services and many others), a Federal executive office (akin to the Australian Transport Safety Bureau) or a formalised coalition of key agencies.

Research suggests that countries which have road safety targets tend to perform better than countries without targets and that countries with ambitious targets generally have better outcomes than those which have less ambitious targets, even if the targets are not achieved. National Road Safety Action Plan (NRSS), 2009

The parties to this Submission are mindful of the need to consider a range of structural options in discussing the forms that one or more new organisations might take in this area. What is clear at this point is that there are a range of functions necessary to pursue a more effective, integrated national strategy and build on the achievements to date.

Monitoring, evaluation and research

Transparency and accountability have been clearly lacking in Australia's NSPS to this point. There has not been a strategic approach nor any significant investment in building an evidence base in suicide prevention. Only through a strategic, planned and systematic approach to monitoring, evaluation, research and public reporting will real and sustained reductions in suicide and self-harm be achieved.

The contrast with the nation's approach to reducing road trauma could not be more stark.

The National Road Safety Strategy (NRSS) set a target of bringing the annual number of road deaths per 100,000 population below 5.6 by the end of 2010, representing a 40 percent reduction relative to the benchmark 1999 rate. Indicative estimates were provided of the contribution of different types of measures to the overall 40 percent reduction target: improvements in roads (19 per cent); improved road user behaviour (9 per cent); improved vehicle occupant protection (10 per cent); and new technology to reduce human error and its consequences (2 per cent).

> *Public health care systems clearly have failed to prevent suicide and suicide attempts … a major factor has been an unbelievable dearth of treatment development and evaluation research.*
> ***Linehan, 2008***

In 1970, over 3800 Australians died on the nation's roads. Last year the national road toll was fewer than 1500. This represents an annual decline in the road toll of nearly 4% per annum every annum. Nationally we have seen road deaths decline from 30.4 in 1970 to 6.8 deaths in 2008 per 100,000 people (DITRDLG, 2009).

This has been achieved through a combination of strategy, coordinated action across areas of government and industry and sustained investment in research, evaluation and monitoring. An example of this investment are the 529 research and evaluation reports available on the Australia Government's Road Safety website.

Evaluation and Research

During the period of the NSPS, a total of 36 grants to the value of $5.84m have been provided for projects or fellowships in the area of suicide prevention (Robinson et al, 2008).

Robinson et al (2008) conducted a comparison of current research efforts and through a survey of stakeholders, identified priorities for research in suicide prevention. In part, this work was stimulated by the absence of any strategic research agenda. Niner et al (2009) used group interviews to inform priority setting in Australian suicide prevention research.

While the results from these two studies had differences arising from method, a number of key points emerged:

- That priority should be given to evaluating the efficacy of specific interventions and examining the response of the health and community service systems;
- That the epidemiological profile of suicidal individuals had been explored, at least with respect to rates and individual-level risk factors;

- That evaluation activities should focus on groups with particularly high levels of risk;
- Most saw limited value in continuing to explore individual-level risk factors;
- There is a need to considering wider societal influences on suicide and individual-level protective factors;
- That evaluation efforts should employ mixed methods, should be multidisciplinary and should be relevant to the Australian context;
- That there was scope for increasing the use of and access to research findings by policy-makers, planners and practitioners;
- There were calls for a more cohesive framework for suicide prevention that could guide suicide prevention research.

ConNetica Consulting also conducted an online survey during the preparation of this Submission. An invitation to complete the survey was forwarded to approximately 200 known researchers in the suicide prevention field. A total of 49 respondents completed the survey. Over 70% of respondents had over 5 years experience in suicide prevention research and 33% had more than 10 years. The major area of research cited was risk factors, followed by rates of suicide and/or self-harm and program evaluations. Cultural, literature, historical and sociological studies were all among the least researched areas. The quality of data was only seen as adequate in relation to risk factors and media studies. In all other 17 areas cited in the survey, the quality of data was seen as "non-existent", "very poor" or "poor".

In relation to the available funding, over 85% of respondents indicated that the current level of funding was totally inadequate or less than required. The need for research funding was rated as high or very high in all but historical, media and cultural studies. However, it should be noted that fewer researchers included these areas of study in their areas of activity.

The lack of available funding, difficulties obtaining ethics committee approval, the dominance of the medical model and the limited capacity to apply for funding grants were seen as major barriers to undertaking suicide prevention research. Ethics committee approval processes generally prohibit involving any person who may be demonstrating suicidal behaviour (ConNetica Consulting, unpublished 2009).

Research priorities for better understanding the causes of suicide

- How do we respond to risk factors and precipitating events? – Applying our knowledge of risk and protective factors and precipitating events to prevent suicide
- How do we identify those most at risk? - Many people who would be described as being at a high risk of suicide never have suicidal thoughts or behaviours and some people who have limited to no risk factors and many protective factors attempt or complete suicide
- Identifying the critical point for action – at what point are suicide prevention efforts most effective in reducing the loss of life?
- Protective factors – how can protective factors be increased in high-risk populations and individuals?
- Points of transition – the times/points of highest risk tend to be those that occur during a transition (e.g. transition between secondary school and higher education/training or employment; transition between in-patient care and community care)

Improving National Suicide Data

The problem of underreporting of suicide has been addressed earlier in this Submission. This underreporting of suicides in the past ten years may have given false hope that suicides were in decline when, in fact, no substantial change had occurred (De Leo, 2007; De Leo et al, in press). This issue must be addressed if we are to make real progress on suicide prevention in Australia.

National Committee for the Standardised Reporting on Suicide

Given the need to respond to and address the problems with data, a coordinated and widely consultative approach is essential. Standardised reporting of suicide has also previously been identified as a principal objective/outcome of the Federal Government's *National Suicide Prevention Strategy*.

A national committee, whose membership canvasses the diversity of stakeholders requisite to addressing the problem of under-reporting of suicide in Australia, could provide the necessary oversight and collaborative direction for such an initiative. With this in mind, in 2008, SPA commenced a consultative process aimed at exploring the pragmatics of achieving improved and standardised reporting of suicide and self-harm in Australia. As part of this project, SPA consulted broadly on the issue with NCIS, key researchers, regional projects between local coroners and services, various health and community services, representatives from the Child Death Review Committee (NSW) and Victorian Institute of Forensic Medicine. It was this process that led us to believe a National Committee for Standardised Reporting on Suicide (NCSRS) needed to be established.

With representatives from ABS, NCIS, the Australian Institute for Suicide Research and Prevention (AISRAP), the Australian Institute of Health and Welfare (AIHW), the

Australian Suicide Prevention Advisory Council (ASPAC), the Australian Government's Department of Health and Ageing (DoHA), police, coroners, funeral directors and university researchers, among others, the key objective of the NCSRS is to help coordinate the various stakeholders (and projects) within the system to appropriately address the challenges associated with developing a standardised and collaborative approach to suicide recording and reporting. So far, this collective has met on two separate occasions and has already identified a number of priorities for systemic reform, as well as a provisional implementation strategy.

These efforts need to be formally recognised and supported by all Australian governments and adequately resourced.

Suicide and Accountability

A recurring theme of this Submission relates to existing data and information problems. In this regard, suicide mirrors the mental health sector generally. There is an urgent need for sustained investment in new, transparent and independent processes to collect data on suicide.

The 4th National Mental Health Plan states the following as key actions specifically in relation to suicide:

- Provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors
- Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them.

The Plan does not specify how progress against these actions is to be assessed, but instead commits all governments to the development of a new system of accountability over the coming two years.

Seventeen years of mental health reform have failed to deliver the accountability required to provide funders, service providers, politicians and the general community with any confidence in our mental health system and our capacity to manage suicide. Efforts in this regard have been mostly directed by governments, in essence, putting in place measures to assess their own performance. This fails the independence test. A robust system of accountability depends on independence and transparency and these must be the key features of a new effort to better understand suicide and its impact on the Australian community.

To be very specific and as a start, the Table below lists the data items which would be of most relevance to a new Suicide Accountability Framework.

Table 13: Measures as part of a suicide related accountability framework

Data Item to be Collected	Rationale
Suicide Rate	Accurate and reliable data is critical to understand the scale of the problem and the impact of strategies designed to prevent suicide.
Death rates <3 and <12 months post discharge from a mental health facility, including cause of death	It is critical to know if a person is alive after interacting with the mental health system. Death may be from a range of causes, including the significant physical health issues that often affect a person with mental illness. This data will allow us to understand both trends in numbers and identify causes.
Percentage of the population receiving mental health care – both among general population and among population aged 12-25 years, specifically	With 75% of all mental illness manifesting before the age of 25 years, it is critical to monitor access to care among this population in particular, as well as among the general population.
Prevalence of mental illness	While a Household Survey on Drugs involving 25,000 households is carried out every three years, Australia waits a decade between surveys into the prevalence of mental illness. This is unacceptable.
Mental health outcomes of people who receive acute care, care in primary care settings and in the community	The Government is spending more money than ever before on primary mental health care – is this spending leading to better mental health outcomes for clients? The same questions need to be asked of care provided in acute settings.
Patient follow-up in the community	Many patients currently disappear from the health system following discharge from a service. This item would track the rate of follow-up care provided in the community, via GPs or through provision of psychological services or other care.
Rates of licit and illicit drug use that contribute to mental illness among young people	Alcohol and other substances are a key factor in many suicides and tracking their impact on young people is important for this reason.
Delay before first treatment	There is considerable evidence to suggest that a rapid response to the emergence of psychosis is a vital

Data Item to be Collected	Rationale
for psychosis	ingredient in successful ongoing care.
Participation rates by people with a mental illness of working age in employment	Australia's employment participation rate for people with a mental illness is around half that of comparable OECD countries, at 29% (MHCA, 2007). This must be tracked to demonstrate the effectiveness of programs designed to increase participation.
Participation rates by people with mental illness aged 16-30 years in education and training	Keeping younger people engaged in education and training is a key marker of social participation.
People with a mental illness reporting they have stable housing	The link between stable housing and good mental health has been understood for some time.
Community surveys of attitudes towards mental illness and suicide	It is important to track stigma and discrimination in the community, both generally and by specific target groups, such as employers etc. This data can inform health promotion activities.
Readmission rates to hospital < 28 days following discharge	This is a process measure, indicating the extent to which community services were available to a person discharged from hospital (N.B. there is conjecture in international literature about this as a valid indicator)
Re-presentation to emergency department < 28 days following discharge	Similar to the preceding marker, an indicator of the availability of services outside of hospital.
Percentage of involuntary admissions and involuntary community care compared to total admissions and total registered clients	An organised and supportive mental health system should see dependence on involuntary admissions reduce over time.
Waiting time for admission to a supported mental health place in the community	A marker designed to assess the availability of these key services.
Percentage of persons seen by a community-based health professional within seven	A process measure indicating the connectedness of the mental health system as a person moves between service settings, to demonstrate some continuity of care.

Data Item to be Collected	Rationale
days of discharge from a facility	
Level of family assessment and support provided to carers	To better understand the risk factors for families and children of people with a mental illness.
National Mental Health Workforce Survey	In addition to monitoring the morale and wellbeing of mental health staff (across all services), this survey could also assess staff skills, etc in relation to suicide management and prevention.

Workforce development, training and education

Research conducted by the Inspire Foundation - Bridging the Digital Divide - found that while information communication technology (ICT) is an integral part of the lives of a diverse range of young people, many youth service providers have limited capacity to use technology in their engagement with young people (Blanchard et al., 2007). While most service providers feel confident completing basic ICT tasks, many lack the knowledge, skills and confidence to provide support to young people using technology. They report not understanding the websites that young people engage with and have a poor understanding of the role technology plays in young people's lives.

As information and communication technology (ICT) plays a central role in the lives of young people, it follows that building capacity of health care professionals to utilise ICT in their practice could provide a powerful compliment to face to face interventions. Recognising the significant role technology plays in the lives of young people, Inspire Foundation's Reach Out Pro provides access and advice for health care professionals on a range of technologies and online resources that can be used to enhance the effectiveness of the psychosocial support and mental health care provided to young people.

Reach Out Pro encourages health care professionals to become acquainted with new technologies and their significance to young people and to integrate the use of technology into their practice to better meet the needs of young people and ultimately improve mental health outcomes. Reach Out Pro is closely linked to ReachOut.com to help provide young people with access to an online community and trusted information and advice. The two main objectives of Reach Out Pro are to: (1) increase health care professionals' understanding of the role technology plays in the world of young people and how it allows them to express themselves and connect with their peers; and (2) increase health care professionals' understanding of how internet-based technology can be used to engage young people in improving their mental health and well-being.

Training programs for gatekeepers, particular police and emergency services, are necessary and well proven. At present, only the Queensland Police is committed to training all frontline police officers in responding to mental health and emotional crises. This needs to be a national effort.

National awareness and education (including anti-stigma programs and campaigns)

The WA Mentally Health Campaign is one of the only larger scale mental health promotion programs in Australia at present. Evaluation has commenced and the results are promising. Built around an *Act-Belong-Commit* or ABC message, the program aims to build individual and community resilience, social connections and promote physical activity. However, funding is for three years and it operates in a small number of regional communities in WA (Donovan et al, 2007).

Internet-based resources are acknowledged for their ability to engage and empower marginalised and traditionally 'hard to reach' groups via the transgression of geographical, logistical and even psychosocial barriers that may otherwise inhibit such groups from accessing offline health promotion programs or health care providers.[7] ICT, therefore, offers significant potential as a tool and setting for mental health promotion and suicide prevention.

A well-funded national anti-stigma campaign and suicide prevention awareness program is required to address existing community knowledge deficits and attitudes toward suicide. A five year program, with a minimum budget of $10M per year would begin the process of change. Australia has an enviable record in social marketing campaigns and this expertise can be harassed for the purposes set out here.

New funding for successful programs

Throughout this submission, a number of successful and promising approaches and programs have been addressed. Like so often in mental health care, effective programs in suicide prevention tend to be operating on a small or local scale, over short periods, continually relying on ad hoc, competitive funding arrangements (i.e. short term, variable, multi-source) and have onerous reporting and monitoring requirements from funders.

Telephone helplines or crisis-lines have been in existence for nearly 50 years in Australia and should be regarded as essential service infrastructure in suicide prevention. The value and evidence to support investment in these services is very sound. Clear evidence regarding the efficacy of new technologies for services and some treatments is also now available. Australia's population distribution, difficulties in accessing mainstream services and workforce shortages make an investment in online, telephone and other communications technologies an obvious choice for Australia. Education of the Australian community to increase the acceptance and utilisation of online services and products should also be considered.

There are many innovative and effective programs that can be scaled up to operate nationally. The missing ingredients are funds and political will. It includes programs such as:

7 Sources: Alexander, J. (2002). Queer Webs: Representations of LGBT People and Communities on the World Wide Web. International Journal of Sexuality and Gender Studies, 7(2-3), 77-84; Burns, J., Morey, C., Lagelee, A., Mackenzie, A., & Nicholas, J. (2007). Reach Out Innovation in service delivery. Medical Journal of Australia, 187(7), S31-S34; Cline, R. J. W., & Haynes, K. M. (2001). Consumer health information seeking on the Internet: the state of the art. Health Education Research, 16(6), 671-692; Drabble, L., Keatley, J., & Marcelle, G. (2003). Progress and opportunities in Lesbian, Gay, Bisexual and Transgender Health Communications. Clinical Research and Regulatory Affairs, 20(2), 205-227.

- Call-back and postcard follow-up services
- StandBy Suicide Response Program
- ASIST Suicide Intervention Training
- ReachOut! and ReachOut Pro
- Hope for Life
- OzHelp workplace programs
- *Kidsmatter* & *MindMatters* for schools
- Men's Shed
- Many others.

Beyond these investments, to build national suicide prevention, intervention and postvention services, the transformation of mental health services to early invention, evidence based community services must be tackled and driven by the COAG.

Glossary of Terms[8]

Attempted suicide: (Also suicide attempt) Non-fatal self-injury, but with an intention to cause death. (Note: the issue of intention is not a simple matter. People have varying degrees of intention to kill themselves or cause hurt or pain in varying degrees of severity.)

Best practice: The use of methods (often evidenced-based) that achieve improvements and/or optimal outcomes.

Capacity building: ***Individual*** **–** Enhancing and/or developing personal aptitude, strength, coping and/or independence.

Community **–** The ability of a communities' organisations, groups and individuals (collectively) to build their structures, systems, people and skills, so they are better able to define, implement, manage and achieve their shared objectives.

Client-centred: Client-centred therapy or the person-centred approach is a movement associated with humanistic psychology that emphasises "the capacity of each individual to arrive at a personal understanding of his or her destiny, using feelings and intuition rather than being guided by doctrine and reason. Rather than focusing on the origins of client problems in childhood events (psychodynamic) or the achievement of new patterns of behaviour in the future (behavioural), concentrate on the 'here and now' experiencing of the client". [1]

Clinical paradigm: This paradigm focuses on repairing damage within a disease or medical model of human functioning.

Cognitive: Mental processes and conscious intellectual activities such as planning, reasoning, problem solving, thinking, remembering, reasoning, learning new words or imagining.

Common Factors: Features of therapy that are common to success despite the differing theoretical position of each therapist and the specific techniques used.

Community ownership: A community takes responsibility for an issue, such as suicide, and agrees to work together to develop effective and sustainable solutions.

Connectedness: Enquiry into protective factors for suicide has focused on the capacities within people ('resilience factors') and on external 'protective factors' [2], including a person's sense of belonging and connectedness with others. There is evidence that connections with family, school or a significant adult can reduce risk of suicide for young people. Feelings of connectedness to a partner or parent or responsibility for care of children appear to be protective factors, and 'connectedness' within a community has been linked to health and well-being.

Contagion or imitation: Suicidal thinking and/or behaviour in those bereaved by suicide, resulting from exposure to suicide.

8 Developed & adapted from the glossaries in the Draft Life is for Living Strategy and the websites of the Australian Bureau of Statistics and the Bureau of Transport Economics (accessed November 12 & 19 2009).

Content: The quality and the proportion or quantity of information adequately matched to the need.

Continuing care: Engagement with longer-term treatment, support and care where needed.

Continuum of care: A model that encompasses the coordination / provision of health promotion, prevention, early intervention, symptom identification, treatment and long-term care.

Data: Statistics that inform on specific aspects of suicide, such as rates and trends of suicide and suicide attempts. Data collection can also be a means of monitoring service arrangements, such as post-discharge follow-up or outcomes.

Effectiveness: Whether there is the capacity to bring about an effect or outcome.

Efficacy: The capacity of a service to deliver a desired result or outcome.

Efficiency: The production of an agreed output with a minimum of waste and the minimum consumption of resources (time, cost, labour).

Evaluation: The continuous process of asking questions, reflecting on the answers to these questions and reviewing ongoing strategy and action.

Evidence-based: Approaches that use and are based on clear evidence from existing literature.

Help-seeking: The process of an individual asking for help or support in order to cope with potentially traumatic life events or other difficult circumstances.

Holding environment: Refers to a therapeutic setting that permits the client to experience safety, and thus enhances therapeutic work.

Household and community production: The costs associated with lost productivity in the home and elsewhere in the community. Such losses are calculated for the employed and the unemployed.

Household productivity lost: The present value of lost productive household activity, valued at the market price to hire someone else to accomplish these tasks.

Imminent risk: The point at which suicide is extremely likely in the near future; intervention may be necessary.

Indicated prevention: Work with people who are showing early signs of risk for health problems, with the aim of preventing a condition from arising. In suicide prevention, examples include work with families of those who have died or been injured by suicide to respond to their grief and loss and elevated risk of suicide; or work with children who are survivors of child abuse.

Indigenous Australians: People who identify themselves as of Aboriginal and Torres Strait Islander descent. Note: it does not include descendants of South Sea Islanders brought to Northern Australia in the late 1800s.

Integrated response: Interventions that respond to a range of issues using a multi-faceted approach.

Insurance administration costs: The administrative costs associated with processing insurance claims resulting from motor vehicle crashes.

Jurisdiction: The area for which a particular government (Commonwealth, State or Territory, local) is responsible.

Legal/court costs: The legal fees and court costs associated with any civil litigation following a suicide (most often following a failure of acute mental health care).

Loss: Loss is produced by an incident which is perceived to be negative by those involved and results in long-term change.

Medical costs: The cost of all medical treatment associated with injuries resulting from suicidal behaviours, including ambulance transport, emergency room and in-patient costs, follow-up visits, physical therapy, rehabilitation, prescriptions, prosthetic devices and home modifications.

Medium: The mode, means or carrier (person or resource) through which information or support is provided.

Mental disorder: A recognised, medically diagnosable illness or disorder that results in significant impairment of an individual's thinking and emotional abilities and may require intervention. There are many different mental disorders.

Mental health promotion: Action to maximise mental health and well-being among populations and individuals. Includes strategies to reduce stigma, build individual and community resilience, promote help-seeking behaviours and self-care/management and strategies to address social and environmental determinants of mental illness.

Multi-sector, multi-disciplinary approach: Approaches that involve a combination of expertise from a range of disciplines and professions, involving agencies, organisations, and persons from a range of distinct parts or branches of enterprise and/or society.

Pain and suffering: Pain and suffering is taken to include the pain and distress endured by the parties directly involved in suicide and suicidal behaviours, excluding the pain and suffering of bereaved families and friends.

Paradigm: A set of rules and regulations (written or unwritten) that does two things: 1) it establishes or defines boundaries; and 2) it tells you how to behave inside the boundaries in order to be successful. It is a shared set of assumptions about how we perceive the world – a set of tacit assumptions and beliefs within which research goes on.

Participation rate: The labour force (persons employed and unemployed) expressed as a percentage of the civilian population aged 15 and over (including all those able to work but voluntarily not working or looking for work).

Peer education: The use of identified and trained peers to provide information aimed at increasing awareness or influencing behaviour change.

Population-based interventions: Interventions targeting populations rather than individuals. They include activities targeting the whole population as well as activities targeting population subgroups such as rural or Aboriginal peoples and Torres Strait Islander peoples.

Postvention: Interventions to support and assist the bereaved after a suicide has occurred.

Potentially traumatic life event: An incident within one's life that has the potential to cause emotional upset, disruption, or negative health outcomes.

Premature funeral costs: The difference in the funeral cost in the present versus the funeral cost at the actuarially expected lifespan.

Predispositional factors: Non-modifiable factors that may increase a person's susceptibility to suicidal behaviours, such as genetic and neurobiological factors, gender, personality, culture, socio-economic background and level of isolation.

Prevention: Preventing conditions of ill health from arising.

Primary care: The care system that forms the first point of contact for those in the community seeking assistance. It includes community-based care from generalist services such as general practitioners, Aboriginal medical services, school counsellors and community-based health and welfare services.

Productivity losses in the workplace: Productivity losses in the workplace due to deaths and serious and minor injuries. The assumption is that, had the suicide or suicidal behaviour not happened, the person/s would have worked and made contributions to the community.

Property loss and damage: Loss and damage to any property as a result of a suicide (e.g house fire).

Protective factors: Capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health.

Psychache: Hurt, anguish and aching pain in the psyche, can also describe the feelings of those experiencing loss.

Quality of Life Valuing: lost quality of life involves placing a dollar value on the pain, suffering and lost quality of life that a person who suicides and suicidal persons suffer.

RCT: A random controlled trial or study. Often considered to be the gold standard of evaluation designs. This is one where a group of subjects are exposed to an intervention or treatment and a similar group of people are not exposed to the intervention or treatment, but both groups are monitored and changes analysed. A third group of people may be subject to a "placebo" treatment.

Receptivity of client: The capacity and willingness of the person to receive and absorb information and support.

Recovery: Recovery is the process of a gradual restoration of a satisfying, hopeful and meaningful way of life.

Rehabilitation and long-term care: The cost of returning a person from injury to 'functionality', and when that is not possible, the cost of long-term care and attention required by the person.

Resilience: Capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk of suicide. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem-solving, cognitive and emotional skills, communication skills and help-seeking behaviours.

Risk factors: Factors such as biological, psychological, social and cultural agents that are thought to increase the likelihood of suicide/suicide ideation. Risk factors can be defined as either *distal* (internal factors, such as genetic or neurochemical factors) or *proximal* (external factors, such as life events or the availability of lethal means).

Selective prevention: Activities that target population or community groups at higher risk for a particular problem, rather than the whole population or particular individuals.

Self-harm: Deliberate damage of body tissue, often in response to psychosocial distress, without the intent of suicide.

SSRIs – Selective Serotonin Reuptake Inhibitors - A sub-class of first line antidepressants often used in the treatment of anxiety disorders and depression (.e.g. serratline, paroxetine, fluxoetine, escitalopram). Effective in the treatment of psychological symptoms of anxiety (e.g. apprehension and worry).

SNRIs – Serotonin-Nonepinephrine Re-uptake Inhibitors - A sub-class of first line antidepressants often used in the treatment of anxiety disorders and depression (.e.g. veniafaxine)

Stigma – Stigma can be broken into three related components: a problem of knowledge, namely ignorance; a problem of negative attitudes, namely prejudice; and a problem of behaviour, namely discrimination resulting in exclusion from social and economic participation (Thornicroft, in press).

Suicide: The act of purposely or intentional taking of one's life. For the purposes of this submission it does not include "assisted suicide" for those in palliative care.

Suicidal behaviour: Includes the spectrum of activities related to suicide and self-harm, including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts. Some writers also include deliberate recklessness and risk-taking behaviours as suicidal behaviours.

Suicidal ideation: Thoughts about attempting or completing suicide.

Suicidology: Scientific study of suicide.

Sufficiency: The minimum amount of information and support to provide comfort and to achieve a successful outcome without undue stress or information overload.

Support: To assist with the burden or the weight of an issue, problem or adversity. Support can take many forms, including information provision, services and face-to-face counselling.

Sustainability: The ability of a program to function over the long-term through adequate funding and the appropriate use of resources.

Systemic, longitudinal, multi-disciplinary approach: Interventions that address the underlying social, cultural and economic issues that may influence suicidal behaviours within the community over the long-term and with the involvement of all sectors.

Timeliness of service: Provision of information, service or support at the most appropriate or opportune moment for it to be received, understood and meaningfully applied.

Tricyclic antidepressants (TCAs) - Are considered second-line treatments, given the concerns of safety and tolerability and potential exacerbations in suicidal patients. (e.g. amitriptyline, imipramine).

Vocational rehabilitation: The cost of job or career retraining needed due to disability caused by suicidal behaviour and any resulting injuries.

Workplace cost: The cost of workplace disruption due to the loss or absence of an employee, including the cost of retraining new employees, overtime needed to accomplish the work of the injured employee and administrative costs of processing personnel changes.

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Appendix 1 - Senate Community Affairs Committee Inquiry into Suicide in Australia

TERMS OF REFERENCE

On 10 September 2009 the Senate referred the following matter to the Community Affairs References Committee for inquiry and report by the last sitting day in April 2010:

The impact of suicide on the Australian community including high risk groups such as Indigenous youth and rural communities, with particular reference to:

a. the personal, social and financial costs of suicide in Australia;
b. the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk);
c. the appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide;
d. the effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide;
e. the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk;
f. the role of targeted programs and services that address the particular circumstances of high-risk groups;
g. the adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy; and
h. the effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress.

The Committee is seeking written submissions from interested individuals and organisations preferably sent electronically by email to community.affairs.sen@aph.gov.au as an attached PDF or Word format document. The email must include full postal address and contact details.

Alternatively written submissions may be sent to:

Committee Secretary
Senate Community Affairs References Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Appendix 2 – The National Suicide Prevention Strategy 1999-2008

(The following information is taken from archival material located on the Department of Health and Ageing website – accessed 12 November 2009 – and the Urbis keys Young Evaluation Report, May 2006)

Goals and philosophy

The stated aims of the NSPS are to reduce the incidence of suicide and self harm and to promote mental health and resilience across the Australian population. The key objectives of the NSPS are:

- to support national suicide prevention activities across the life span, and
- to develop and implement a strategic framework for a whole of government and whole of community approach to suicide prevention across all levels of government, the community and business.

The strategic framework which guides the NSPS is *Living is For Everyone (LIFE): A framework for the prevention of suicide and self-harm in Australia.* The LIFE Framework provides a six year (2000-2006) framework for action by all levels of government and the community.

The four broad goals of the LIFE Framework are to:

- reduce deaths by suicide across all age groups in the Australian population, and reduce suicidal thinking, suicidal behaviour, and the injury and self-harm that result
- enhance resilience and resourcefulness, respect, interconnectedness and mental health in young people, families and communities, and reduce the prevalence of risk factors for suicide
- increase support available to individuals, families and communities affected by suicide or suicidal behaviours
- provide a whole of community approach to suicide prevention and to extend and enhance public understanding of suicide and its causes.

The LIFE Framework identifies six Action Areas. Each Action Area has a variety of outcomes and associated strategies. The six Action Areas are:

- promoting well-being, resilience and community capacity across Australia
- enhancing protective factors and reducing risk factors for suicide and self-harm across the Australian community
- services and support within the community for groups at increased risk
- services for individuals at high risk
- partnerships with Aboriginal and Torres Strait Islander peoples
- progressing the evidence base for suicide prevention and good practice.

Governance structure

Overview

The governance structure of the NSPS, the NACSP, was developed to provide strategic advice to the Australian Government on suicide prevention and to guide funding activity under the NSPS in line with the LIFE Framework. The NACSP model facilitates broad stakeholder representation in advisory roles and the administration of a percentage of NSPS funding through the State/Territory Offices (STOs) of DoHA.

The NACSP plays a key role in ensuring that activities under the NSPS are informed by:

- current suicide prevention research
- an understanding and knowledge of existing Australian, State and Territory Government programs, and
- a community based approach to suicide prevention.

There have been two NACSP structures. The initial NACSP was inaugurated in 2000 and ran until the end of 2003. A modified structure was introduced in 2004 with the aim of further enhancing community participation. Descriptions of each layer of these governance structures are provided in the following sections.

Initial governance structure

The initial NACSP consisted of the Board, the State and Territory Forum, the Community and Expert Advisory Forum, the Commonwealth Interagency Forum and the SPAC in each State and Territory. The roles of these groups are briefly described below.

The Board

Individuals were selected on the basis of their positions of leadership and influence in the community within their various fields and were appointed by Cabinet. The responsibilities of the Board included providing advice to the Australian Government on a number of aspects of the NSPS, including the implementation and ongoing development of the LIFE Framework as a national framework for the NSPS, and providing advice on project funding.

The Board was established as an expert advisory structure, not as a decision-making body.

The Community and Expert Advisory Forum

The initial Community and Expert Advisory Forum was set up to formalise community representation, with members selected to provide a blend of expertise from the community sector and academia. The Terms of Reference (ToR) for the Forum were very broad. The Forum's responsibilities included providing advice to the NACSP Board on a range of issues and developing, monitoring and reporting on the progress and effectiveness of NSPS community based suicide prevention activities.

The State and Territory Forum

This Forum was established to provide a link with State and Territory Government suicide

prevention initiatives and to support joint projects across jurisdictions.

The Commonwealth Interagency Forum

The Commonwealth Interagency Forum was to promote a whole of government approach to the prevention of suicide and self-harm. Seven Commonwealth agencies nominated a representative to participate in this Forum. The Commonwealth Interagency Forum did not meet.

The Suicide Prevention Advisory Committees (SPACs)

These committees were established by the STO in each jurisdiction. In some States and Territories, such as Tasmania, the SPAC built on an existing suicide prevention committee. In most other areas, however, the SPAC was established as a new entity.

The key role for the SPACs was the development of recommendations regarding the allocation of NSPS funds to community based projects funded in each State and Territory in a way that would address local needs and conditions. This role was implemented in a number of different ways (see Section 3.5).

Members of SPACs were drawn from relevant State or Territory Departments, STOs and NGOs with expertise in mental health or suicide prevention.

In addition, the NACSP developed an *Evaluation Policy Group*, an *Executive Board* and an *Annual Suicide Prevention Planning Forum*.

Evaluation Policy Group

The Evaluation Policy Group (EPG) was established as part of the initial structure of the NACSP.

The 'Executive Board'

An Executive Committee of the NACSP was established to facilitate special meetings from time to time and to discuss specific issues between formal meetings. The membership generally consists of the Chairperson, one other Board member, and the Department's representative on the Board.

The Executive was established as an efficiency mechanism to allow processing of out-of-session matters.

Revised governance structure

The first term of the NACSP expired in December 2003. In March 2004, the NACSP was reappointed and incorporated both new and existing members. At this time, the governance structure was slightly modified in order to simplify and streamline previous arrangements. The revised structure consists of a Board, the Community and Expert Advisory Forum and a SPAC in each State and Territory.

The Board

The Board was expanded and now includes fifteen Cabinet-appointed members who are experts in a range of relevant fields, including mental health, suicide prevention, research, Indigenous issues, business, counselling, general practice and cultural diversity.

The main differences under the revised ToR are that the new Board now has responsibility for monitoring and reporting on the progress and effectiveness of the

NSPS-funded community based suicide prevention activities, which was previously part of the Community and Expert Advisory Forum's responsibility. The other significant change in the Board's ToR is that it no longer directly advises the Australian Government on communication strategies with regard to the portrayal and reporting of suicide in the media. Under the revised structure, the Board remains an expert advisory structure, not a decision-making body.

The Community and Expert Advisory Forum

The new Community and Expert Advisory Forum consists of two members from each SPAC and four members representing national initiatives. Proposed members are considered by the Board and approved by the Prime Minister.

The ToR for this Forum are not as broad as the previous version. The new Community and Expert Advisory Forum is to provide advice to the Board on a number of issues relating to community needs and activities and the progress of the communication and evaluation strategies for the NSPS.

The Forum held its first meeting in November 2005.

State and Territory Suicide Prevention Advisory Committees (SPACs)

Under the revised governance structure, the STOs were encouraged to form a joint committee with existing State and Territory suicide prevention steering committees (where these existed). It was envisaged that the revised SPACs would consist of community organisations, experts in the field, and representatives of State or Territory Governments and DoHA.

Each SPAC has developed its own ToR, but the overall responsibilities of the committees as set out under the revised structure focus on providing advice to DoHA on the State and Territory context in which suicide prevention activities occur, participating in funding rounds, and nominating two members to represent the jurisdiction on the Community and Expert Advisory Forum.

Under the revised structure, the NACSP also developed the ***Evaluation Working Group (EWG)*** and an ***Annual Suicide Prevention Planning Forum*.**

Appendix 3 – The National Suicide Prevention Strategy 2008

(Listed here is the information published on the NSPS on the Department of Health and Ageing website. The information was last updated on 15 September 2009 and accessed on 15 November 2009)

What is the *National Suicide Prevention Strategy*?

The Australian Government's *National Suicide Prevention Strategy* promotes suicide prevention activities across the Australian population, as well as for specific at-risk groups. Its goal is to reduce deaths by suicide and reduce suicidal behaviour by:

- adopting a whole of community approach to suicide prevention to extend and enhance public understanding of suicide and its causes; and
- increasing support and care available to people, families and communities affected by suicide or suicidal behaviour by providing better support systems.

Responsibility for managing the *National Suicide Prevention Strategy* rests with the Australian Government Department of Health and Ageing.

Why is this important?

Nearly two thousand Australians take their own lives every year with impacts on families, friends, workplaces and communities.

People from all ages and from all walks of life in Australia take their own life and the causes often appear to be a complex mix of adverse life events, social and geographical isolation, cultural and family background, socio-economic disadvantage, genetic makeup, mental and physical health, the extent of support of family and friends, and the ability of a person to manage life events and bounce back from adversity.

- In 2007, the most recent year for which mortality data are available, there were 1,881 registered deaths from suicide representing an overall rate of 9.0 per 100,000. Suicide accounts for approximately 1.3% of all deaths in Australia.
- The rates of suicide in Australia have fallen consistently since a peak in 1997 when 2,720 suicide deaths were registered.
- Male suicides continue to outnumber female suicides, accounting for 77% of all suicide deaths in 2007.
- As in recent years, the highest age-specific suicide death rates for males occurred in those aged 85 years and over (22.8 per 100,000). However, suicide deaths were a relatively low proportion of the total deaths (0.2%) due to the relatively small population in this group.
- In the younger age groups, the highest rates for males aged 25 to 34 years and 35 to 44 years (20.5 and 20.8 per 100,000 respectively.
- However, rates for young males aged 15-24 years (12.5 per 100,000) were low compared to men overall, as was the rate for 65-74 year olds (12.2 per 100,000).
- For females, the age-specific death rates were highest for those aged 45-54 years and 55-64 years (both 5.7 per 100,000) and, by contrast to males, lowest for

elderly females aged 75-84 years and 85 years and over (3.3 and 3.9 per 100,000).

1. 3303.0 - Suicides, Australia, 2007 Australian Bureau of Statistics.

Who will benefit?

Projects under the *National Suicide Prevention Strategy* target the whole of the population as well as groups identified as being at greater risk of suicide, such as Aboriginal and Torres Strait Islander people, men aged between 20 and 54, people with a mental illness and people living in rural and remote areas. The program also targets those bereaved by suicide who are known to be at higher risk of suicide themselves.

What will National Suicide Prevention Strategy deliver?

The goal of the *National Suicide Prevention Strategy* is to reduce deaths by suicide across the population and among at risk groups, and reduce suicidal behaviour. To inform and support this goal, the Australian Government is working together with communities across Australia to build resilience, resourcefulness and social connectedness in people, families and communities to protect against the risk factors for suicide.

The *National Suicide Prevention Strategy* supports national and community based initiatives and projects that enhance the capacity of individuals and services to access information and provide support and training on suicide prevention. These projects also aim to increase the number of individuals seeking help regarding their emotional and social wellbeing and increase the identification, referral and treatment of at risk individuals by service systems and professionals.

How does it work?

The NSPS is supported by a number of resources including the *Living Is For Everyone: a framework for prevention of suicide in Australia*. The Framework provides a practical suite of resources and research findings on how to address the complex issues of suicide and suicide prevention.

Membership of the new Australian Suicide Prevention Advisory Council (ASPAC) was announced on 10 September 2008. ASPAC will provide a forum for expert service providers, researchers and clinicians to share expertise, contribute to national decision-making processes and to identify community needs and priorities for the National Suicide Prevention Strategy. More information on ASPAC can be found at www.livingisforeveryone.com.au.

What funding is attached to this Strategy?

The total funding attached to the NSPS is $127.1 million for 2006-07 to 2011-12. This includes an additional $62.4 million over five years towards *Expanding Suicide Prevention Programmes* provided as part of the Commonwealth's component of the COAG National Action Plan on Mental Health 2006 - 2011.

When did the *National Suicide Prevention Strategy* start?

The *National Suicide Prevention Strategy* commenced in 1999.

How is the National Suicide Prevention Strategy progressing?

- A workplan for the National Suicide Prevention Strategy (NSPS) was approved by the Minister for Health and Ageing in June 2008 which outlines directions and priorities for the NSPS for the period 2008-2009.
- This workplan is characterised by a number of significant shifts in approach to suicide prevention:
    - a more collaborative and planned approach to the implementation of community-based suicide prevention activities through partnerships with state and territory governments via COAG and directly with community organisations;
    - a shift to supporting service provision for individuals at greatest risk of suicide, particularly individuals who have attempted suicide or self harm or who are otherwise at high risk of suicide;
    - a stronger emphasis on support for people at risk of suicide in rural and remote areas of Australia; and
    - more proactive and targeted support for other high risk groups, including people bereaved by suicide, Indigenous people, people with a mental illness, young people and men.

- ASPAC is currently providing advice on the development of a new workplan to define priorities for the period 2009-2011.

What's been done in the past?

The *National Suicide Prevention Strategy* builds on the former *National Youth Suicide Prevention Strategy*, which existed between 1995-1999.

Further Information

Evaluation of the National Suicide Prevention Strategy – Summary Report (PDF 295 KB)
The National Suicide Prevention Strategy website: www.livingisforeveryone.com.au
The LIFE framework: http://www.livingisforeveryone.com.au/LIFE-Resources.html
Research and Evidence in Suicide Prevention:
http://www.livingisforeveryone.com.au/LIFE-Resources.html
Fact sheet of projects funded under the National Suicide Prevention Strategy:
www.livingisforeveryone.com.au/Projects.html

Page currency, Latest update: 15 September, 2009

Appendix 4 – The National Committee for Standardised Reporting of Suicide Workshop – List of Attendees, Sept 2009

National Committee for Standardised Reporting of Suicide (NCSRS) Workshop

Friday, 25th September 2009

ATTENDEES

Title	First name	Surname	Position	Organisation
Ms	Caroline	Aebersold	Vice Chairperson	Suicide Prevention Australia
Ms	Susan	Beaton	National Advisor on Suicide Prevention	Lifeline Australia
Mr	Marc	Bryant	Mindframe Projects Manager	Hunter Institute of Mental Health
Ms	Leanne	Daking	Quality Manager	National Coroners Information System
Professor	Olaf	Drummer	Head (Forensic Scientific Services)	Victorian Institute of Forensic Medicine
Dr	Michael	Dudley	Chairperson	Suicide Prevention Australia
Acting Senior Sergeant	Therese	Fitzgerald	Manager	Coroners Assistant's Unit, State Coroners Office
Ms	Samantha	Hauge	Manager, Coroner's Prevention Unit	State Coroner's Office of Victoria
Leading Senior Constable	Sarah	Hose		Coroners Assistant's Unit, State Coroners Office
	Marde	Hoy	Access Officer	National Coroners Information System
Mr	Chris	Killick-Moran	Director	Suicide Prevention Programs Section, Mental Health and Suicide Prevention Programs Branch, Mental Health and Chronic Disease Division, Dept of Health & Ageing Australian Govt
	Rhea	Lewthwaite		Office of the Chief Coroner
Mr	Ryan	McGlaughlin	Executive Officer	Suicide Prevention Australia
Ms	Sarah	O'Regan	Suicide Prevention Coordinator	Mental Health Program, NT Dept of Health and Families
Dr	Robert	Parker	Director of Psychiatry	Top End Mental Health Services, Department of Health and Community Services, NT
Mr	Shawn	Phillips	Executive Officer	WA Ministerial Council for Suicide Prevention, Telethon Institute for Child Health Research
Ms	Tara	Pritchard	Director, Health and Vital Statistics	Qld Office, Australian Bureau of Statistics

Title	First name	Surname	Position	Organisation
Associate Professor	David	Ranson	Deputy Director	Victorian Institute of Forensic Medicine
Ms	Ellen	Rosenfeld	Senior Research Officer	Office of the Public Advocate
Ms	Suzy	Saw	Adviser in the Data Analysis & Program Evaluation Section	Mental Health and Workforce Division
Ms	Tracey	Siebert	Principal Safety, Quality & Research Advisor	Mental Health Unit, SA Health, Government of South Australia
Mr	Anthony	Smith	Health Promotion Officer	Health Promotion Unit (Central Coast), North Sydney Central Coast Area Health Service
Ms	Sue	Walker	Associate Director	National Centre for Classification in Health School of Public Health Queensland University of Technology
Emeritus Professor	Ian	Webster	Chairperson	Australian Suicide Prevention Advisory Council
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