The Senate

Community Affairs References Committee

The Hidden Toll: Suicide in Australia

June 2010

ISBN 978-1-74229-209-0

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This document was produced by the Senate Community Affairs Committee Secretariat and printed by the Senate Printing Unit, Parliament House, Canberra.

HELP INFORMATION

Lifeline

13 11 14 (24 hour crisis hotline)

www.lifeline.org.au

Kids Help Line

1800 551 800

www.kidshelpline.com.au

Mensline

1300 78 9978

www.menslineaus.org.au

Veterans and Veterans Families Counselling Service

1800 011 046

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42nd Parliament

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AGPN	Australian General Practice Network
AIHW	Australian Institute of Health and Welfare
AISRP	Australian Institute for Suicide Research and Prevention
ASIST	Applied Suicide Intervention Skills Training
ASPAC	Australian Suicide Prevention Advisory Council
AMA	Australian Medical Association
ARC	Australian Research Council
ATAPS	Access to Allied Psychological Services
BMRI	Brain and Mind Research Institute
CALD	Culturally and linguistically diverse
COAG	Council of Australian Governments
DEEWR	Department of Education, Employment and Workplace Relations
DoHA	Department of Health and Ageing
DVA	Department of Veterans Affairs
ED	Emergency Department
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
HCRRA	Health Consumers of Rural and Remote Australia
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LLNH	Lifeline Newcastle Hunter
GP	General Practitioner

LIFE	Living Is For Everyone
MHCA	Mental Health Council of Australia
MMHA	Multicultural Mental Health Australia
NCIS	National Coroners Information System
NCESP	National Centre of Excellence in Suicide Prevention
NCSRS	National Committee for Standardised Reporting on Suicide
NDRI	National Drug Research Institute
NHMRC	National Health and Medical Research Council
NSPP	National Suicide Prevention Program
NSPS	National Suicide Prevention Strategy
NSW	New South Wales
NT	Northern Territory
NYSPS	National Youth Suicide Prevention Strategy
QSR	Queensland Suicide Register
RANZCP	Royal Australian & New Zealand College of Psychiatrists
SA	South Australia
SPA	Suicide Prevention Australia
SPMI	Severe and persistent mental illness
Suicide is Preventable	Joint submission (*Submission 65*)
ToR	Term of reference
TMHC	Transcultural Mental Health Centre
WA	Western Australia
WHO	World Health Organisation

EXECUTIVE SUMMARY

At least six Australian lives are taken by suicide every day, however there continues to be a lack of public awareness about the impact of suicide on the community. The title of the Committee's report *The Hidden Toll: Suicide in Australia* reflects this situation as well as the hope that increased public attention and support for suicide prevention can reduce the damage it causes. The following summarises the Committee's recommendations.

The costs for individuals, families and communities affected by suicide cannot be measured but are clearly enormous. The financial cost of suicide is likely to be measured in the billions every year. The Committee has recommended a detailed independent economic assessment of the cost of suicide and attempted suicide in Australia.

The number of suicides in Australia has been underreported. The Committee has recommended continued and expanded support for the activities of the National Committee for Standardisation of Reporting on Suicide, the standardisation of coronial legislation and practices, the national adoption of a standardised police form and additional resources and training for staff in coronial offices to improve accuracy of the statistics relating to suicide.

Frontline staff, workers in community organisations and other 'gatekeepers' need suicide awareness and prevention training. The Committee has recommended staff in primary care, law enforcement and emergency services receive mandatory suicide risk assessment, prevention and awareness training, all 'front line' staff should receive suicide awareness training and increased access should be provided for staff in community organisations and the general community to undertake suicide awareness and prevention training.

People who have attempted suicide, have suicidal ideation or have received psychiatric care should be assisted and supported. The Committee has recommended all hospital emergency departments should maintain at least one person at all times with mental health training and the capacity to undertake suicide risk assessments, mandatory procedures should be implemented to provide follow up support to those leaving care, programs should link services and agencies to improve the continuity of care for those at risk of suicide, and additional funding should be provided for stepped accommodation.

The public awareness of suicide needs to be increased through a long term awareness campaign and responsible reporting in the media. The Committee has recommended a national suicide prevention and awareness campaign using a range of media including targeted approaches to high risk groups as well as a review of the Mindframe guidelines and current media practices for the reporting of suicide. The Committee has also recommended national estimates on suicide should be released at least biannually to raise community awareness about suicide.

People seeking assistance from telephone crisis and counselling services should not be deterred by call costs. The Committee has recommended the Commonwealth government act to ensure affordable access to telephone crisis services are maintained and that an implementation study be commissioned for a national toll-free telephone crisis support service to assist those at risk of suicide.

Access to the means of suicide must be reduced and programs to address 'suicide hotpots' should be implemented. The Committee has recommended funding be made available for projects to aimed at reducing access to means of suicide and adding suicide prevention measures at 'suicide hotspots' according to established guidelines.

Groups with an increased risk of suicide should continue to be targeted with specific programs. The Committee has made number of recommendations:

- that there be an increase in the number of projects and funding for men;
- that a separate strategy be developed for Indigenous communities;
- that suicides by children should officially reported;
- that support group assistance should be developed for those who attempt suicide or self harm;
- that additional resources be provided to mental health services;
- that additional suicide awareness and risk assessment training be made available to 'gatekeepers' in regional, rural and remote areas;
- that LGBTI people be recognised in suicide prevention strategies and policies and the development of targeted programs;
- that a national suicide bereavement strategy be developed; and
- specific initiatives be developed to assist recently released prisoners.

New research should focus on the efficacy of suicide prevention interventions and results should be widely available to practitioners and others. The Committee has recommended additional funding for research should be provided through the National Suicide Prevention Program, including the evaluation of suicide prevention interventions. A suicide prevention resource centre should be established to collect and disseminate research and best practice regarding suicide prevention.

Increased coordination of programs and services is necessary for effective suicide prevention in Australia. The Committee has recommended a national suicide prevention strategy with participation and funding from all levels of government as well as collaboration with community stakeholders and service providers. The benefits of a national suicide prevention governance and accountability structure external to government should also be evaluated.

Increased funding of programs and support for those at risk of suicide is necessary to reduce the number of suicides and attempted suicides in Australia. The Committee has recommended that, at a minimum, Commonwealth government funding should be doubled and further increases should be assessed as the efficacy of suicide prevention

interventions is established by research. Furthermore a Suicide Prevention Foundation should be established to encourage funding from government, business, community and philanthropic sources and to direct these resources to priority areas of suicide prevention awareness, research, advocacy and services. Suicide prevention project and program funding should be provided in longer cycles to assist their success and stability.

Finally the Committee has recommended that a target should be set by government for the reduction of suicide in Australia by 2020 to focus the attention of the public and policy makers on suicide prevention.

RECOMMENDATIONS

Recommendation 1

2.28 The Committee recommends that the Commonwealth government commission a detailed independent economic assessment of the cost of suicide and attempted suicide in Australia, for example by the Productivity Commission.

Recommendation 2

3.3 The Committee recommends that Commonwealth, State and Territory governments, in consultation with the National Committee for Standardised Reporting on Suicide, implement reforms to improve the accuracy of suicide statistics.

Recommendation 3

3.63 The Committee recommends that the Standing Committee of Attorneys-General, in consultation with the National Committee for Standardised Reporting on Suicide, standardise coronial legislation and practices to improve the accurate reporting of suicide.

Recommendation 4

3.65 The Committee recommends all Australian governments implement a standardised national police form for the collection of information regarding a death reported to a coroner.

Recommendation 5

3.66 The Committee recommends that the Commonwealth, State and Territory governments enable timely distribution of suicide data from coroners' offices regarding suicides to allow early notification of emerging suicide clusters to public health authorities and community organisations.

Recommendation 6

3.67 The Committee recommends that State and Territory governments provide additional resources and training to staff in coronial offices to assist in the accurate and timely recording of mortality data.

Recommendation 7

3.69 The Committee recommends the National Committee for Standardisation of Reporting on Suicide liaise with peak insurance and financial associations, such as the Insurance Council of Australia, regarding exclusionary conditions in contracts which may deter the reporting of suicides.

Recommendation 8

4.78 The Committee recommends that Commonwealth, State and Territory governments ensure that staff in primary care, law enforcement and emergency services receive mandatory and customised suicide risk assessment, prevention

and awareness training as part of their initial training and ongoing professional development.

Recommendation 9

4.79 The Committee recommends that Commonwealth, State and Territory governments mandate that hospital emergency departments maintain at least one person with mental health training and capacity to conduct suicide risk assessments at all times.

Recommendation 10

4.80 The Committee recommends that Commonwealth, State and Territory governments review debriefing procedures and counselling support available to frontline workers regularly exposed to suicide and attempted suicide related incidents.

Recommendation 11

4.82 The Committee recommends that Commonwealth, State and Territory governments establish mandatory procedures to provide follow up support to persons who have been in psychiatric care, have been treated following an attempted suicide or who are assessed as being at risk of suicide.

Recommendation 12

4.84 The Committee recommends that Commonwealth, State and Territory governments provide funding for programs to identify and link agencies and services involved in the care of persons at risk of suicide. These programs should aim to implement agreements and protocols between police, hospitals, mental health services, telephone crisis support services and community organisations and to improve:

- **awareness by different personnel of suicide prevention roles and expectations; and**
- **handover procedures and continuity of care for persons at risk of suicide.**

Recommendation 13

4.86 The Committee recommends that Commonwealth, State and Territory governments provide additional funding for graded accommodation options for people at risk of suicide and people with severe mental illness.

Recommendation 14

4.88 The Committee recommends that the Australian governments oblige health care staff to offer prior consent agreements, such as advance health directives and standing medical powers of attorney, to patients at risk of suicide.

Recommendation 15

4.91 The Committee recommends that Commonwealth, State and Territory governments provide accredited suicide prevention training to all 'front line' staff, including those in heath care, law enforcement, corrections, social security, employment services, family and child services, education and aged care.

Recommendation 16

4.94 The Committee recommends that the National Suicide Prevention Strategy promote and provide increased access for community organisation and the general community to appropriate suicide prevention training programs.

Recommendation 17

5.92 The Committee recommends that the Commonwealth government fund a national suicide prevention and awareness campaign that provides information to all Australians about the risks and misconceptions of suicide, and advice on how to seek and provide help for those who may be dealing with these issues. This campaign should utilise a range of media, including television, radio, print and online, and other methods of dissemination in order to best reach the maximum possible audience. This campaign should also create links with efforts to alleviate other public health and social issues, such as mental health, homelessness, and alcohol and drug use.

Recommendation 18

5.93 The Committee recommends that the development of a national suicide prevention and awareness campaign should recognise the risks of normalising and glamorising suicide, and draw on wide consultation with stakeholders and a solid evidence base.

Recommendation 19

5.94 The Committee recommends that a national suicide prevention and awareness campaign, once developed, should operate for at least 5 years, and with adequate and sustained resources. This should include the provision of additional resources, support and suicide awareness training for health care professionals.

Recommendation 20

5.100 The Committee recommends that the Mindframe guidelines and current media practices for the reporting of suicide are reviewed. Research should be undertaken to determine the most appropriate ways to better inform the Australian public about suicide through the media, including mainstream news reporting, as well as through internet and social networking sites.

Recommendation 21

5.101 The Committee recommends that national figures on suicide should be released to the Australian public, at a minimum, biannually, in an effort to raise community awareness about suicide, and should be provided together with information about available services and support.

Recommendation 22

5.105 The Committee recommends that a national suicide prevention and awareness campaign should include a targeted approach to high-risk groups, in particular young people, people in rural and remote areas, men, Indigenous populations, lesbian, gay, bisexual, transgender and intersex people and the

culturally and linguistically diverse communities. This approach should include the provision of culturally sensitive and appropriate information and services.

Recommendation 23

6.127 The Committee recommends that the Commonwealth government ensure telecommunications providers provide affordable access to telephone and online counselling services from mobile and wireless devices.

Recommendation 24

6.129 The Committee recommends that the Commonwealth government commission an implementation study for a national toll-free crisis support telephone service to assist those at risk of suicide.

Recommendation 25

6.132 The Committee recommends that the National Suicide Prevention Program include funding for projects to reduce access to means of suicide and prevention measures at identified 'suicide hotspots'. These interventions should be evidence based and in accordance with agreed guidelines.

Recommendation 26

6.134 The Committee recommends that the National Suicide Prevention Program should increase the funding and number of projects targeting men at risk of suicide.

Recommendation 27

6.137 The Committee recommends that the Commonwealth governments develop a separate suicide prevention strategy for Indigenous communities within the National Suicide Prevention Strategy. This should include programs to rapidly implement postvention services to Indigenous communities following a suicide to reduce the risk of further suicides occurring.

Recommendation 28

6.141 The Committee recommends that the Australian Bureau of Statistics and other public agencies which collect health data record and track completed suicides and attempted suicides of those under 15 years of age.

Recommendation 29

6.143 The Committee recommends that targeted programs be developed to provide community support group assistance for people who have attempted suicide and those who self harm.

Recommendation 30

6.145 The Committee recommends that additional resources be provided by Commonwealth, State and Territory governments to mental health services. These services are recognised as functioning to reduce the rate of suicide and attempted suicide in Australia.

Recommendation 31

6.147 The Committee recommends that additional 'gatekeeper' suicide awareness and risk assessment training be directed to people living in regional, rural and remote areas.

Recommendation 32

6.149 The Committee recommends that lesbian, gay bisexual, transgender and intersex people be recognised as a higher risk group in suicide prevention strategies, policies and programs, and that funding for targeted approaches to assist these groups be developed.

Recommendation 33

6.151 The Committee recommends that the Commonwealth, State and Territory governments together with community organisations implement a national suicide bereavement strategy.

Recommendation 34

6.153 The Committee recommends the development of a National Suicide Prevention Program initiative targeting assistance to people recently released from correctional services.

Recommendation 35

7.35 The Committee recommends that the Commonwealth government provide funding in the National Suicide Prevention Program for research projects into suicide prevention, including detailed evaluations of suicide prevention intervention.

Recommendation 36

7.39 The Committee recommends the Commonwealth government, as part of the National Suicide Prevention Strategy, create a suicide prevention resource centre to collect and disseminate research and best practice regarding suicide prevention.

Recommendation 37

8.57 The Committee recommends that following extensive consultation with community stakeholders and service providers, the next National Suicide Prevention Strategy include a formal signatory commitment as well as an appropriate allocation of funding through the Council of Australian Governments.

Recommendation 38

8.60 The Committee recommends that an independent evaluation of the National Suicide Prevention Strategy should assess the benefits of a new governance and accountability structure external to government.

Recommendation 39

8.64 The Committee recommends that the Commonwealth government double, at a minimum, the public funding of the National Suicide Prevention Strategy, with further increases to be considered as the research and evaluation of suicide prevention interventions develops.

Recommendation 40

8.65 The Committee recommends that the Commonwealth, State and Territory governments should facilitate the establishment of a Suicide Prevention Foundation to raise funding from government, business, community and philanthropic sources and to direct these resources to priority areas of suicide prevention awareness, research, advocacy and services.

Recommendation 41

8.67 The Committee recommends that, where appropriate, the National Suicide Prevention Program provide funding to projects in longer cycles to assist the success and stability of projects for clients and employees.

Recommendation 42

8.69 The Committee recommends that the Commonwealth government as part of a national strategy with State, Territory and local governments for suicide prevention set an aspirational target for the reduction of suicide by the year 2020.

CHAPTER 1

INTRODUCTION

Terms of reference

1.1 On 10 September 2009 the Senate referred the following matter to the Senate Community Affairs References Committee (the Committee) for inquiry and report by the last sitting day in April 2010 (the reporting date was later extended to 24 June 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.

Conduct of the inquiry

1.2 The inquiry was advertised in *The Australian* newspaper and on the Committee's website, inviting submissions from interested parties. Due to the considerable interest in the reference subject matter, the Committee undertook to continue to receive submissions up to 17 June 2010. The Committee also wrote to relevant organisations and individuals notifying them of the inquiry and inviting submissions.

1.3 The Committee received 258 public submissions, which were made available through the Committee website.[1] Due to the nature of the reference subject matter the Committee determined that a number of these would be published with the name of the submitter(s) withheld, or with material of a sensitive nature (such as information identifying unrelated third parties) removed. A number of submissions were also accepted as confidential submissions. A list of individuals and organisations that made submissions or provided other information authorised for publication by the Committee is contained in Appendix 1.

1.4 A joint submission to the inquiry was funded by Lifeline Australia, Suicide Prevention Australia (SPA), the Inspire Foundation; OzHelp Foundation; the Salvation Army; the Mental Health Council of Australia (MHCA), and the Brain and Mind Research Institute (BMRI) and supported by many other organisations and individuals. This joint submission (*Submission 65*, referred to in the report as the Suicide is Preventable submission) was presented to the Chair and Deputy Chair of the Committee at Parliament House, Canberra, on 23 November 2009.

1.5 The Committee held 12 public hearings over the course of the inquiry. These were:

- 1 March 2010, Canberra
- 2 March 2010, Brisbane
- 3 March 2010, Sydney
- 4 March 2010, Melbourne
- 24 March 2010, Canberra
- 25 March 2010, Canberra
- 30 March 2010, Perth
- 31 March 2010, Perth
- 4 May 2010, Adelaide
- 17 May 2010, Darwin
- 18 May 2010, Canberra
- 20 May 2010, Hobart

1.6 Witnesses who appeared at these hearings are listed in Appendix 2.

Acknowledgements

1.7 The Committee wishes to thank the many people who gave evidence in person or in writing regarding their experiences in relation to suicide which were often

1 Public submissions available at: http://www.aph.gov.au/senate/committee/clac_ctte/suicide/index.htm

personal and distressing. Much of this evidence was received confidentially and the Committee would like to record its appreciation for the time and effort made by these persons to assist the inquiry.

1.8 The Committee would also like to thank the managers and staff of the Understanding & Building Resilience in the South West Project and Lifeline Hobart for allowing the Committee to visit their offices in Perth and Hobart respectively.

1.9 The Committee is also grateful to the members and secretariat of the Australian Suicide Prevention Advisory Council (ASPAC) who made time to meet with Committee members in Canberra on 28 May 2010.

Appropriate language

1.10 The Committee recognises that suicide is a subject that needs to be discussed carefully and sensitively. Inappropriate discussion and reporting of suicide can be distressing for those bereaved by suicide and can have negative influences on those at risk of suicide. Nonetheless the Committee also has a responsibility to clearly and accurately report on this significant issue. While the Committee has made efforts to use appropriate language in this report, evidence and quotations from submissions and witnesses have not been edited where inappropriate language may be used. This may include descriptions regarding methods of suicide and locations where suicides have taken place.

Suicide and euthanasia

1.11 During the course of the inquiry the Committee received a substantial number submissions linking the terms of reference to the issue of self, voluntary and assisted euthanasia.[2] While the issue of euthanasia has several linkages with some of the topics covered during the inquiry, the Committee has made a decision not to focus on the issue of euthanasia in this report.

1.12 The Committee acknowledges that there are strong views on both sides of this issue and the decision may be disappointing to those who have made submissions addressing this topic. However the Committee considers suicide is the focus of the terms of reference of the inquiry. The evidence received in relation to euthanasia has been noted by the Committee and will be tabled as part of the final report of the inquiry.

Structure of the report

1.13 The structure of this report broadly follows the terms of reference (ToR) provided by the Senate. Chapter 1 includes a brief background to the issue of suicide in Australia. Chapter 2 deals with the personal, social and financial costs of suicide in

2 For example Exit International, *Submission 68*, p. 1; FamilyVoices Australia, *Submission 115*, pp 2-3.

Australia ToR (a). Chapter 3 addresses the suicide reporting issues in ToR (b). Chapter 4 combines ToR (c) and (e) to examine the appropriate role, effectiveness and training of agencies, frontline personnel and others in assisting persons at risk of suicide. Chapter 5 covers ToR (d), public awareness campaigns as well as the many issues concerning stigma covered during the inquiry. Chapter 6 deals with groups at high risk of suicide in ToR (f), the programs and services which support them, and the balance between universal and targeted approaches to suicide prevention. Chapter 7 addresses ToR (g), the adequacy of current suicide research and the dissemination of research results to practitioners and policy makers. Chapter 8 focuses on the National Suicide Prevention Strategy (NSPS), addressing ToR (h). Chapter 9 concludes the Committee's comments and summarises the recommendations made.

Background to suicide and suicide prevention

1.14 A suicide occurs when a person dies as a result of a deliberate act intended to cause the end of his or her life. The World Health Organisation (WHO) has estimated that around the globe approximately 1 million people die from suicide every year. In Australia, suicide is a leading cause of death with over 2000 persons dying every year, three quarters of these deaths are men. Attempted suicide is also an important issue with estimates that in Australia over 60,000 people a year attempt to take their own lives, the majority being women. It is recognised that the number of suicides and attempted suicides is likely to be underreported for a number of reasons including the practical problems of determining a person's intentions, reporting problems and the stigma around suicide and self harm.

1.15 A completed suicide often has many complex causes and motivations. It may be an impulsive, irrational act or a carefully planned choice. Biological, cultural, social, economic and psychological risk and protective factors have been identified, which reduce or increase the likelihood of suicidal behaviour. People who attempt to take their own life usually have many risk factors and few protective factors. Risk and protective factors are often at opposite ends of the same continuum. For example, while social isolation is a risk factor for suicide, social connectedness is a protective factor. In Australia links have been recognised between suicide and geographic location (regional, rural and remote) and socio-economic disadvantage (low socio-economic status).[3] However there is not always a clear relationship between a particular risk or protective factor and suicide. For example mental illness is a frequently cited risk factor, but not everyone who takes their own life will be mentally ill.

1.16 While completed suicide can be considered a low prevalence event, when it occurs it has devastating and wide spread impacts on those connected to the person who has died and their community including personal, social and economic costs.

3 DoHA, *LIFE: A framework for prevention of suicide in Australia*, 2007, p. 12.

Suicide prevention in Australia

1.17 Australia was one of the first countries to develop a dedicated national strategy to address suicide. The initial focus of suicide prevention was on youth suicide following international, government and community concerns raised during the 1980s and 1990s. The National Youth Suicide Prevention Strategy (NYSPS), introduced in 1995, was administered and coordinated through the Mental Health Branch of the then Commonwealth Department of Health and Aged Care.[4]

1.18 In 2000, the NYSPS was expanded into the NSPS with a broader focus preventing suicide over the whole life span. The first iteration of the LIFE Framework, *Living Is For Everyone: A Framework for Prevention of Suicide and Self-harm in Australia* was also developed to provide a strategic framework for national action to prevent suicide and promote mental health and resilience.

1.19 In 2006, the Council of Australian Governments (COAG) agreed to a National Action Plan on Mental Health 2006-2011 which included a commitment from the Commonwealth Government to double funding for the NSPS (from $62 million to $127 million) to enable the expansion of suicide prevention programs, particularly those targeting groups at high risk.[5] These funds have been directed to programs and projects through the National Suicide Prevention Program (NSPP). A new LIFE Framework suite of resources was commissioned, developed and made available after consultations in 2006-07.

1.20 In 2008 the ASPAC was established to provide national leadership and strategic advice to Minister for Health and Ageing on suicide prevention issues.

4 Australian Institute of Family Studies, *Valuing young lives: evaluation of the National Youth Suicide Prevention Strategy*, 2000, pp 29 – 35.

5 DoHA, *LIFE: A framework for prevention of suicide in Australia*, 2007, p. 8.

CHAPTER 2

COSTS OF SUICIDE

Introduction

2.1 This chapter will address term of reference (a) the personal, social and financial costs of suicide in Australia. The circumstances surrounding each suicide will vary, and so too will the consequences, the personal, social and financial costs.

Personal costs

2.2 The inquiry received a large number of submissions outlining the personal experiences of people who had attempted suicide, who cared for someone who had attempted suicide or who had been bereaved by suicide. Often these people described how their lives had been profoundly and negatively affected by a suicide attempt or the completed suicide of someone close to them. The Suicide is Preventable submission commented that those close to a person who has completed suicide will often blame themselves for the decision of the individual to take their own life and the 'combination of grief, guilt and remorse can remain for years'.[1] One submission received by Committee described the feeling of personal loss from a completed suicide as an 'emptiness in your very existence that will never be filled again'.[2]

2.3 Many submissions argued that suicide bereavement is different from bereavement associated with other forms of death.[3] The Australian Institute of Family Studies commented:

> Suicide-bereaved people tend to have more difficulties understanding the meaning of the death, and can experience guilt and blame (from self and others) for not preventing the death, feelings of rejection … isolation and abandonment, anger towards the deceased …complicated grief… and slower recovery. [4]

2.4 The Private Mental Health Consumer Carer Network Australia stated that in addition to grief those bereaved by suicide often experienced 'emotions of guilt, blame, anger and frustration'. They stated:

> People find it hard to fathom why someone chooses to take their own life. Both grief and guilt are often heightened for those left after a suicide

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1 Suicide is Preventable, *Submission 65*, p. 41.

2 Name withheld, *Submission 22*, p. 2.

3 For example, Salvation Army, *Submission 142*, p. 39.

4 Australian Institute of Family Studies, *Submission 80*, p. 3.

> because of their belief that the death could have been avoided and that in some way some responsibility rested with them and their inaction. Research shows that people affected by the death by suicide of someone close to them are at a greater risk of suicide themselves.[5]

2.5 Many people who provided submissions to the inquiry described the personal consequences of their experiences in losing a loved one to suicide. These consequences included losing their employment, needing to seek counselling, requiring medication such as antidepressants, becoming drug or alcohol dependent, the destruction of relationships with partners, family and friends and contemplation of suicide themselves.

2.6 The Lifeline Australia submission included a large number of confidential personal stories from persons who had been affected by suicide. Lifeline Australia noted there were common themes in relation to personal costs experienced:

> In many instances, the bereaved by suicide left their employment when the suicide occurred, and reported feeling as though they could no longer live in the home they shared with the loved one, or even the same city or town.
>
> Some reported that close relationships with their own support networks also suffered, often due to a friend not knowing what to say, and avoiding the bereaved person. Having to grieve the often sudden and unexpected loss of their loved one, paired with having to rebuild almost every aspect of their lives, meant that many who were bereaved by a family member's suicide expressed that they began feeling suicidal themselves with the weight of the burden.[6]

2.7 The lack of community awareness and stigma around suicide can also be an additional burden for those recovering from an attempted suicide or bereaved by suicide.[7] The bereaved may face community perceptions that the suicide resulted from a failure, weakness or shortcoming of the deceased or their family. A common situation in the stories received was that families would hide the fact a suicide had occurred and invent another cause of death. A submission the Committee received described how this stigma could also influence behaviour in less obvious ways:

> My relationships with friends were affected but I could not describe how. My close friends knew about my experiences, but even then they preferred not to talk about the incident believing it would make me sad. The contrary was in fact true, I needed to speak with someone who I trusted and could open up to… Whilst my family are not very traditional, the stigma associated to suicide is hard to shake and the lack of support from family and friends did not help.[8]

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5 Private Mental Health Consumer Carer Network (Australia), *Submission 10*, p. 2.

6 Lifeline Australia, *Submission 129*, p. 23.

7 Suicide is Preventable, *Submission 65*, p. 42.

8 Name withheld, *Submission 236*, p. 4. The issues of public awareness and stigma will be discussed further in Chapter 5.

Social costs

2.8 It was made clear during the inquiry that each completed suicide has a ripple effect on the family and friends of the deceased as well as on work colleagues, neighbours, school mates and the rest of the community. The number of people estimated to be immediately affected by one completed suicide is six. [9] The Suicide is Preventable submission noted that this 'measure probably underestimates the number of people grieving each suicide death, the ramifications of which are likely to extend more broadly'.[10]

2.9 Ms Dulcie Bird of the Dr Edward Koch Foundation argued that whole communities are often affected when a suicide occurs and described low estimates of the number of people effected by suicide as 'a load of nonsense'. She gave the example of the suicide of a 16-year-old boy in a small town and noted her organisation had completed '43 face-to-face interventions for that one suicide'.[11] The Foundation commented that suicide results in the loss of the deceased person's contribution to society as a whole. They argued:

> This loss to society is then compounded through the impact of that loss on the ability to function at an optimum level of productivity (both within the home and the workplace) when people are massively impacted by someone near to them suiciding. Also there is the wider impact on the broader community's psyche following an individual's loss. There is as well, the fear for the wellbeing of that person's social network as this group has been identified as being at greater risk of suicide in the postvention period.[12]

2.10 The Australian Institute of Health and Welfare (AIHW) has assessed causes of death in Australia according to potential years of life lost (PYLL) between the age of death and 75. In this calculation suicide ranks second for males and fourth for females as a leading specific cause of PYLL. The AIHW noted that in 'contrast to the basic mortality measures where all deaths are counted equally, PYLL highlights deaths (such as suicide) that occur at younger ages'.[13]

2.11 The Australian Institute for Suicide Research and Prevention (AISRP) also suggests PYLL may be a more appropriate measure to assess the social cost of suicide. They argued:

> The PYLL measure incorporates two quantitative measures (the number of suicides and the age of suicide) into a single metric (or measure), and is the more relevant measure when making social judgments. These two variables, number of suicide and age at suicide, are easy to understand, and

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9 Peer Support Australia, *Submission 25*, p. 6.

10 Suicide is Preventable, *Submission 65*, p. 43.

11 Ms Dulcie Bird, Dr Edward Koch Foundation, *Committee Hansard*, 2 March 2010, p. 31.

12 Dr Edward Koch Foundation, *Submission 94*, p.1.

13 AIHW, *Australia's Health*, 2008, p. 50.

> most people who look at suicide data know there is a connection. It is commonplace to hear people say something like the following: "Yes, the suicide rate is staying much the same, but it is very worrying that there is so much youth suicide." The PYLL measure quantifies this unease with the headcount measure.[14]

2.12 Ms Collen Krestensen from the Department of Health and Ageing (DoHA) also noted that the AIHW studies have suggested that suicide comprises 2.2 per cent of the total burden of disease in Australia.[15]

Financial costs

2.13 A number of submissions suggested that the financial cost of suicide could not be estimated until the number of suicides and attempted suicides in Australia was accurately reported. Lifeline Australia's submission stated that attempts to estimate the financial costs of suicide are hampered by debates about the statistical value of life. They stated:

> There continues to be robust 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. Proposed indices 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 or the cost of illness. Examples include human capital (foregone earnings), willingness-to-pay (WTP) estimated through indirect market methods and cost–or-illness.[16]

2.14 Lifeline highlighted recent research re-evaluating the cost of human lives lost in car accidents in 2009 which estimated the average cost of a life lost in a car accident at $6 million.[17] If a similar cost value was assumed for each of the approximately 2000 deaths by suicide each year in Australia the total cost would be around $12 billion per year.

2.15 The Suicide is Preventable submission noted that there are no reliable national estimates available on the financial costs associated with suicide and suicide attempts in Australia. It argued that more work was required to more accurately and fully cost

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14 AISRP, *Submission 237*, pp 29 -30.

15 Ms Colleen Krestensen, DoHA, *Committee Hansard*, 1 March 2010, pp 77-78.

16 Lifeline Australia, *Submission 129*, p. 26.

17 Lifeline Australia, *Submission 129*, p. 27; David Hensher et al, 'Estimating the willingness to pay and value of risk reduction for car occupants in road environment', *Transportation Research Part A: Policy and Practice*, August 2009, p. 692.

the economic impact of suicide and suicidal behaviour on the Australian economy. Dr Michael Dudley from SPA also stated that:

> We believe that suicide needs to be comprehensively costed in Australia and that resources need to be allocated to do this.[18]

2.16 The Suicide is Preventable submission suggested a number of possible components for costing suicide and self harm in Australia. These included the total number of suicides, lost production value, the cost of ambulatory services, years of life lost due to premature mortality, productivity losses for survivors, cost of insurances and superannuation claims, the cost of prevention and intervention programs. They proposed that 'a conservative estimate for the economic cost of suicide and suicidal behaviour in the Australian community is $17.5 [billion] every year'.[19]

2.17 In 1998, Jerry Moller estimated the cost of injury by suicide or self-harm Australia in 1995-96 using data supplied by the National Injury Surveillance Unit and a methodology developed by the Monash University Accident Research Centre for estimating injury costs. These study estimated direct costs of injury by suicide or self harm (relating to the treatment of injury) were estimated at $208.2 million while the indirect costs (relating to the loss to society of the productive efforts (both paid and unpaid) of injury victims) were estimated to be $344.6 million (morbidity) and $1,477.9 million (mortality).[20]

2.18 In 2005 the New Zealand Ministry of Health commissioned a report titled *The Cost of Suicide to Society*. It estimated in 2004 (in New Zealand dollars) that the economic cost per suicide was $448,250 and the economic cost per suicide attempt was $6,350. It also attempted to estimate non-economic costs and values for lost life and quality of life. It judged the non-economic cost per suicide was $2,483,000. It noted that on the calculations used it was 'the value of life component that dominates all others'.[21]

2.19 A study assessing the cost of injury in California between 1999 and 2003 found that the cost of individual suicides based on costs incurred by individuals, families, employers, government programs, insurers and tax payers could be calculated at $4,781 (US) for the average medical cost and more than $1.2 million (US) for the average lifetime productivity loss. The average medical cost per hospitalisation for a suicide attempt was more than $12,000 (US), and the average

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18 Dr Michael Dudley, SPA, *Committee Hansard*, 1 March 2010, p. 26.

19 Suicide is Preventable, *Submission 65*, p. 48.

20 NSW Government, *Submission 136*, p. 5.

21 Des O'Dea and Sarah, Tucker, *The Cost of Suicide*, 2005, p. 26, http://www.moh.govt.nz/moh.nsf/pagesmh/3347 (accessed 31 May 2010).

work-loss per case was over $14,000. Based on these assumptions the combined cost of suicides and attempted suicides in California was $4.2 billion (US) per year[22]

2.20 The economic costs of suicide identified during the inquiry were not always in expected areas. The NSW Government noted that RailCorp estimated that on average each suicide on the NSW railways costs the passenger service operator $76,000 and an attempted suicide $6,021.[23] It was also noted that some research studies suggest that the premature deaths resulting from suicide may actually derive savings to society from the avoidance of having to treat the depressive and other psychiatric disorders of some of those who complete suicide as well as the avoidance of other costs such as pensions, social security and nursing home care costs.[24]

2.21 While SPA outlined their concerns that some economic approaches to the cost of suicide may be 'uncomfortably close to seeing human value in terms of productivity', it also noted that estimates of the economic cost of suicide can be useful in providing guidance as to where the burden is greatest and where 'research on developing new interventions might be best focused to give greatest potential gain'. Consequently they recommended increased funding towards research into the economic cost of suicide, including detailed assessments of the burden of suicide by postcode to assist in advocating and determining funding priorities by geographic need.[25]

2.22 The limited nature of existing Australian research on the impact of suicide was confirmed during the inquiry. AISRP indicated that they had recently started to apply for research grants to examine the personal, social and financial cost of suicide in detail.[26] DoHA acknowledged the Commonwealth government had previously not done any economic modelling on the cost of suicide in Australia. Ms Rosemary Huxtable commented:

> To do a proper body of work on this issue would take significant time. It would need to be allocated a priority from within a government and the normal way this would occur would be through the engagement of a body like the Productivity Commission that can apply the appropriate robust methodologies to work like this.[27]

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22 RANZCP, *Submission 47*, p. 11; Suicide is Preventable, *Submission 65*, p. 46; Phaedra Corso et al, 'Medical costs and productivity losses due to interpersonal and self-directed violence in the United States', *American Journal of Preventive Medicine*, 2007, vol. 3, no. 3, p. 265.

23 NSW Government, *Submission 136*, p. 5.

24 Suicide is Preventable, *Submission 65*, p. 43; Freemasons Foundation for Men's Health, *Submission 52*, p. 4.

25 SPA, *Submission 121*, pp 30 -32.

26 Dr Kairi Kolves, AISRP, *Committee Hansard*, 18 May 2010, p. 17.

27 Ms Rosemary Huxtable, DoHA, *Proof Committee Hansard*, 18 May 2010, p. 29.

Conclusion

2.23 The personal and social impacts of suicide and attempted suicide on those affected cannot be quantified but are clearly enormous. For some of those writing their personal stories to the Committee, it was the first time they had recorded their experiences with suicide. It was apparent many struggled to find the words to convey their feelings of personal loss and grief following the suicide of a family member, partner or friend. In describing their experiences with suicide, submitters described their lives as being 'scarred' and 'changed irrevocably'.

2.24 Others who had attempted suicide, or cared for someone who had attempted suicide, often expressed their feelings of confusion, shame and frustration at the difficulties in finding assistance. While the financial impact of suicide in Australia appears to be large, the Committee agrees with several of the submissions which argued that the personal and social cost of suicide would always be more significant than the financial cost. No matter what the economic cost of suicide is calculated to be, a moral or a human obligation exists to assist those at risk of suicide and those who have been bereaved by suicide.

2.25 The Committee also heard many stories from people who had come through their experiences of suicide and had devoted themselves to assisting other people at risk.[28] For example Ms Joanne Riley of SPA told the Committee:

> In the months after Dad died, I made a personal commitment to take some action. I thought that, if I could just stop one person from taking their own life by drawing on my own experiences, while it would never bring Dad back it would in some way honour his life.[29]

2.26 Similarly Ms Lyn Mahboub described her 'journey of recovery' from mental illness which had involved hospitalisation with suicidal ideation. She now assists other people at risk through the Hearing Voices Australia Network.[30] The Committee was inspired to hear the personal stories of individuals who now worked assist others at risk.

2.27 The financial cost of suicide in Australia is significant. Suicide clearly imposes economic costs in a broad range of areas including health care, law enforcement, emergency services and insurance. The Committee will not engage in the economic debate about the statistical value of life. However the Committee considers that a study of the financial cost of suicide would assist suicide prevention activities in Australia. It would serve to identify areas where suicide and attempted suicide have an economic impact, it would highlight the cost of suicide to the

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28 Lifeline Australia, *Submission 129*, p. 23; Ms Lyn Mahboub, Hearing Voices Network Australia, *Committee Hansard*, 30 March 2010, p. 23.

29 Ms Joanne Riley, SPA, *Committee Hansard*, 1 March 2010, p. 29.

30 Ms Lyn Mahboub, Hearing Voices Network Australia, *Committee Hansard*, 30 March 2010, p. 23.

community and would encourage policy makers to allocate appropriate resources to the prevention of suicide.

Recommendation 1

2.28 The Committee recommends that the Commonwealth government commission a detailed independent economic assessment of the cost of suicide and attempted suicide in Australia, for example by the Productivity Commission.

CHAPTER 3

SUICIDE REPORTING & STATISTICS

Introduction

3.1 This chapter will address term of reference (b) the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any underreporting on understanding risk factors and providing services to those at risk). This was an issue which received considerable attention during the inquiry in part due to an existing debate regarding the underreporting of suicide in Australia.

Data on suicide and trends

3.2 The Australian Bureau of Statistics (ABS), Australia's official national statistical agency, reports annually on all registered deaths where sufficient information exists for coding. The 2008 *Causes of Death* stated there were 2,191 deaths coded as Intentional self harm [Suicide]. Of these deaths 1,710 (78 per cent) were male and 481 (22 per cent) were female. Suicide was identified as the 14th leading cause of death as 1.5 per cent of all deaths in 2008.[1]

3.3 The ABS statistics over the past decade have suggested a steady decline in the number of suicides in Australia, from 2,683 in 1998 to 1,799 in 2006. However the ABS has acknowledged these figures may be influenced by reporting issues. Since 2005, the ABS has published a caution in relation to the reported suicides data. The caution reads:

> Care should be taken in using and interpreting suicide data due to issues affecting data quality. It is important to note that the number of suicide deaths may be affected by the number of open coronial cases with insufficient information available for coding at the time of ABS processing.[2]

3.4 On these unrevised figures the largest falls in the number of suicides reported appear to have occurred in the large states, particularly NSW and Queensland. The rate of suicide appears relatively even across Australia (9.8 deaths per 100,000) with the exceptions of Tasmania (15.4 deaths per 100,000) and the Northern Territory (22.8 deaths per 100,000).[3]

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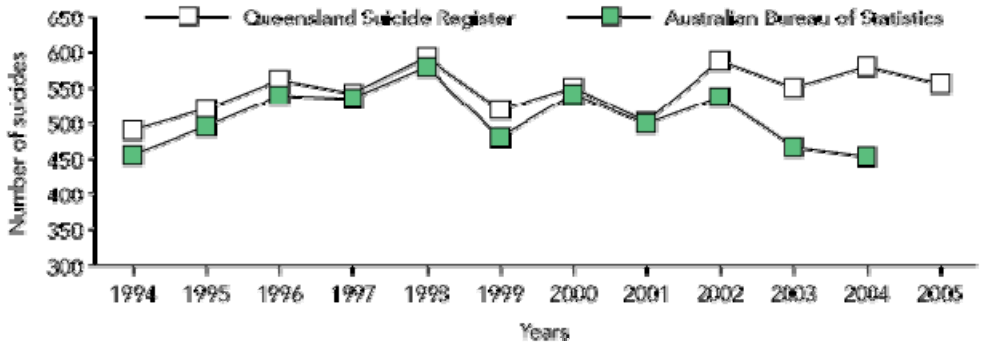
1 ABS, *Causes of Death*, 2008, p 9.

2 ABS, *Submission 111*, p. 8.

3 DoHA, *Submission 202*, p. 12.

3.5 In recent years there has been growing concern regarding the accuracy of the ABS statistics of deaths by suicide. For example in 2007 Professor Diego De Leo highlighted discrepancies between the ABS data for suicides in Queensland and the Queensland Suicide Register (QSR) maintained by AISRP.[4]

Comparison of Queensland Suicide Register and ABS data[5]



3.6 In 2009 the AIHW published a report into suicide statistics which investigated deaths occurring in 2004 using cases extracted from the National Coroners Information System (NCIS) from early 2008. It concluded that the ABS mortality data underestimated death by Intentional self harm [Suicide] '…to a significant extent, at least for deaths in 2004'. The revised estimate of 2,458 deaths from Intentional self harm [Suicide] compared to the ABS data of 2,110.[6]

3.7 In response to the concerns regarding the reporting of suicides in Australia SPA has facilitated the establishment of the National Committee for Standardised Reporting on Suicide (NCSRS) with the support of DoHA. The NCSRS is a cross jurisdictional committee to coordinate the various projects and stakeholders involved in the collection and compilation of suicide statistics, with the aim of achieving a standardised, accurate and consistent approach to suicide recording and statistical reporting.

4 Diego De Leo, 'Suicide mortality data needs revision', *Medical Journal of Australia*, vol. 186, no. 3, pp 157-158.

5 Diego De Leo, 'Suicide mortality data needs revision', *Medical Journal of Australia*, vol. 186, no. 3, p. 158.

6 AIHW, *A review of suicide statistics in Australia*, July 2009, pp 82 & 97.

ABS revisions

3.8 Reacting to the concerns raised regarding the underreporting of suicide deaths the ABS has implemented a revision process in the *Causes of Death* data collection process. All coroner certified deaths registered after 1 January 2007 will be subject to the revision process. The revision process will enable the use of additional information relating to coroner certified deaths as it becomes available over time, resulting in increased ability to identify suicide deaths. In particular this process will be able to include the results of completed coronial cases which have been finalised.

3.9 This is a change from previous years where ABS processing of *Causes of Death* data was finalised approximately 13 months after the end of the reference period. Where insufficient information was available to code a cause of death, less specific codes were assigned. The ABS noted the revision process would increase the number of deaths that are identified as 'suicides' for a given reference period compared to statistics previously released for that period.[7]

3.10 On 31 March 2010 the ABS released the latest *Causes of Death* data including the revised data for deaths by suicide which was clearly higher than previously reported. The revised data from 2007 showed a 9.2 per cent increase in the number of deaths coded to suicide, from 1,881 to 2,054.[8]

3.11 The ABS also outlined to the Committee a number of other activities it has recently undertaken to improve the quality of suicide data. These included revised instructions for ABS coders in coding suicides to ensure greater consistency in outcomes between individual coders and the implementation of revised rules for the use of the 'undetermined intent' coding which has had the effect of removing a number of potential suicides from 'accidental' death codes, making potential suicides easier to identify.[9]

The collection of suicide data in Australia

3.12 The registration of deaths is the responsibility of the individual State and Territory Registrars of Births, Deaths and Marriages (RBDMs). As part of the registration process, information about the cause of death is supplied by the medical practitioner certifying the death or by a coroner. Each state and territory has its own legislation covering the death registration process, as well as the role and responsibilities of the RBDM. Additionally, each jurisdiction has its own coronial legislation covering the role and responsibilities of coroners and the manner in which deaths reported to the coroner are investigated and findings made.[10]

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7 ABS, *Submission 111*, p. 10.

8 ABS, *Causes of Death, 2008*, p. 85.

9 ABS, *Submission 111*, p. 8.

10 ABS, *Submission 111*, p. 3.

3.13 In order to classify a death as a suicide the current International Classification of Diseases (ICD-10) requires that specific documentation from a medical or legal authority be available regarding both the self-inflicted nature and suicidal intent of the incident.[11] The ABS *Causes of Death* notes:

> Coronial processes to determine the intent of a death (whether intentional self harm, accidental, homicide, undetermined intent) are especially important for statistics on suicide deaths because information on intent is necessary to complete the coding under ICD-10 coding rules.[12]

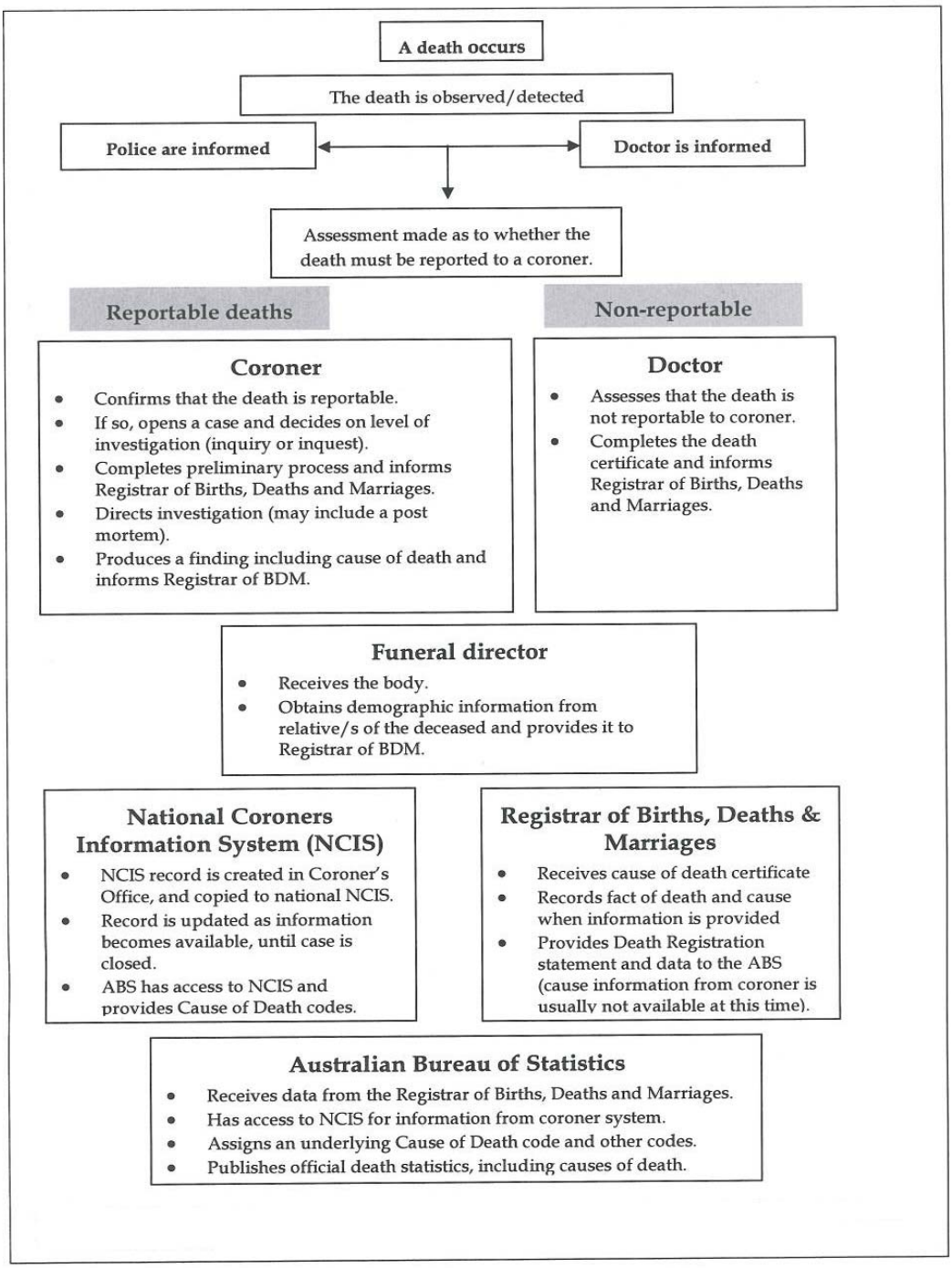
3.14 Since 2006 the ABS has used the NCIS as its primary source of information for coding causes of death for cases reported to the coroner. The NCIS is a database which contains information concerning every death reported to a coroner in Australia since 1 July 2000 (Queensland data commenced in 1 January 2001). Based on standardised coding performed by staff at coroners' offices around Australia, authorised users of the NCIS are able to view details about deaths reported to a coroner using a web based interface.[13]

11 ABS, *Submission 111*, p. 5.

12 ABS, *Causes of Death, 2008*, p. 47.

13 NCIS, *Submission 84*, p. 3.

Flowchart Causes of Death data collection[14]



14 Extracted from AIHW, *A review of suicide statistics in Australia*, July 2009, p. 19.

Impediments to accurate suicide reporting

3.15 A number of impediments to the accurate collection of suicide data in Australia were highlighted during the inquiry.

Determining intent

3.16 The difficulties in determining the intent of a person who might have completed suicide were frequently raised as an impediment to accurate suicide recording. Many examples were given of situations where it would be difficult to accurately determine the intent of a person in the absence of an obvious indication (such as the discovery of a suicide note). These scenarios included:

- drug overdoses which may be accidental or a suicide;
- single vehicle accidents where the driver has crashed into a fixed object;
- falls or drowning which could also be accidental;
- incidents of murder/suicide which could also be a double suicide; and
- hangings where there is the possibility of autoeroticism or there may be questions about the capacity of the person to understand the seriousness of their actions (for example young children).

3.17 The WA State Coroner, Mr Alastair Hope noted there was also a 'grey area' between recklessness and intent. He used the example of a person driving a '…vehicle in a manner which was so reckless that it would be very difficult to decide whether she wanted to die or just did not care'.[15]

Duration of coronial processes

3.18 The main rationale for the ABS revision process was that the time taken for coronial processes to occur did not allow data to be included in their regular annual reports. DoHA noted a key problem 'has been the increasing number of still pending decisions by coroners, that is ‘open’ cases, at the time the ABS must finalise the data for annual publication'. They also noted that there was significant variation in the case closure rates of states and territories, from 10.6 per cent in the ACT to 72.3 per cent in Queensland.[16]

3.19 While SPA considered the retrospective revision of suicide numbers was commendable, it noted the process would delay final counts and the benefit of this information by several years. Similarly Associate Professor James Harrison

15 Mr Alastair Hope, *Committee Hansard*, 31 March 2010, p. 69.

16 DoHA, *Submission 202*, p.16. Note: Mr Michael Barnes, Queensland State Coroner disputed the figure of 'open' cases. Mr Michael Barnes, Queensland State Coroner, *Proof Committee Hansard*, 18 May 2010, pp 49-50.

commented that this 'slowness greatly reduces the value of the data for purposes related to policy and programs'.[17]

Coronial legislation and practices

3.20 Coroners are judicial officers who under coronial legislation investigate reportable deaths and make findings as to the cause of death. Each State and Territory has its own coronial legislation which may prescribe the roles and responsibilities of the coroner differently. For example Mr Mark Johns, State Coroner of SA, told the Committee that under the coronial legislation in that jurisdiction there were two avenues for reportable deaths, either an inquest or making a finding. He noted that because of the wording of the legislation 'unless there is an inquest [the SA Coroner] will not make a coronial finding as to the intention of the deceased'.[18]

3.21 The NCSRS commented:

> Given differences in legislative requirements across States and Territories, particularly with regards to coroners' requirements to determine and report 'intent', national consistency may necessitate legislative reform as well as coronial practice guidelines. With a view to achieving a unified system, it is suggested that recommendations regarding coronial determination of intent be made at the National level for adoption by the various States and Territories.[19]

3.22 In addition to legislative differences between jurisdictions the ABS highlighted the lack of standardisation in coronial reporting practices. They stated '…different reporting formats, structures and forms are used in different coronial offices' and that '…coronial statements about the intent of a death are worded in different ways, there may be no statement regarding intent and if there is a statement of intent, it can be located anywhere in the coronial finding'.[20]

3.23 There were also differences between the jurisdictions identified in the availability of full-time coroners as opposed to local magistrates acting as coroners. The NCSRS argued the use of full-time coroners would improve the consistency of reporting practices.[21]

3.24 DoHA noted that accurate suicide statistics depend on '…what coroners conclude and write, they are a by-product of their work'.[22] However currently

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17 Associate Professor James Harrison, *Submission 131*, p. 3.

18 Mr Mark Johns, *Proof Committee Hansard*, 4 May 2010, p. 2.

19 NCSRS, *Submission 229*, p. 11.

20 ABS, *Submission 111*, p. 5.

21 NCSRS, *Submission 229*, p. 14.

22 DoHA, *Submission 202*, p. 15.

facilitating quality mortality statistics is not a formal part of a coroner's role. Coroners can rule on the intent of person but are not mandated to do so.[23]

3.25 No jurisdiction in Australia requires a coroner to make a specific determination about intent. The NCIS noted that an informal review of relevant coronial findings revealed 29 per cent had no mention of intent made by a coroner.[24] Similarly the AIHW study of suicide statistics found a large variation between different jurisdictions in the extent to which coronial findings provide a clear statement of the conclusion that the coroner reached about the role of intent in the death.[25] The Queensland Coroner commented that NCIS coding was a '…much lower priority for coroners than case managing their own workloads with a view to making findings to satisfy family members' concerns and getting deaths registered onto the local deaths registries'.[26]

3.26 To resolve this issue the NCIS recommended the amendment of coronial legislation in each jurisdiction to require a determination of intent and professional education for coroners about the importance of their suicide determinations.[27]

3.27 The high standard of proof used by coroners was also identified as a possible factor in the underreporting of suicides. The standard of proof for coroners is the civil standard, namely the balance of probabilities, but the gravity of the consequences of a finding of suicide is also a consideration. A high degree of certainty regarding intent is often required before a coroner will rule a death as a suicide. However Mr Michael Dudley of SPA noted this legal standard of proof may be '…not necessarily the same as a research or a suicidologist's standard of proof'.[28] The NCIS commented:

> This test of probability can result in some instances where it is 'possible' that a suicide occurred although was not determined as such by a coroner, with a statement such as 'I am unable to determine whether the deceased intended to take their own life' seen in some coronial findings.[29]

Data entry and coding

3.28 The NCIS noted several issues with the recording of intent data on their system. The first was that some coroners' offices were not completing the *Intent Notification* field until an investigation by the coroner has been completed. This field was included to allow timely data collection as to the prevalence of 'suspected

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23 Diego De Leo et al, 'Achieving standardised reporting of suicide in Australia: rationale and program for change', *Medical Journal of Australia*, 2010, vol. 192, no. 8, p. 454.

24 NCIS, *Submission 84*, p. 9.

25 AIHW, *A review of suicide statistics in Australia*, July 2009, p. 93.

26 Mr Michael Barnes, *Proof Committee Hansard*, 18 May 2010, p. 49.

27 NCIS, *Submission 84*, p. 6.

28 Dr Michael Dudley, *Committee Hansard*, 1 March 2010, p. 31.

29 NCIS, *Submission 84*, p. 6.

suicides', without the need to wait until all coronial processes were completed. They also commented that where a coroner does not make a statement as to intent 'a conservative process of assigning intent has to be undertaken by the coronial clerks entering the code on NCIS'. They stated:

> This current method of determination of intent is ultimately unsatisfactory, as it places the onus of determination for suicide on a coronial clerk, and only allows for capture of the most unambiguous self harm events.[30]

3.29 The SA State Coroner also raised the issue of resources and staff in coronial offices in relation to accurately coding data in the NCIS system. He noted this task was delegated to relatively junior staff who were '… under a fair bit of pressure'. He suggested staff were not always identifying 'the more ambiguous causes of death' and as a result '… there is simply no way that in South Australia we are accurately recording via the NCIS all the suicides that occur'.[31]

3.30 Finally NCIS noted that for the ABS to have complete information when compiling official statistics the data entry into NCIS needs to be timely. They stated that a backlog of coding exists and not all coroners' offices are able to complete coding on the NCIS with 60 days of a coroner's finding. This could contribute to the underreporting of suicides.[32]

The system of data collection

3.31 The ABS noted the accuracy and timeliness of suicide statistics '…depends on the goodwill and resources available in other organisations'. It was noted that the complexity of the data gathering system meant it was 'so fragile that decisions made by individuals can have a massive impact'.[33]

3.32 SPA commented:

> 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.[34]

3.33 Some witnesses argued that the recent ABS reliance on the NCIS had also affected the accuracy of data collection. Dr Michael Dudley of SPA noted that with

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30 NCIS, *Submission 84*, p. 8.

31 Mr Mark Johns, *Proof Committee Hansard*, 4 May 2010, p. 4.

32 Ms Jessica Pearse, NCIS, *Committee Hansard*, 4 March 2010, p. 46.

33 Mr David Rosenberg, BMRI, *Committee Hansard*, 1 March 2010, p. 56.

34 SPA, *Submission 121*, p. 33.

the '…transfer to a purely electronic system, there had been an abandonment of file inspections at coroners' offices…' by the ABS. [35] Similarly Mr Michael Barnes stated that following the change to the new system it was unlikely '…there will be same consistency and accuracy as when [ABS] staff reviewed coroners' files themselves'.[36]

Police data collection

3.34 The NCIS noted that some progress had been made towards a national standard form for police to collect information regarding a death reported to a coroner. Several jurisdictions (ACT, Queensland, Tasmania and NSW) have introduced to varying degrees a standard national police form that records evidence of suspected suicide and demographic data.[37] However the other four jurisdictions had not implemented the national standard form and there were inconsistencies in the use of the form. Technology and resource constraints are generally cited as the primary reasons for delay in adopting the form.[38]

3.35 Ms Jessica Pearse of NCIS commented that there was no standard process for police in investigating a possible suicide. She stated they '…collect a range of information about what they consider relevant and, depending on that variable level of information provided to them, a coroner may not have all the relevant information needed to help make a determination'. She stated:

> Any method that would encourage more standard information collection—things like the deceased's history, any previous attempts and possible triggers—would assist in the best evidence-based determination being made by a coroner.[39]

3.36 The NCIS recommended support for research to determine the reliability of initial 'intent notification' codes based on police notifications and/or initial clerk assessments. They suggested an initial assessment as to 'suspected suicides' could provide a guide to current trends or patterns surrounding such instances in the community, which could later be revised/confirmed once coronial investigations are completed. [40] Similarly Associate Professor James Harrison highlighted that most deaths that are ultimately found by a coroner to be due to suicide have been flagged as likely suicides when they were notified to the coroner, generally by police. He argued this 'intent notification' could provide a good proxy measure as 'sufficiently complete data based on it could be reported quickly'.[41]

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35 Dr Michael Dudley, SPA, *Committee Hansard*, 1 March 2010, p. 30.

36 Mr Michael Barnes, *Proof Committee Hansard*, 18 May 2010, p. 49.

37 Diego De Leo et al, 'Achieving standardised reporting of suicide in Australia: rationale and program for change', *Medical Journal of Australia*, 2010, vol. 192, no. 8, p. 454.

38 NCSRS, *Submission 229*, p. 7.

39 Ms Jessica Pearse, NCIS, *Committee Hansard*, 4 March 2010, p. 46.

40 NCIS, *Submission 84*, p. 12.

41 Associate Professor James Harrison, *Submission 131*, p. 3.

National Police Reporting Form Template[42]

Section 13 – SUSPECTED SUICIDE

a) What evidence is there to indicate that the deceased intended suicide? (tick the relevant box(es)) ☐ Statement to Family/Friends ☐ Statement to Health Professional ☐ Note / Letter ☐ Other (specify):
b)(i) Has the deceased previously attempted suicide? ☐ No ☐ Yes ☐ Unknown
b)(ii) If yes, approx number of times:
c)(i)Has the deceased previously been hospitalised for self harm? ☐ No ☐ Yes ☐ Unknown
c)(ii) If yes, approx number of times:
d) Is there any possible motive / trigger for the suicide? (tick the relevant box(es)) ☐ Relationship Breakdown ☐ Sexual Abuse ☐ Financial Problems ☐ Loss of a Loved One ☐ Illness ☐ Prospect of Criminal Sanction ☐ Alcohol / Drug Dependency ☐ Unknown ☐ Other (specify)
e) Was deceased being treated / seen by any of the following professionals? (tick relevant box(es)) ☐ General Practitioner ☐ Psychiatrist ☐ Psychologist ☐ Case Manager
f)(i) Was the death accompanied by the murder / suicide of other person(s)? ☐ No ☐ Yes
f)(ii) If yes, what was the relationship between the deceased and the person(s)?

Stigma and family pressure

3.37 The stigma around suicide was also frequently mentioned as a reason a death may not be recorded as a suicide. Lifeline Australia commented that stigma as well as cultural and religious beliefs could lead to circumstances where 'family members either directly or indirectly seek to influence death certificate statements regarding suicide'.[43]

3.38 The ABS also noted there may be reluctance by coroners to record a finding of suicidal intent because of 'sympathy with the feelings of the family, or sensitivity to the cultural practices and religious beliefs of the family'.[44] It was suggested these types of inconclusive findings were delivered by coroners and others to 'spare the family shame and chagrin, the agonising doubts and questions'.[45]

3.39 Mr Alastair Hope, State Coroner of WA also noted that there is frequently pressure from families in the case of public inquests 'to find that the death is by accident or some other mechanism apart from suicide'. Family members may believe that a finding of suicide might reflect adversely on their own interaction with the deceased person.[46] The Queensland Coroner, Mr Michael Barnes commented that there had been 'numerous appeals against suicide finding by family members seeking

42 Extracted from NCIS, *Submission 84*, p. 15.

43 Lifeline Australia, *Submission 129*, p. 30.

44 ABS, *Submission 111*, p. 5.

45 Professor Colin Tatz, *Submission 16*, p. 2.

46 Mr Alastair Hope, *Committee Hansard*, 31 March 2010, p. 68.

a different finding and this may also cause coroners to be more hesitant to make a finding of suicide.[47]

3.40 No evidence was received which estimated the extent to which stigma influences the reporting of suicide. However the ACT Government noted the feedback it had received from '…emergency workers and others who are frequently first on the scene at motor vehicle fatalities report is that indicators such as [suicide] notes in single vehicles are frequently overlooked during coronial determinations'.[48]

Insurance and financial issues

3.41 Family and relatives may also fear that an official report of a death as a suicide may prevent or delay the payment of life insurance or other forms of financial payment. Lifeline Australia stated:

> In regional and rural areas in particular, this delay can have a catastrophic impact on the economic future of a family, such as where a family farm or business is involved. Accordingly, inaccurate recording of the cause of death can occur through the intention to avoid financial hardship for a family – especially in smaller communities where families know each other and socialise together.[49]

3.42 Other submissions noted the practice for life insurance policies to include a clause excluding payments for deaths by suicide within a certain period following commencement of the policy. Typically this exclusionary period was between 13 and 24 months. It was suggested that these life insurance policies contributed to the underreporting of deaths as suicides.[50]

Consequences of underreporting

3.43 The underreporting of suicide deaths was seen as masking the extent of the problem in Australia and thwarting efforts to assess the efficacy of suicide prevention programs and activities. Professor Ian Hickie from BMRI described the lack of accurate suicide figures as a 'national catastrophe'. He suggested underreporting of suicides presented 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

47 Mr Michael Barnes, *Proof Committee Hansard*, 18 May 2010, p. 50.

48 ACT Government, *Submission 44*, p. 3.

49 Lifeline Australia, *Submission 129*, p. 30.

50 Diego De Leo et al, 'Achieving standardised reporting of suicide in Australia: rationale and program for change', *Medical Journal of Australia*, 2010, vol. 192, no. 8, p. 456.

> meagre resources for suicide prevention away from high risk groups in the community.[51]

3.44 Similarly the Royal Australian and New Zealand College of Psychiatrists (RANZCP) commented:

> Accurate statistics provide the foundation for appropriately targeted prevention strategies and research and understanding the full costs of suicide. Without reliable data, the effectiveness of suicide prevention strategies is not detectable.[52]

3.45 Underreporting was also seen as having consequences for research into the causes of suicide. The NCIS commented that a '…reduced amount of information collected in a consistent, searchable format about suspected suicides may also later limit the ability of researchers to identify risk factors for suicide'.[53]

3.46 The Suicide is Preventable submission commented that while there was general agreement that suicide rates are underreported in Australia there was disagreement about whether, despite this underreporting, '…enough is known to establish patterns, the dimensions of the phenomenon' and to base effective prevention programs.[54]

3.47 For example the Queensland Coroner Mr Michael Barnes considered the need for accurate suicide statistics was self evident, noting that it was difficult to design, implement or evaluate prevention strategies if there was uncertainty regarding the size, scope and distribution of the problem. He argued that the changes to way the ABS has been gathering data had resulted in 'obscuring even the trend in the statistics'.[55] SPA also highlighted the uncertainty created by underreporting. They stated:

> How much of the downward trend in deaths registered as suicides since 1998 is due to a real decline in the number of suicide deaths as opposed to under-enumeration or misclassification is therefore not immediately apparent, nor the full extent of the problem of under-reporting known.[56]

3.48 However Professor Graham Martin and others argued that suicide prevention activities to date have been 'quite successful' and there was evidence that there had been a real decline in the number of suicides in Australia, particularly amongst men,

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51 Suicide is Preventable, *Submission 65*, p. 11.

52 RANZCP, *Submission 47*, p. 12.

53 NCIS, *Submission 84*, p. 13.

54 Suicide is preventable, *Submission 65*, p. 10.

55 Mr Michael Barnes, *Proof Committee Hansard*, 18 May 2010, pp 49-50.

56 SPA, *Submission 121*, p. 33.

despite the problems with data collection and the issue of misclassification of deaths.[57] Professor Robert Goldney commented that ambiguity in suicide statistics had a long history but that '… detailed analyses have been re-assuring in establishing that broad trends can be reliably inferred from data provided'.[58]

3.49 Similarly Dr Ching Choi and Dr Lado Ruzicka commented that while it was clear that the ABS have been under reporting suicide deaths, '…it is not at all clear that the declining suicide mortality trend is not real'. They pointed to the declining trends in many other developed countries as well as the decline in suicides associated with firearms but noted suicides by hanging have not declined.[59]

Scope of reporting

3.50 Another area of reform in reporting was the scope of data collected in relation to suicide. RANZCP noted that the 'lack of information in death records on some characteristics of people dying by suicide further contributes to the ignorance of suicide risk factors and distribution'.[60] The Committee frequently heard evidence that there was little reliability in the recording of the characteristics of a person who completed suicide. Additional information such as whether the person was Indigenous, gay, lesbian, bisexual, transsexual or intersex or from a particular ethnic community was not being consistently recorded.[61] Others noted that the lack of ethnicity data made it impossible for assessments of trends and issues in culturally and linguistically diverse communities.[62]

3.51 The NCSRS noted that a range of information gathered during a police investigation which has the potential to inform both coronial determinations and suicide prevention activities and research. They suggested the collection of more wide ranging background information concerning the deceased's social life and relationships and a complete medical and mental health history could assist the determination of suicide intent or risk. The NCSRS recommended a standard psycho-social autopsy be developed, taking into account a broad source of information, and implemented as a matter of course in all cases of suspected suicide.[63]

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57 Professor Graham Martin, *Committee Hansard*, 2 March 2010, p. 80; Professor Graham Martin, *Submission 107*, p. 13. Dr Andrew Page; Professor Greg Carter; Professor Richard Taylor; Dr Michael Dudley; Dr Stephen Morrell; Professor Graham Martin and Professor Wayne Hall, *Submission 64*, p. 5.

58 Professor Robert Goldney, *Submission 51*, p. 1.

59 Dr Ching Choi and Dr Lado Ruzicka, *Submission 42*, p. 2.

60 RANZCP, *Submission 47*, p. 13.

61 SPA, *Submission 121*, p. 33; Central Australian Aboriginal Congress, *Submission 19*, p. 1.

62 Ethnic Communities Council of Western Australia, *Submission 36*, p. 1.

63 NCSRS, *Submission 229*, pp 7-8.

3.52 Accurate and timely recording of suicides could also enable authorities to identify problem areas, clusters of suicides or areas requiring postvention services following a series of related suicides. Lifeline Australia stated:

> Better access to accurate information on suicide and suicidal behaviour could enable more effective local responses to communities and regions in Australia – notably in cases where several deaths by suicide occur in a short space of time. The early identification of 'clusters' of suicide in localities or particular social/demographic groups will support more effective suicide prevention responses.[64]

3.53 A number of submissions and witnesses argued that not only did the number of suicides in Australia need to be accurately recorded but other factors also needed to be tracked. Professor Ian Hickie noted that contacts with care were common for people before they attempted suicide but that no national tracking mechanisms existed to link cares services to patient outcomes. He stated:

> …we need to track those who have contact with the health system through its emergency departments, its primary care services and particularly its specialist mental health services. We have seen a complete lack of will in the health systems to join up occasions of service with the key outcome of care: are you alive or dead at three months? Are you alive or dead at 12 months? If dead, what is the cause of death? They are the simple things that we need to know.[65]

3.54 Professor Ian Hickie also commented that there may be services which do not want to be held accountable for outcomes because they provide short episodes of care to people who may be at risk of suicide.[66]

3.55 Broader data collection regarding suicide could also assist service providers refine the targeting of groups at risk of suicide. OzHelp commented it would be assisted if data such as age, gender, occupation, income and other social determinants of health could be collected.[67] Orygen Youth Health Research Centre argued that the failure to record suicide attempts '… restricts our ability to accurately monitor progress towards reducing suicide and significantly hampers research in this area'.[68]

3.56 The Private Mental Health Consumer Carer Network Australia recommended that the reporting protocol of deaths with 28 days of discharge from a mental health facility be linked to coronial reporting requirements. The Network concluded that

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64 Lifeline Australia, *Submission 129*, p. 29.

65 Professor Ian Hickie, BMRI, *Committee Hansard*, 1 March 2010, p. 58.

66 Professor Ian Hickie, BMRI, *Committee Hansard*, 1 March 2010. p. 58.

67 OzHelp Foundation, *Submission 86*, p. 8.

68 Orygen Youth Health Research Centre, *Submission 82*, p. 3.

efforts must be made to collect, report and review all occasions of death by suicide following discharge from mental health services.[69]

3.57 Mr Michael Barnes suggested one solution to the scope and accuracy of the recording of suicides would be to expand the QSR model nationally. The QSR is a database of suicide mortality data managed since 1990 by AISRP. The database gathers information on deaths by suicide of all residents of Queensland, including data obtained from police reports, post-mortem and toxicology reports. This information is predominantly provided by the Queensland Office of the State Coroner and cross-checked with the data available on the NCIS. Causes of death are then scrutinised in the QSR following a Suicide Classification Flow Chart, developed by AISRP, and categorised into: Beyond Reasonable Doubt, Probable, or Possible.[70]

Conclusion

3.58 Accurate and timely statistics are essential to the creation, implementation and evaluation of good policy in any area, but particularly for social and health policy. The rate of suicide is widely used internationally as a broad progress measure or indicator of the effectiveness of social and health (particularly mental health) policy.

3.59 The Committee acknowledges that because of the difficulties around determining intent a completely accurate recording of suicides in any given year is unlikely to be achieved. However this does not preclude substantially more accurate, timely and useful recording of suicide. The Committee considers that accurate and timely statistics about suicide and attempted suicide should be given a high priority under the NSPS.

3.60 The Committee acknowledges the recent efforts made by the ABS to improve the accurate recording of suicide data through revisions. Without the benefit of several years of ABS revised data, it is not clear whether there is a clear downward trend in deaths registered as being a result of suicide. As the revision of previous years by the ABS continues this situation will become clearer.

3.61 The creation of the NCSRS, which brings together many of the participants and users of suicide data collection system, demonstrates there is considerable goodwill and a shared commitment to reforming many of the technical issues which prevent accurate suicide reporting.

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69 Private Mental Health Consumer Carer Network Australia, *Submission 10*, pp 4-6. Follow up procedures are discussed further in Chapter 4.

70 DoHA, *Submission 202*, p. 47.

Recommendation 2

3.3 The Committee recommends that Commonwealth, State and Territory governments, in consultation with the National Committee for Standardised Reporting on Suicide, implement reforms to improve the accuracy of suicide statistics.

3.62 It is clear that standardising coronial legislation and practices in relation to determining intent would have the effect of improving the quality of suicide reporting in Australia. However the Committee has concerns about proposals to require coroners to make determinations as to the intent of the deceased in relation to possible suicides. There is a significant difference between a coroner publicly recording a death as a suicide and a coroner officially recording a death as a suicide. The Committee considers it may be possible to develop a system whereby coroners maintain their discretion to not publicly make a finding of suicide (on compassionate grounds) but are required to record their determination officially (on the NCIS or otherwise). This is a difficult area of reform as it involves coronial legislation and practices in all jurisdictions. The Standing Committee of Attorneys-General appears an appropriate forum to progress this issue, particularly considering its previous experience in implementing uniformity of legislation across Australian jurisdictions.

Recommendation 3

3.63 The Committee recommends that the Standing Committee of Attorneys-General, in consultation with the National Committee for Standardised Reporting on Suicide, standardise coronial legislation and practices to improve the accurate reporting of suicide.

3.64 Standardising the input that coroners receive from primary sources such as police will also positively impact the recording of suicides. The important role that police currently (and potentially could) undertake in gathering information about persons at risk of suicide was highlighted to the Committee a number times during the inquiry. The Committee is concerned that the police forces of Victoria, SA, WA and NT do not appear to have implemented the standardised national police form for the collection of information regarding a death reported to a coroner.

Recommendation 4

3.65 The Committee recommends all Australian governments implement a standardised national police form for the collection of information regarding a death reported to a coroner.

Recommendation 5

3.66 The Committee recommends that the Commonwealth, State and Territory governments enable timely distribution of suicide data from coroners' offices regarding suicides to allow early notification of emerging suicide clusters to public health authorities and community organisations.

Recommendation 6

3.67 The Committee recommends that State and Territory governments provide additional resources and training to staff in coronial offices to assist in the accurate and timely recording of mortality data.

3.68 In relation to life insurance policies the Committee is cautious to make any recommendations to change the practice of standard exclusions if the person completes suicide within a certain time period after the policy is commenced. The financial implications of these policies would have the effect of discouraging the reporting of deaths as suicides in some cases. Nonetheless there is also possibility that a change to these insurance policies could act as a dangerous incentive or encouragement those at risk of suicide.

Recommendation 7

3.69 The Committee recommends the National Committee for Standardisation of Reporting on Suicide liaise with peak insurance and financial associations, such as the Insurance Council of Australia, regarding exclusionary conditions in contracts which may deter the reporting of suicides.

CHAPTER 4

ROLES AND TRAINING

Introduction

4.1 This chapter will address two related terms of reference. The first term of reference (c) is 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. The second term of reference (e) is the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk. In the view of the Committee the appropriate roles, effectiveness and training of frontline personnel assisting people at risk of suicide are clearly linked issues.

Suicide prevention roles

Health professionals and primary care

4.2 Primary health care and general practitioners (GPs) were recognised as important for identifying and supporting people who are at risk of suicide and for the provision of postvention support to people who have attempted suicide.[1]

4.3 The Australian Medical Association (AMA) observed that about 88 per cent of Australians visit a GP at least once a year, providing significant opportunities for suicide prevention risk assessment and treatment. They noted that research indicates that those who complete suicide are likely to have seen a GP in the weeks and months prior but rarely communicate their intentions. They are reliant on the GP recognising their risk and providing treatment. While GPs were well placed to identify patients at risk of suicide, the AMA argued that this activity relies on the availability of speciality follow up services patients can be referred to. They stated:

> Specialised out-patient and acute care services need to be immediately available to ensure patient safety. Any delays or problems with accessing these services may undermine the initial efforts to prevent suicide.[2]

4.4 Similarly the Australian General Practice Network (AGPN) highlighted the importance of GPs having the skills to identify and respond to people at risk of suicide or self harm as well as patients at risk of suicide having access to specialised suicide prevention services from psychologists, psychiatrists and social workers.[3] They

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1 AGPN, *Submission 213*, p. 6.

2 AMA, *Submission 55*, p. 8.

3 AGPN, *Submission 213*, p. 7.

emphasised the importance of patients building relationships with a single doctor or practice over time '…which provides a critical foundation for primary health care and encourages GPs and patients to take a long-term approach to care'.[4]

4.5 However GPs and nurses were perceived as having minimal education and training regarding suicide and suicide prevention.[5] RANZCP recommended that ongoing education regarding identification and appropriate treatment of depressive disorders should be provided to GPs and all those training as health professionals should be given suicide prevention education to ensure good literary early in their careers.[6]

Police and ambulance officers

4.6 Police officers are generally regarded as having a number of roles in assisting people at risk of suicide:

- in cases of attempted suicide, seeking the intervention of health professionals, including by utilising legislative provisions, such as detaining persons pursuant to mental health legislation where appropriate;
- assisting health workers when there are issues of safety in dealing with a person who has attempted or is contemplating suicide, to reduce the risk to a safe level to enable intervention; and
- acting as a referral service to health agencies.[7]

4.7 The Committee received mixed evidence regarding the role and effectiveness of police assisting people at risk of suicide. For example Lifeline Australia noted that while in its experience the response by police to people at risk of suicide had been good, 'individual officers may lack the necessary training, experience and skills to adequately assess and assist someone at risk of suicide'. They commented that in '…some instances police response have been described as “heavy handed” by individuals requiring assistance (particularly those with chronic mental illness) and the treatment they have received from police has further traumatised them'. Lifeline argued this demonstrated the need for universal training in suicide awareness and appropriate responses to people at risk of suicide for police and other emergency services.[8] The Salvation Army also suggested that after analysing the feedback they received '… it could be observed that police in major cities appear to have the

4 AGPN, *Submission 213*, p. 8.

5 Ms Dawn O'Neil, Lifeline Australia, *Committee Hansard*, 1 March 2010, p. 8.

6 RANZCP, *Submission 47*, p. 16.

7 South Australia Police, *Submission 245*, p. 1.

8 Lifeline Australia, *Submission 129*, p. 40.

resources and training to respond appropriately and compassionately and more needs to be done to train and support police operating in rural and regional areas'.[9]

4.8 There were also indications police and coronial investigations could impose further trauma on the bereaved families following a suicide. This could occur in situations where there is initial uncertainty as to whether the cause of death was suicide or homicide. Standard police procedures such as questioning family members and treating the location of a suicide as crime scene 'can often be perceived as insensitive and distressing'.[10]

4.9 The NSW Consumer Advisory Group Mental Health told the Committee:

> Police are often the first called to respond to a person experiencing a crisis due to a lack of after-hours crisis services or because of a perceived danger to community mental health clinicians. Consumers have talked about their concerns about marked cars and uniformed police involved in a mental health crisis intervention and how this can be misconstrued as a criminal matter by other members of the community. This can result in feelings of humiliation and shame for the person who is actually in crisis, which can have a very real and long-term effect.[11]

4.10 There were other views expressed that police officers should be allowed to concentrate on law enforcement rather than functioning as 'front line mental health officers'. The challenges that police officers face in dealing with people at risk of suicide were also recognised. The Private Mental Health Consumer Carer Network Australia stated:

> We acknowledge the critical role of police and/or emergency services in de-escalating attempted suicides, risking their own safety and wellbeing. Mental health is a challenging area when people with florid psychotic symptoms, who are at risk of harm to themselves, prove very difficult to manage.[12]

4.11 The SPA submission commented that there is limited information available about 'first responders' such as police in terms of their training and impact on those at risk of suicide. [13] The Committee understands the majority of police receive limited suicide prevention training as part of their training for dealing with people who may have mental health issues.

4.12 The NSW Government noted the success of the pilot NSW Police Mental Health Intervention Team (MHIT) which was developed to reduce the risk of injury to

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9 Salvation Army, *Submission 142*, p. 20.

10 SPA, *Submission 121*, p. 37.

11 Ms Rebecca Doyle, NSW Consumer Advisory Group Mental Health, *Committee Hansard*, 3 March 2010, p. 44.

12 Private Mental Health Consumer Carer Network Australia, *Submission 10*, p. 4.

13 SPA, *Submission 121*, p. 37.

police and people with mental health illnesses. It aims to improve awareness by frontline police of risks involved in dealing with people with mental illness and provide strategies to reduce injuries to police and consumers; improve collaboration with other government and non-government agencies in the response and management of mental health crisis events; and to reduce the time taken by police in the handover of people with mental illness to the health care system. The MHIT has now been established as a fulltime unit and been given the target of training a minimum of 10 per cent of all frontline NSW Police Force staff by 2015.[14]

4.13 Ambulance officers were also highlighted as a group with an important role in assisting people at risk of suicide. Where the consequences of a suicide attempt require medical attention an ambulance is often called to the scene. Ambulance officers usually have basic mental health training. The SPA Position Statement on Crisis Response notes:

> Ambulance staff need the skills to assess suicide risk and provide immediate management, but they also need support and training to safeguard their personal needs and to deal with the trauma associated with crisis response. Knowledge of local mental health legislation, involuntary admission laws and mental health or support services, facilitates ambulance workers' decision-making about suicidal patients.[15]

Emergency departments

4.14 A large amount of evidence was received regarding the responses of hospital emergency departments to persons who had attempted suicide or were at risk of suicide. The Salvation Army had 'grave concerns about the response of many emergency departments to people who are in immediate crisis'. They commented it appeared that many emergency departments are so stretched because of lack of resources and increasing demand that people in crisis do not receive the attention and support they need.[16] They also noted serious concerns with the risk assessments conducted before a person is discharged from hospital.

> Whilst the Mental Health protocols state that suicidal people should not be discharged from hospital without a Risk Assessment being conducted, people quickly learn how to respond to the questionnaire. [17]

4.15 The NSW Consumer Advisory Group described hospital triage systems as not identifying mental health as a priority.[18] RANZCP noted that acutely suicidal persons

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14 NSW Government, *Submission 136*, p. 13.

15 SPA, *Position Statement: Crisis Response and the Role of Emergency Services and First Responders to Suicide and Suicide Attempts*, June 2010, p. 11.

16 Salvation Army, *Submission 142*, p. 81.

17 Salvation Army, *Submission 142*, p. 81.

18 Ms Rebecca Doyle, NSW Consumer Advisory Group Mental Health, *Committee Hansard*, 3 March 2010, p. 43.

can be made to wait for inappropriately long periods of time. They argued that emergency departments need to be able to respond both to the psychological and emotional needs of suicidal persons as well as any physical consequences of a suicide attempt. RANZCP outlined Australian research which found '…about one third of suicide attempt survivors described their satisfaction with their hospital treatment as 'mixed' and one fifth as 'poor' or 'very poor''. Similarly, 28 per cent of suicide attempt survivors described the attitudes of health care professionals in the hospital environment as 'mixed' and 33.5 per cent as 'poor' and 'very poor'.[19]

4.16 SPA suggested that persons at risk of suicide may benefit from improved widespread training of all emergency department staff in current suicide risk assessment protocols. They argued that:

> When a person who has attempted suicide comes to the attention of an emergency department, a prime opportunity opens up for intervention. However, the majority of those who do come to attention following a suicide attempt do not receive any subsequent help.[20]

4.17 A number of witnesses and submissions emphasised the importance of taking seriously any situation where someone is talking about suicide. Many related personal stories when they had difficulty in receiving assistance from emergency departments, particularly where a person had suicidal ideation but had not attempted suicide. Ms Carla Pearse from the Community Action for the Prevention of Suicide commented:

> I have got a great deal of respect for our public health system, our public mental health system, but they are absolutely snowed. They simply cannot respond to people… My experience with my clients is that they might go to A&E. If they are accepted into the system they will be sitting there for hours and hours unless they have made an attempt. But if they are going to A&E with suicidal thoughts then they are sent home.[21]

4.18 The Committee understands that guidelines and protocols exist in most jurisdictions for healthcare staff to undertake suicide risk assessment of patients. The NSW Government noted that the *Framework for Suicide Risk Assessment and Management for NSW Health Staff* provides detailed information for health staff on conducting suicide risk assessments, and includes specifics on the roles and responsibilities of generalist and mental health services. The Framework states:

> People with possible suicidal behaviour must receive preliminary suicide risk assessment and, where appropriate, a referral for a comprehensive mental health assessment including a detailed suicide risk assessment. The

19 RANZCP, *Submission 47*, p. 14.

20 SPA, *Submission 121*, p. 56.

21 Ms Carla Pearse, Community Action for the Prevention of Suicide, *Committee Hansard*, 2 March 2010, p. 42.

> goal of a suicide risk assessment is to determine the level of suicide risk at a given time and to provide the appropriate clinical care and management.[22]

4.19 However the Psychotherapy and Counselling Federation of Australia reported that its practitioners who support staff working in emergency departments of hospitals report that these personnel feel unsupported in assessing suicide risk.[23]

4.20 Some State and Territory governments appear to be responding to the difficulties for persons in crisis attending hospital emergency departments. The NSW Government reported it had established nine psychiatric emergency care centres (PECC) for patients with acute mental health needs. The ACT Government also noted an initiative it was undertaking to assist in the referral of persons at risk of suicide.

> Recognising the crucial role that Emergency Departments (ED's) play in assisting people at risk of suicide, the ACT is currently constructing a Mental Health Assessment Unit (MHAU) which will be attached to the ED of the Canberra Hospital. The MHAU will be a 6 bed mental health assessment unit that will provide specialised mental health assessment, crisis stabilisation and treatment for all people presenting to the ED with an acute mental illness or disorder.[24]

Other services

4.21 The Committee also received evidence that other government agencies as well as commercial services often need to display more tact and discretion in their transactions with people who may be at risk of suicide. For example the Psychotherapy and Counselling Federation of Australia commented:

> Many Centrelink workers do not have skills in adequately responding to the needs of at risk clients. It was noted that when discussing depression with their clients staff may not be sensitive to the needs of the individual.[25]

4.22 The NSW Government noted Mental Health First Aid training would also be rolled out to RailCorp station staff in 2010 as part of an initiative 'to address the risk and incidence of suicide in the NSW rail system'.[26]

Stigma

4.23 The Committee heard many stories from people who felt that they had not been treated appropriately by frontline personnel after an attempted suicide or completed suicide. Mr Alan Woodward of Lifeline related an experience of one of the

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22 NSW Health, *Framework for Suicide Risk Assessment and Management for NSW Health Staff*, 2004, p. 1.

23 Psychotherapy and Counselling Federation of Australia, *Submission 72*, p. 2.

24 ACT Government, *Submission 44*, p. 4.

25 Psychotherapy and Counselling Federation of Australia, *Submission 72*, p. 6.

26 NSW Government, *Submission 136*, p. 13.

Lifeline managers where a man was not treated appropriately by hospital staff after attempting suicide. He noted:

> Lifeline believes that whatever else is provided to suicidal persons, whatever else is done to keep suicidal persons safe, whatever else is done to prevent the onset of suicidality, there must be genuine, non-judgmental caring in our response.[27]

4.24 The Lifeline submission also noted that some emergency service personnel, health, and other community support workers who are the first responders to a suicide incident can suffer from 'compassion fatigue', and at times can have misinformed attitudes towards suicidal behaviours and risk factors.[28] Similarly Salvation Army stated there was a perceived lack of empathy or concern for patients who are suicidal and a perception health professionals often believe the person who has attempted suicide is attention seeking.[29]

4.25 Submitters and witnesses, including those who have worked as health professionals, gave evidence to the Committee that health care services are not always free of stigmatised views of suicide, and that people presenting with suicide attempts have had experiences of punitive and dismissive attitudes from health care professionals.[30]

4.26 The Committee was disturbed to receive evidence of practices in hospitals and by doctors whereby patients who presented following an attempted suicide or self-harm were treated badly or even 'punished'. This included publicly scolding them for their actions and treatment such as stitches for self inflicted injuries without anaesthetic. Professor Graham Martin linked these practices to the stigmatisation of people who self-harm by medical professionals.[31]

4.27 SPA also submitted the following descriptions of personal experiences which patients had contributed:

> The nurse informed me that I was both selfish and stupid to have done what I did and that her nephew had also done something similar that week and was equally selfish and stupid. I lied to every medical person who came to see me in order to get out of the hospital quicker. The experience I had in hospital meant I didn't go and see a GP for quite a few years.

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27 Mr Alan Woodward, Lifeline Australia, *Committee Hansard*, 1 March 2010, p. 3.

28 Lifeline Australia, *Submission 129*, p. 41.

29 Salvation Army, *Submission 142*, p. 22.

30 For example Dr John Crawshaw, Department of Health and Human Services Tasmania, *Committee Hansard*, 20 May 2010, p. 60; Associate Professor Ione Lewis, Psychotherapy and Counselling Federation of Australia, *Committee Hansard*, 25 March 2010, p. 12; Lifeline, *Submission 129*, p. 20

31 Professor Graham Martin, *Committee Hansard*, 2 March 2010, pp 84-86.

> I found that ambulance workers, nurses and doctors (both from ER and ICU) were judgmental of me as if I had brought my sickness on myself and was wasting the resources available for deserving sick people.
>
> Some hospital staff are still under the impression that suicide and self harmers are attention seekers. This is far from the case, and needs to be recognised without prejudice.[32]

Support for frontline personnel

4.28 The support available for those frontline staff dealing with suicide and attempted suicide was frequently raised. Their experiences were seen as resulting in 'vicarious trauma' causing stress-related anxiety, depression and post traumatic stress disorders. As an example Professor John Mendoza related the circumstances of two Queensland Ambulance Service officers who were deeply traumatised by their experience of assisting a young man to an emergency department and then being subsequently called to attend the scene of the man's suicide a few hours later.[33] SPA commented:

> The vicarious trauma and impact of suicide (particularly where the deceased was a patient or client) on first responders, clinicians, general practitioners and other health professionals (including coronial staff), and also volunteers, work colleagues and whole communities more broadly, should not be underestimated.[34]

4.29 The SPA Position Statement on Crisis Response recommended:

> First responders who are exposed to crisis situations and suicide attempts as part of their job should have formal structures of support and debriefing embedded in their work practices….
>
> Strategies for debriefing and support embedded in organisational practice should safeguard the professional's own needs to reduce distress and burnout.[35]

Discharge and follow up support

4.30 The time following discharge from hospital or inpatient psychiatric care was identified as a period of particular risk for people who were at risk of suicide. DoHA commented that studies have estimated that the rate of suicide in people with a mental illness following discharge from inpatient psychiatric treatment could be over 200 times the rate of death by suicide in the general population. They stated:

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32 SPA, *Submission 121*, p. 40.

33 Professor John Mendoza, *Committee Hansard*, 1 March 2010, p. 92.

34 SPA, *Submission 121*, p. 38.

35 SPA, *Position Statement: Crisis Response and the Role of Emergency Services and First Responders to Suicide and Suicide Attempts*, June 2010, p. 17.

> The elevated risk of suicide is highest immediately following discharge, with 12.8% of deaths by suicide after discharge occurring on the day of discharge, 28.4% in the week following discharge, 47.7% in the month following discharge and 80% within one year of the last episode of inpatient psychiatric treatment.[36]

4.31 Despite this period being recognised as a time of risk for suicide Lifeline Australia noted that discharge from hospital 'does not always include a workable discharge plan, and a person at risk of suicide can return home with limited or no supports in place'.[37] Similarly the MHCA noted that it was 'commonplace for a person to be discharged from a mental health service following an attempted suicide and disappear into the community, without any arrangements for follow-up care in the community'.[38] They argued:

> There needs to be a compulsory follow-up plan for people discharged from hospital or other services after attempting suicide. There is currently no requirement upon hospital and frontline staff to ensure that individuals at high-risk of suicide are given the necessary follow up care and ongoing case-management.[39]

4.32 The NSW Consumer Advisory Group Mental Health argued that 'discharge planning needs to extend beyond the current minimum of making sure the individual has somewhere to go or that someone has been informed of there discharge…[t]here needs to be a process in place to ensure a continuity of care…'.[40] RANZCP commented that the majority of those who do come to attention following a suicide attempt do not receive any subsequent help.

> Non-attendance of suicide attempt survivors at follow-up interviews is alarmingly high with some researchers estimating this non-compliance to be as high as 50 to 60 per cent.[41]

4.33 The Private Mental Health Consumer Carer Network Australia recommended mandatory introduction and routine use in public and private mental health sectors of a clinician rated, validated suicide risk assessment tool at admission and discharge from inpatient settings as well as a 3 monthly review in community settings.[42]

4.34 The NSW Government noted that the period following discharge is a period of increased risk for mental health patients and stated this was recognised in the

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36 DoHA, *Submission 202*, p. 60.

37 Lifeline Australia, *Submission 129*, p. 39.

38 MHCA, *Submission 212*, p. 4.

39 MHCA, *Submission 212*, p. 12.

40 Ms Rebecca Doyle, NSW Consumer Advisory Council Mental Health, *Committee Hansard*, 3 March 2010, pp 43-44.

41 RANZCP, *Submission 47*, p. 19.

42 Private Mental Health Consumer Carer Network Australia, *Submission 10*, pp 4-6.

Discharge Planning Policy for Adult Mental Health Inpatient Services. This policy 'provides direction on the principles and practices that mental health clinicians must follow to promote the safe transition to the community for patients leaving mental health units'.[43]

4.35 Research which indicated that follow up procedures with patients after their discharge could reduce their rate of suicide was frequently mentioned in submissions. The MHCA commented that enough evidence exists to demonstrate that an appropriate discharge follow-up care plan and management by appropriately trained staff cannot only prevent future attempts, but assist in rebuilding the lives of people.[44] SPA outlined a range of interventions after discharge through which contact with the person at risk of suicide could be maintained. They noted:

> Recent studies have shown that maintaining contact with suicide attempt survivors or other high risk groups (e.g. psychiatric inpatients refusing follow-up) after discharge significantly reduces their risk of subsequent attempt and death.[45]

4.36 The Suicide is Preventable submission also emphasised that studies have demonstrated that simple letter or postcard interventions, where postcards are mailed to persons discharged from acute care mental health units inviting them to stay in touch at regular intervals, have been effective in reducing repeat episodes of self-harm and also death by suicide.[46]

4.37 DoHA highlighted two programs relevant to this area of support. The first was the Consumer Activity Network operated Community Connections project in Sydney which provides peer support and practical assistance to mental health consumers in the community for the first 28 days following discharge from psychiatric inpatient units. The service also offers a national telephone peer support non-crisis line for mental health consumers.[47]

4.38 DoHA also highlighted the Access to Allied Psychological Services (ATAPS) Suicide Prevention Pilot which aims to provide better support for people at high risk of suicide after presentation to an emergency department or general practitioner following a suicide attempt or self-harm. It facilitates priority access to referral pathways to specialised allied psychological services for people who have self-harmed, attempted suicide or who have suicidal ideation.[48] Funding is also given to Crisis Support Services to provide 24 hour telephone support.

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43 NSW Government, *Submission 136,* p. 14.

44 MHCA, *Submission 212*, p. 14.

45 SPA, *Submission 121,* p. 56.

46 Suicide is Preventable, *Submission 65*, p. 87.

47 DoHA, *Submission 202*, p. 60.

48 DoHA, Submission 202, p. 61.

4.39 The AGPN provided the Committee with further details about the operations of this pilot project.

> A pilot extension of ATAPS called Specialist Services for Consumers at Risk of Suicide is allowing provision of intensive, prioritised services for people at risk of suicide delivered in 19 GPNs [general practice networks]. It includes treatment for people discharged from hospital to GP care, people who have presented to a GP after an incident of self harm, and people who have expressed strong suicidal ideation to their GP. The GP is then able to refer the person to an experienced psychologist for immediate, intensive counselling (within 24-72 hours, for up to 2 months). The GP maintains responsibility for ongoing clinical case management, ensuring continuity of care. The person receives priority access to care, is followed up actively by the psychologist and receives care through a flexible model of face to face and telephone consultations.
>
> The Interim Evaluation Report for this program indicates the services have been positively received, are attracting increasing numbers of referrals and are providing services to a different group of consumers to those normally seen by ATAPS services, hence complementing the general ATAPS program.
>
> As part of the pilot, participating allied mental health professionals were required to complete a suicide prevention training course developed by the Australian Psychological Society (APS) and delivered through participating GPNs.[49]

4.40 DoHA told the Committee the ATAPS suicide prevention pilot would not be expanded but that it would be 'continuing for another two years' incorporating a comprehensive evaluation. However DoHA indicated it was giving other Divisions of General Practice the capacity to opt into the program. Ms Colleen Krestensen of DoHA stated:

> We are building into our additional funding for ATAPS some additional service capacity for the rest of the divisions, which is about 100 divisions, to enable them to boost their capacity to provide more services to people who have presented to a GP or have been referred to ATAPS post a suicide or a self-harm attempt. [50]

Stepped care and accommodation services

4.41 The lack of appropriate accommodation for those at risk of suicide was frequently highlighted. The Psychotherapy and Counselling Federation of Australia described the number of ‘secure’ or gazetted beds available in ‘acute’ publicly funded residential facilities for adolescents as 'extremely inadequate'. They reported acutely suicidal adolescents have sometimes been admitted to adult psychiatric units. The AMA also noted the while people who are receiving (acute or inpatient) mental health

49 AGPN, *Submission 213*, p. 10.

50 Ms Colleen Krestensen, DoHA, *Proof Committee Hansard*, 18 May 2010, p. 29.

care for suicidal risk may improve in supported accommodation there was a lack of available spaces. This made the appropriate referral of persons at risk of suicide by treating GPs difficult.[51]

4.42 A common observation during the inquiry was the need for alternative and graded accommodation for people at risk of suicide or having a mental health crisis. For example AGPN argued that there was growing evidence that a 'stepped care' approach to mental health service delivery improves mental health outcomes, reduce costs and increases access to care.

> Stepped care models are those in which there are interventions of different levels of intensity, and consumers are assigned to the level of intervention that matches their needs. Care ranges from low to high intensity interventions… Stepped care can better tailor care to meet patients' needs and minimise unnecessarily intensive or invasive treatment.[52]

4.43 One of the projects proposed by the AISRP was for a full residential care facility where clinical specialists and support workers will care for people who have made an attempt at suicide. They described the 'Life House' as filling an important gap by '…offering a coordinated service, outside of the hospital setting, specifically designed to treat people who are suicidal and assist their families'. They commented:

> Research strongly suggests that individualised and coordinated care for first-time attempters in an appropriate environment is critical to providing an effective response and recovery. By providing at least 14 days of care at no charge, the Life House will fill the significant gap between hospital-based care and emergency room or outpatient care for people who are suicidal.[53]

4.44 SPA noted that services which provide one-off short-term accommodation in a supported non-medical environment can allow '…people with a mental illness who require urgent/emergent need to receive crisis stabilisation services in a staff-secure, safe, structured setting that is an alternative to hospitalisation'.[54]

4.45 Similarly a key recommendation of Mr Jim Snow was for the provision of flexible graded services for the mentally ill with alternatives based on care in the community, accommodation in houses, accommodation in larger supervised hostels with respite care arrangements, and accommodation in psychiatric hospitals depending on need. In particular supervised hostels could benefit those people who are able to live in the community but need occasional respite. He argued:

> Properly done, the cost of a flexible system of care for mental health patients would be reduced by greater efficiency, the avoidance of high

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51 AMA, *Submission 55*, p. 8.

52 AGPN, *Submission 213*, p. 11.

53 AISRP, *Submission 237*, p. 112. The Life House is discussed further in Chapter 8.

54 SPA, *Submission 121*, p. 56.

> police, hospital and other costs associated with suicide, suicide attempts, violence, family breakdown and delayed corrective action.[55]

4.46 The need for alternative accommodation options has also been recognised by community organisations. For example the Launceston-based Youth Suicide Action Group (YSAG) has created Time Out House which provides secure accommodation to young people from the age of 14 to 28 years of age at risk of suicide and self harm.[56]

4.47 The Mental Health Coordinating Council noted the Victorian Government funding for Prevention and Recovery Care services (PARC) which provide access to step-up/step-down bed based alternatives to hospital inpatient care showed the '…potential for step-up programs to reduce some of the impact on the acute inpatient services'.[57] Queensland Alliance also highlighted the recent state funding for a Time Out House youth initiative.

> That is about funding community organisations to offer safe, friendly and welcoming spaces. The whole purpose of that is an early intervention response, and the whole purpose of the place is that it is safe, friendly and welcoming—a mental health service that people actually want to access rather than one that you drag people to and that they then get a really bad experience of.[58]

4.48 DoHA noted that $1.6 billion was made available through COAG commencing next financial year to support the 1300 sub-acute beds. The range of target groups for these subacute beds included people with mental health needs coming in and out of hospital.[59]

Coordination of care

4.49 The coordination and continuity of care was seen as essential for persons at risk of suicide to prevent them 'falling between the gaps'. Repeatedly the Committee received personal stories which highlighted a lack of coordination of care between services. The Integrated Primary Mental Health Service of North East Victoria observed that difficulties 'routinely' arise in cross-jurisdictional activities involving emergency services and mental health services and assisting people who are at risk of suicide.[60] Similarly Lifeline Australia noted:

> Lifeline has seen examples of where a lack of coordinated care between services such as drug and alcohol, mental health, and hospitals can mean

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55 Mr Jim Snow, *Submission 17*, p. 3.

56 Ms Verity Tunevitsch, YSAG, *Proof Committee Hansard*, 20 May 2010, pp 1-2.

57 Ms Jenna Bateman, Mental Health Coordinating Council, *Committee Hansard*, 3 March 2010, p. 9.

58 Mr Jeffery Cheverton, Queensland Alliance, *Committee Hansard*, 2 March 2010, p. 20.

59 Ms Rosemary Huxtable, DoHA, *Proof Committee Hansard*, 18 May 2010, p. 43.

60 Integrated Primary Mental Health Service of North East Victoria, *Submission 26*, p. 5.

> that people at risk of suicide do not receive appropriate and holistic care and intervention. Such a lack of cohesion in the health sector can mean that people requiring help 'fall through the gaps' and the onus of responsibility and care is left to friends, family, or carers.[61]

4.50 The Psychotherapy and Counselling Federation of Australia stated that where their members were already involved with a patient they 'report not being included in plans for support following discharge and, for example not being copied into discharge plans and not receiving advice regarding the follow up care that is needed'. They noted:

> Patients can be discharged quite suddenly without the hospital notifying families or the counsellor/psychotherapist involved. This is not effective and discourages clients from seeking further help.[62]

4.51 Mr John Dalgleish of Boystown stated that the reasons for lack of coordination appear varied:

> In the community sector and health sector there still seem to be artificial silos and barriers to coordination. People have different frameworks for intervention, people have different language and different culture. People do not know what services exist in their local community. All those things add up to a lack of coordination.[63]

4.52 The Suicide is Preventable submission highlighted the results of the *Tracking Tragedy* report which included the examination of suicide deaths of patients in community mental health settings. Concerns were raised in this report regarding gaps in assessment documentation, deficient duration and continuity of care, and poor ongoing risk monitoring.

> 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.[64]

4.53 The SPA Position Statement on Crisis Response noted that GPs generally refer suicidal patients needing acute or community care to emergency departments rather than directly to rather than directly to inpatient or community services.[65] SPA suggested one way of ensuring greater continuity of care may be to develop working partnerships between emergency mental health services and crisis hotlines.

> Such care extends beyond the boundaries of the traditional health and mental health care systems. Crisis hotlines also provide relatively low-cost,

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61 Lifeline Australia, *Submission 129*, p. 38.

62 Psychotherapy and Counselling Federation of Australia, *Submission 72*, p. 4.

63 Mr John Dalgleish, Boystown, *Committee Hansard*, 2 March 2010, pp 2-3.

64 Suicide is Preventable, *Submission 65*, p. 83.

65 SPA, *Position Statement: Crisis Response and the Role of Emergency Services and First Responders to Suicide and Suicide Attempts*, June 2010, p. 10.

> effective services to individuals seriously contemplating suicide and are available to all regardless of geographical barriers, appointment availability, or ability to pay.[66]

4.54 The AGPN argued there should be better greater efforts to link people who have attempted suicide to community based primary mental health care following discharge from tertiary services to avoid patients at risk of suicide 'falling into the gaps' between services. They highlighted two key programs: the *Better Outcomes in Mental Health Care* initiative and the *Better Access to Psychiatrists and General Practitioners through the Medicare Benefits Schedule* program. The AGPN stated:

> These programs have increased the capacity of primary health care professionals to more effectively respond to and treat mental health problems by driving uptake of mental health education and training, providing additional referral channels from general practice to mental health specialists, and access to psychiatrist advice.[67]

4.55 It was noted that the transport of suicidal patients by police to psychiatric services or emergency departments can be difficult due to a lack of clarity regarding responsibility for patient safety and supervision. 'Handovers' were seen as a time of particular risk for patients at risk of suicide. The SPA position statement on crisis response highlighted the memorandum of understanding between the NSW Health, the NSW Ambulance Service and the NSW Police as an example of an effective measure to promote safe and coordinated systems of care.[68]

4.56 The Committee also heard of good examples of cooperation and coordination between public agencies and community organisations. For example Ms Dulcie Bird of the Dr Edward Koch Foundation told the Committee:

> The life bereavement service has a memorandum of understanding signed with the Queensland Police Service. It incorporates a faxback referral system, which requires that a Queensland police officer who is attending any unexpected death offers the support of our life bereavement support service to the person bereaved. A person agreeing to this signs the faxback referral assistance request, the police officer faxes it to us and we are able to go out and see these people.[69]

66 SPA, *Submission 121*, p. 41.

67 AGPN, *Submission 213*, p. 7.

68 SPA, *Position Statement: Crisis Response and the Role of Emergency Services and First Responders to Suicide and Suicide Attempts*, June 2010, p. 11.

69 Ms Dulcie Bird, Dr Edward Koch Foundation, *Committee Hansard*, 2 March 2010, p. 31.

Patient information and privacy

4.57 An issue frequently raised in submissions related to the level of access family members should have to the patient information of a person at risk of suicide.[70] Often bereaved family members were frustrated they had not been informed of significant events, for example when a patient had been discharged from a healthcare facility or if the medication of a person had been altered. Lifeline Australia noted that when privacy policies prevent contact with other members of a patient's family '…important information which could be vital to the treatment of the patient is lost'.[71] Similarly Ms Fatima Clark of the White Wreath Association argued:

> Confidentiality and privacy must not be allowed to cause loss of life. Commonsense, natural justice and good professional practice dictate that the preservation of life is of paramount consideration. Doctors and psychiatrists must involve families and use their knowledge and opinion to help fight this epidemic as they would with any other life-threatening condition.[72]

4.58 The balance between patient privacy, family access and risk is reflected in a number of areas. The AMA Code of Ethics states that doctors have an obligation to maintain a patient's confidentiality and exceptions to this must be taken seriously. These include where '…there is serious risk to the patient or another person… or where there are overwhelming societal interests'.[73] The National Privacy Principles also provides that organisations which provide health services must not disclose the health information of an individual. Exceptions include where the organisation reasonably believes that the use or disclosure is necessary to lessen or prevent a serious and imminent threat to an individual's life, health or safety.[74] The Committee was also referred to the NSW *Mental Health Act 2007* which includes recognition that carers and family members need greater access to information about the consumer and also giving some control to the patient regarding who can be provided with information.[75]

4.59 Mr Michael Barnes, the Queensland Coroner, also highlighted the refusal of mental health practitioners to involve families in treatment decisions for patient as an area of concern. He suggested greater use be made of advanced health directives and

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70 For example Mr Jim Snow, *Submission 17*, p. 1; SOS Survivors of Suicide Bereavement Support Association, *Submission 106*, p. 2.

71 Lifeline Australia, *Submission 129*, p. 19.

72 Ms Fatima Clark, White Wreath Association, *Committee Hansard*, 2 March 2010, p. 25.

73 *AMA Code of Ethics*, 2006, 1.1 (l).

74 *National Privacy Principles*, Principle 2.1.

75 Mr Peter Dodd, Public Interest Advocacy Centre, *Committee Hansard*, 3 March 2010, p. 73.

other standing powers of attorney to authorise the disclosure of patient information to family members.[76]

4.60 Poor information sharing practices between healthcare services and practitioners was also often highlighted during the inquiry. The Suicide is Preventable submission recommended that the Commonwealth, through the National e-Health Strategy, lead efforts to improve collaboration and information sharing and surveillance between and among systems of care for all patients but particularly for those with severe or persistent mental illness (SPMI). They stated:

> 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.[77]

Pharmacological issues

4.61 Different forms of medication were seen as an important method of reducing suicides during the inquiry, particularly antidepressants. In 2005, Professor Robert Goldney's review of recent studies into suicide prevention included positive assessments of effectiveness of psychotropic drugs in decreasing rates of suicide and suicidal behaviour for patients with a range of mental health conditions. These included anti-depressants, mood stabilisers and antipsychotic medication.[78]

4.62 The importance of closely supervising patients with a mental illness commencing or changing medications was highlighted during the inquiry.[79] This was seen as a particular period of high risk. The Suicide is Preventable submission noted that ' 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'.[80]

4.63 The Committee also received conflicting evidence regarding the dangers and efficacy of patients being prescribed two forms of antidepressants simultaneously. Professor David Horgan argued that despite overseas practices in relation to combination antidepressants the practice in Australia '…is to take the patient off that antidepressant, which, unfortunately, means the illness is going to come back again, and to start them on the next one in the hope that the next one will lock on'.[81] However

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76 Mr Michael Barnes, *Proof Committee Hansard* , 18 May 2010, p. 52.

77 Suicide is Preventable, *Submission 65*, p. 27.

78 Robert Goldney, 'Suicide prevention: A pragmatic review of recent studies', *Crisis: Journal of Crisis Intervention and Suicide Prevention*, 2005, vol. 26, no.3, pp 133-134.

79 Mr Jim Snow, *Submission 17*, p. 2.

80 Suicide is Preventable, *Submission 65*, p. 86.

81 Professor David Horgan, Australian Suicide Prevention Foundation, *Committee Hansard*, 4 March 2010, p. 7.

Dr Watson from RANZCP commented the all medications have side effects and 'combinations of drugs have combinations of side effects'. He stated '…the research around combination antidepressants and its relative safety is markedly limited'.[82]

Suicide awareness and assistance training

4.64 The Committee received many recommendations during the inquiry for suicide prevention training to be more wide spread amongst healthcare professionals, government agencies and the general community. Recommendations were also received which suggested mental health first aid and suicide prevention training should be subsidised to encourage broader participation and access.[83] The Suicide is Preventable submission stated that suicide prevention and intervention training and education for frontline workers or 'gatekeepers' (for example. emergency workers, health care workers, GPs.) has been shown to reduce suicide rates.[84] It recommended the development of 'accredited and fully evaluated training programs for front line staff in a range of settings… to better enable staff to identify and support those who are vulnerable or at risk'.[85]

4.65 RANZCP and others also identified 'gatekeepers' in the communities '…whose contact with potentially vulnerable populations provides an opportunity to identify at-risk individuals and direct them to appropriate assessment and treatment'. These included include clergy, first responders, pharmacists, geriatric caregivers, personnel staff, and those employed in institutional settings, such as schools, prisons, and the military. Large scale evaluations of gatekeeper training in institutional settings such as the US Air Force suggest this approach can be an effective in lowering suicide rates.[86]

4.66 Ms Jacinta Hawgood of AISRP noted the education and training of GPs was one of the demonstrated ways of preventing suicide. She stated:

> Training usually takes the form of targeting, at a gatekeeper level, allied health professionals, community workers, including emergency workers, and/or targeting GPs. Since there is evidence about the effectiveness of this particular initiative, we often ask the question: why do we not invest more in this initiative?[87]

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82 Dr Darryl Watson, RANZCP, *Committee Hansard*, 4 March 2010, p. 75.

83 For example MMHC, *Submission 93*, p. 11; Ms Verity Tunevitsch, YSAG, *Proof Committee Hansard*, 20 May 2010, p. 5.

84 Suicide is Preventable, *Submission 65*, p. 82.

85 Suicide is Preventable, *Submission 65*, p. 26.

86 RANZCP, *Submission 47*, pp 13-14.

87 Ms Jacinta Hawgood, AISRP, *Committee Hansard*, 18 May 2010, p. 12.

4.67 Lifeline Australia argued that competence in role appropriate suicide intervention knowledge and skills should be a foundational requirement for front-line health and community workers providing services to persons at risk of suicide. However it noted that 'systematic suicide intervention training to agreed standards across sectors, among emergency services personnel, and within professions has yet to be realised'.[88]

4.68 The Salvation Army stated 'there is no doubt' that suicide prevention training raises the confidence of frontline and community workers in intervening to support people who are at risk of suicide. They considered it was imperative that all workers in community services are able to understand and recognise warning signs and know how to take action to get people the assistance they need.[89]

Suicide prevention training programs

4.69 A range of different models of suicide prevention training were outlined during the inquiry. Some focused on health care professionals or community workers while others were aimed at members of public.

4.70 The Lifeline Australia LivingWorks program delivers both safeTALK and the ASIST (Applied Suicide Intervention Skills Training). They commented:

> Whereas ASIST prepares people to engage more fully with suicidal persons to review their risk and develop and mobilise a safety plan, safeTALK enables a briefer engagement – recognising risk, reaching out and enabling referral. These two programs can potentially work together within an organisational or community setting.[90]

4.71 The AGPN recommended the SQUARE education and support package as a useful resource for GPs and other frontline workers providing services to people at risk.[91] DoHA stated:

> ….important work has been done to increase the capacity of primary care clinicians to work with patients who are experiencing suicidality, most notably through the development and dissemination of the SQUARE (Suicide QUestions, Answers and REsources) resources developed by the South Australian Division of General Practice and Relationships Australia SA with joint funding from the NSPP and the South Australian Government.[92]

4.72 The Kentish Regional Clinic also outlined their CORES (Community Response to Eliminating Suicide) training program which has provided services to 25

88 Lifeline Australia, *Submission 129*, p. 47.

89 Salvation Army, *Submission 142*, p. 37.

90 Lifeline Australia, *Submission 129*, p. 52.

91 AGPN, *Submission 213*, p. 9.

92 DoHA, *Submission 202*, p. 61.

communities around Australia. The CORES model is based around a community package which delivers one-day suicide intervention training to members of different communities with local volunteer team leaders trained to deliver the program and 'champion' the training locally. Communities are then responsible for shaping the way the program is delivered in the future.[93]

4.73 The Salvation Army referred to the online suicide prevention training course which they deliver called QPR (Question, Persuade, Refer). The one hour QPR training includes myths and facts about suicide, warning signs of suicide, applying QPR and how to offer hope and support.[94]

4.74 It was also recommended that suicide awareness training should be as accessible and promoted as First Aid courses for the public.[95] A Lifeline telephone counselling trainee told the Committee about her significantly increased ability to provide appropriate support to a friend who was considering ending their life after completing an ASIST suicide intervention course:

> This leads me to two points: one, is that having recently been made aware of a practical model for responding to this distressing and confronting situation gave me infinitely better resources for coping, and hopefully helping, than I would have had a month previously…. Secondly, I wondered at the time if my friend sought me out to talk to about their situation because they knew I was doing the suicide intervention course…Perhaps they thought that I would be not afraid to talk about this confronting topic. Most people would have few or no people in their life that they would feel comfortable openly sharing pain this dark with, as it changes the nature of a relationship, and talk about mental illness and death by suicide is highly stigmatised…Any strategies that lead to people having a greater number of safe avenues for dialogue with someone else about how they are feeling can only be positive.[96]

Conclusion

Suicide prevention roles

4.75 The role of staff in primary care, law enforcement and emergency services and care was seen as vital to the detection and treatment of persons at risk of suicide and care for bereaved families. The Committee considers it is necessary for staff in these areas to receive broad suicide prevention training which is assessed, updated and maintained.

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93 Kentish Regional Clinic, *Submission 40*, p. 3.

94 Salvation Army, *Submission 142*, p. 9.

95 Frances, *Submission 18*, p. 2; Professor Nicolas Allan, *Committee Hansard*, 4 March 2010, p. 98.

96 Frances, *Submission 18*, p. 2.

4.76 Any person who seeks assistance because of suicidal ideation or following a suicide attempt should be taken seriously and treated appropriately. In the view of the Committee is important that there is at least one person in each emergency department with the mental health training and capacity to conduct suicide risk assessments and referral for persons who may be suicidal.

4.77 Front line staff often encounter confronting and stressful situations which involve suicide and attempted suicide. Adequate support, debriefing and counselling services should be made available to these key personnel to access.

Recommendation 8

4.78 The Committee recommends that Commonwealth, State and Territory governments ensure that staff in primary care, law enforcement and emergency services receive mandatory and customised suicide risk assessment, prevention and awareness training as part of their initial training and ongoing professional development.

Recommendation 9

4.79 The Committee recommends that Commonwealth, State and Territory governments mandate that hospital emergency departments maintain at least one person with mental health training and capacity to conduct suicide risk assessments at all times.

Recommendation 10

4.80 The Committee recommends that Commonwealth, State and Territory governments review debriefing procedures and counselling support available to frontline workers regularly exposed to suicide and attempted suicide related incidents.

Discharge and follow up

4.81 The period following discharge from mental health services or hospital following psychiatric care or an attempted suicide was recognised as critical during the inquiry. Discharging persons who have attempted suicide or are at risk of suicide without providing follow up support or referral to appropriate services appears to the Committee a breach of duty of care. The Committee considers everyone should have a well resourced and supported care plan when being discharged from hospital or psychiatric care if they are assessed as having been at risk of suicide.

Recommendation 11

4.82 The Committee recommends that Commonwealth, State and Territory governments establish mandatory procedures to provide follow up support to persons who have been in psychiatric care, have been treated following an attempted suicide or who are assessed as being at risk of suicide.

Coordination of care

4.83 The Committee heard many personal stories of people at risk of suicide 'falling through the gaps' between services because of lack of coordination between agencies and service providers. The coordination and collaboration of agencies and services such as law enforcement, emergency care, mental health services, primary care, telephone crisis support services and community organisation is essential in providing continuity of care for people at risk of suicide.

Recommendation 12

4.84 The Committee recommends that Commonwealth, State and Territory governments provide funding for programs to identify and link agencies and services involved in the care of persons at risk of suicide. These programs should aim to implement agreements and protocols between police, hospitals, mental health services, telephone crisis support services and community organisations and to improve:

- **awareness by different personnel of suicide prevention roles and expectations; and**
- **handover procedures and continuity of care for persons at risk of suicide.**

Stepped accommodation

4.85 The need for graded or stepped accommodation and alternatives to acute inpatient care for people at risk of suicide and people with severe mental illness was emphasised during the inquiry. The Committee notes some governments are providing some funding for subacute accommodation and other alternatives. However the Committee considers further investment in this area is necessary and has the potential to significantly assist people who have attempted or who are assessed as being at risk of suicide. The Committee also received evidence that closely supervised accommodation may be necessary where patients change their medication as this was a period of increased risk for suicide.

Recommendation 13

4.86 The Committee recommends that Commonwealth, State and Territory governments provide additional funding for graded accommodation options for people at risk of suicide and people with severe mental illness.

Patient privacy

4.87 The Committee recognises the difficult balance that must be maintained between persons at risk of suicide (who can often suffer from a mental illness) and rules regarding the privacy of patient information. There does not appear to be an easy solution to this problem. Any significant changes to patient privacy could potentially lead to patients not feeling comfortable or able to entrust medical information to their doctors. The Committee considers that medical practitioners should recognise the

benefits of family involvement in the treatment and care of patients as well as the possible use of waivers of privacy where the patient is willing to give consent.

Recommendation 14

4.88 The Committee recommends that the Australian governments oblige health care staff to offer prior consent agreements, such as advance health directives and standing medical powers of attorney, to patients at risk of suicide.

Training

4.89 Training issues have been recognised in the *Fourth National Mental Health Plan.* One of the Prevention and Early Intervention National Actions is to 'provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors'. It states:

> Supporting these groups to better understand and recognise mental illness and to know how to react to individuals during an acute episode of illness or suicidal behaviour will improve earlier intervention and bring better outcomes for individuals and their families. Workers that are particularly important include police, ambulance, child protection workers, correctional services staff, employment support officers, pharmacists, residential aged care workers and teachers.[97]

4.90 The Committee considers it is appropriate for Australian governments to provide leadership in this area through providing suicide prevention training to their frontline staff. This would also function to improve understanding and awareness of suicide in community.

Recommendation 15

4.91 The Committee recommends that Commonwealth, State and Territory governments provide accredited suicide prevention training to all 'front line' staff, including those in heath care, law enforcement, corrections, social security, employment services, family and child services, education and aged care.

4.92 Increasing the number of persons with suicide prevention training was seen as having a number of benefits during the inquiry. These benefits included the improving the opportunities for someone at risk of suicide to be detected and assisted and building community awareness and understanding about suicide. Better training is a suicide prevention strategy with a supportive evidence base.

4.93 The NSPP already grants funding to a number of projects which provide suicide prevention training such as the CORES program. The Committee considers there is scope for this access to suicide prevention and awareness training to be

97 DoHA, *Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009- 2014*, p. 35

extended. Several community organisations noted the cost of suicide prevention training and mental health first aid training was a disincentive to participation.

Recommendation 16

4.94 The Committee recommends that the National Suicide Prevention Strategy promote and provide increased access for community organisation and the general community to appropriate suicide prevention training programs.

CHAPTER 5

PUBLIC AWARENESS CAMPAIGNS

Introduction

5.1 This chapter deals with term of reference (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. It will also address the related issues of the community stigma concerning suicide and the reporting of suicide in the media.

Awareness in the community

> A mother whose daughter died by suicide, talked about her anger at seeing everything turning pink in October. "Why can't the community have the same reaction and response to suicide?"[1]

5.2 The Committee heard great concern about the lack of awareness about suicide that currently exists in the Australian community. For example, the State Coroner of SA, Mr Mark Johns, was one of a number of persons who commented on the common lack of awareness of the 'reality' suicide in the general public.[2]

5.3 The Salvation Army outlined the results of a Roy Morgan survey commissioned to examine the level of community awareness about suicide and to gauge knowledge levels in the community regarding how to help a person who may be contemplating suicide. While 80 per cent of the survey respondents were not aware of the level of suicide in Australia, over 64 per cent stated they had known someone who had died by suicide. Around 24 per cent did not know any services or organisations in the community that provide support for people who are suicidal.[3] The Salvation Army therefore commented:

> The results of the survey confirm our belief that there is still a sense of ignorance about the full extent of suicide in Australia. We know that more people die by suicide in a single year than through road trauma and yet the awareness levels of the issues surrounding these two social issues in Australia is vastly different. We are constantly reminded through public awareness campaigns about the extent of the road toll and how we can remain safe on our roads and yet the issue of suicide remains shrouded in

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1 Referring to October which is National Breast Cancer Awareness Month, and pink ribbons which are used to signify breast cancer awareness; Lifeline Newcastle Hunter, *Submission 8*, p. 4.

2 Mr Mark Johns, *Proof Committee Hansard*, 4 May 2010, p. 1.

3 Salvation Army, *Submission 142*, pp 31-32.

> mystery and seems to be seen as an individual issue and not fully recognised as the public health issue that it is.[4]

5.4 SPA submitted to the Committee that a lack of awareness in the community has also resulted in the existence of damaging misconceptions about suicide. These include 'if they talk about it, they won't do it'; 'talking about it gives people ideas'; 'not much can be done to prevent it, as people who are serious about it will do it no matter what anyone tries to do'.[5] SPA also directed the Committee to literature and stakeholder consultations that indicate a perception that suicide is only a medical problem or a response to mental illness. SPA stated that this misconception ignores the complexities of suicide, and the many 'social determinants of suicide and self-harm in Australia'.[6]

5.5 The Committee heard that improved awareness about suicide is important to ensure that suicidal cues are identified and support can be provided:

> A person who is suicidal may not be in the best position to be seeking the help…As a community, Australians need to ensure that when someone does reach out for help, they are linked with someone who is equipped to provide them with appropriate support. In order to do this, the Australian community needs a basic knowledge of what signs of suicidality to look out for, how to have safe conversations around suicide, and how to access appropriate help.[7]

5.6 Dr Darryl Watson from the RANZCP told the Committee that good awareness about suicide was particularly important in some occupations:

> People working in education, social security and community services often see people in distress. Improved awareness of suicide risk factors and education to reduce stigma can be broadly targeted in this area. Mental health literacy should be a key skill.[8]

5.7 Submissions also presented a strong view that there is a need to 'promote openness, acknowledgement and understanding of suicide in the community',[9] in order to overcome misunderstandings and encourage the Australian community to become involved in suicide prevention.

> We need to break down the barriers so that the community will get involved, so that it will start taking an interest or offer its support or its

4 Salvation Army, *Submission 142*, p. 32.

5 SPA, *Submission 121*, p. 45.

6 SPA, *Submission 121*, p. 44.

7 Lifeline Australia, *Submission 129*, p. 18

8 Dr Darryl Watson, RANZCP, *Committee Hansard*, 4 March 2010, p. 4.

9 Lifeline Australia, *Submission 129*, pp 10-11.

> help. Breaking down the barriers will by definition reduce the rate of suicide in Australia.[10]

5.8 Improving public awareness was not necessarily seen as straightforward however, with submissions highlighting research by Professor Robert Goldney and Ms Laura Fisher which examined initiatives in Australia between 1998 and 2004 to enhance public and professional knowledge about mental orders, particularly depression. This study found that while these initiatives had improved mental health literacy and help seeking, there was less change for those most in need of intervention (those with major depression and suicidal ideation).[11]

Stigma

5.9 A number of submissions presented serious concerns about the lack of conversation, the "silence" and the stigma that exists around suicide in the Australian community. Many submissions consider that the lack of awareness and understanding about suicide contributes to this stigma:

> Across Australia, there is poor awareness and understanding of the risk factors and warning signs for suicide and the most appropriate responses or actions to take to prevent suicide or following a suicide event. This can lead to feelings of stigma and shame for people bereaved by suicide and reduce their capacity or willingness to seek help and support.[12]

5.10 Lifeline Australia also commented that 'ignorance, stigma, fear and uncertainly about what to say or do clearly remain barriers to the provision of support by community members when a suicide occurs'.[13] Ms Kate Matherson provided an insight into the stigma that exists for people who experience suicidal ideation:

> The stigma that surrounds depression and suicide makes it hard for one to ever return to the somewhat normal life that they may have had before, it makes them feel ashamed, unworthy, disgusting, different and alienated all things I have experienced recently.[14]

5.11 Similarly, SPA presented to the Committee a large number of alarming personal stories they had received that were associated with the experience of social stigma around suicide.

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10 Mr Darrin Larney, SOS Survivors of Suicide Bereavement Support Association Inc., *Committee Hansard*, 2 March 2010, p. 30.

11 Robert Goldney and Laura Fisher, 'Have Broad-Based Community and Professional Education Programs Influenced Mental Health Literacy and Treatment Seeking of those with Major Depression and Suicidal Ideation?', *Suicide and Life-Threatening Behaviour*, 2008, p. 129.

12 United Synergies, *Submission 141*, p. 4.

13 Lifeline Australia, *Submission 129*, p. 21.

14 Ms Kate Matherson, *Submission 194*, [p.1]

> For a long time I felt intense embarrassment… about attempting to commit suicide…I found that suicide was still very much a taboo issue within society and I felt guilt and shame associated with it. It would be great if we could be more open and honest about this issue within society as it affects many people. Perhaps if we could speak more freely and honestly, we could prevent the devastation caused by suicide.
>
> We live a daily horror that we can't share or discuss with anyone else… I feel like I am on a merry-go-round that will not stop and I cannot get off.[15]

5.12 Queensland Alliance further argued that stigma, particularly that which is associated with mental health issues, is not only about attitudes in the broader community but also self-stigma and 'internalised discrimination':

> …they identify themselves as an illness. 'Hi, I've got schizophrenia and my name's John.' They are very focused on what their diagnosis term is and forget that there is a human being in there that is valuable and can contribute to a community. [16]
>
> It is internalised discrimination. There are a lot of people with mental illness out there running the country, but they are not going to tell us. That is discrimination, that is stigma. Similarly, in business and with people who you are working with, as soon as you start going down that mental health path, men, and I think women as well, are just like, 'No way, I might be a bit odd, or I might be feeling down, but I'm not crazy!' It acts as a barrier to people seeking help and telling their wife, husband, friends, workmates.[17]

5.13 Submitters noted considerable efforts to increase mental health literacy in the Australian community, recognising the significant relationship between mental health issues and suicide. However, it was presented to the Committee that despite large-scale mental health awareness-raising campaigns such as Beyondblue, there have been far fewer attempts to raise community awareness about suicide.[18]

5.14 Professor Diego De Leo, in discussing the approach of the Life house project for suicide prevention, further outlined the need to focus awareness-raising efforts on suicide, not just mental health. He stated:

> One of the key issues is that when a suicide attempter…If I mingle with people like me I can hope to be understood. But if I am with other people – a psychotic guy, a bipolar a panic attack and severely disordered et cetera – I will be the most stigmatised of the patients.[19]

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15 SPA, *Submission 121*, p. 20.

16 Ms Judith Bugeja, Queensland Alliance, *Committee Hansard*, 2 March 2010, p. 22.

17 Mr Jeffery Cheverton, Queensland Alliance, *Committee Hansard*, 2 March 2010, p. 22.

18 SPA, *Submission 121*, pp 18 & 44; Ms Joanne Riley, SPA, *Committee Hansard*, 1 March 2010, p. 28.

19 Professor Diego De Leo, AISRP, *Proof Committee Hansard*, 18 May 2010, p. 18.

Stigma and help-seeking

5.15 Many submitters expressed a strong view that the stigma that is associated with suicide acts as significant barrier for people to seek help, and contributes to an experience of discrimination from health professionals, community members and peers.[20] The Suicide is Preventable submission also argued that the fear of being stigmatised contributes to many who attempt suicide failing to seek help from health care professionals, and less than half receiving medical attention.[21]

5.16 Mr David Crosbie from the MHCA also commented:

> It is my belief that there are many suicide attempts that we do not see, we do not record and we do not intervene in. I am not sure of the exact number; I know there are estimates, but I think there is still very much a stigma, a barrier, to people acknowledging that they are experiencing mental health issues or feeling suicidal, which means that people can go through a process of making a decision to suicide, attempting suicide, recovering from that suicide and people around them do not know…It is really frightening that people can go through that whole process and there is no point of intervention, no service or acceptance that that is needed.[22]

5.17 Clinical Associate Professor David Horgan from the Australian Suicide Prevention Foundation also noted that given the effect of stigma in discouraging people to seek help and the difficulty in overcoming this stigma, treatment and intervention should be sensitive to this issue, and provide people with support that 'does not stigmatise them any further'.[23]

Stigma and bereavement

5.18 The Committee heard that the stigma and "taboo" that exists around suicide significantly affects the bereaved and their recovery process, including cases of 'complete isolation of individuals during the period immediately following the suicide or suicide attempt'.[24]

5.19 SPA told the Committee that the misunderstandings about suicide, and the isolation, shame or social stigma experienced by those who have been bereaved by suicide 'can detrimentally impact a bereaved person's sense of self-worth and can result in a general reluctance towards help-seeking and any discussion of their clinical

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20 For example SPA, *Submission 121*, p. 7; Suicide is Preventable, *Submission 65*, p. 71.

21 Suicide is Preventable, *Submission 65*, p. 71.

22 Mr David Crosbie, MHCA, *Committee Hansard*, 1 March 2010, p. 19.

23 Clinical Associate Professor David Horgan, Australian Suicide Prevention Foundation, *Committee Hansard*, 4 March 2010, p. 3.

24 Suicide is Preventable, *Submission 65*, p. 42; See also SPA, *Submission 121*, p. 54.

needs, concerns and emotional experiences, which can have a number of negative follow-on effects'.[25]

5.20 The Committee heard a number of stories about suicides that have been "kept secret" or "covered up" because of shame or social stigma, and the inability of the bereaved to talk about it. Lifeline Australia further highlighted cases of suicide that have been labelled 'as "a heart attack" or similar, to prevent their community from knowing the real cause of death',[26] and cases discussed with local funeral directors where 'the families of people who have died by suicide have the funeral notice request funds to the "Cancer Foundation or Heart Foundation", so that the general public thinks that the person died as a result of these causes, and not from suicide'.[27]

Public discussion of suicide

> …my view is we must keep the conversation alive to keep the person alive. Peer support is critical; those that have attempted suicide and are here to share the experience of coming back from that choice are essential weapons of the power of their story to be given to those that believe there is no choice. [28]

5.21 The Committee received concerns about the difficulty that exists for people who have thoughts about or attempt suicide and those around them to talk about their experience, due to a lack of awareness and social stigma. It was recommended to the Committee that suicide prevention should include as a central element efforts to make it easier for 'future generations to discuss and address suicide', and to provide the community 'with the tools to recognise, acknowledge and prevent suicide'.[29]

5.22 The Suicide is Preventable submission noted that a Newspoll Omnibus Survey commissioned by Lifeline Australia had found a low proportion of respondents believe that those who were suicidal would tell someone about it. It was argued that this showed an investment 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.[30]

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25 SPA, *Submission 121*, p. 54.

26 Lifeline Australia, *Submission 129*, pp 20-21.

27 Lifeline Australia, *Submission 129*, p. 30.

28 SPA, *Submission 121*, p. 18.

29 Lifeline Australia, *Submission 129*, pp 20-21.

30 Suicide is Preventable, *Submission 65*, pp 13-14.

5.23 RANZCP, while recognising that reducing stigma associated with suicide and self-harm remains controversial, stated:

> Suicide should be able to be discussed without fear and, as part of public awareness programs, there is a need for debate on how to talk about suicide. This includes the need for those bereaved through suicide, and also suicide attempt survivors, to talk openly about their experiences.[31]

Suicide awareness programs

5.24 The NSPS, which is guided by the LIFE Framework adopts a 'whole of community approach to suicide prevention to extend and enhance public understanding of suicide and its causes'. Funding is provided through the NSPP for a variety of programs, many of which include suicide awareness raising activities.[32] For example, the Life Matters project delivered by Lifeline Newcastle Hunter (LLNH) conducted 36 suicide awareness presentations and two community forums provided to 465 participants.[33]

5.25 DoHA has informed the Committee that Commonwealth Government investment into suicide prevention activities has included training for frontline staff, early intervention and the promotion of help-seeking. DoHA also given evidence of other Commonwealth Government programs which 'play a significant role in upstream support for people who may be at risk of suicide'. This includes investment in mental health promotion and prevention activities such as Beyondblue, mental health programs targeting groups at high-risk of suicide such as the Mental Health Services for People in Rural and Remote areas initiative, Indigenous specific mental health programs and the Victorian bushfire mental health response.[34] DoHA informed the Committee that the NSPS and the NSPP have had 'significant and positive' impacts, and have included the creation of mental health programs which have lead to programs such as the Headspace Youth Mental Health Initiative.[35]

5.26 The NSPP also provides funding for the R U OK? Day which encourages Australians to connect with family and people in the community if they have concerns about their mental health and wellbeing through coordinated promotion and advertising.[36]

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31 RANZCP, *Submission 47*, p. 15.

32 DoHA, *Submission 202*, pp 25 & 28.

33 DoHA, *Submission 202*, Appendix D, p. 3.

34 DoHA, *Submission 202*, pp 22 & 74

35 DoHA, *Submission 202*, p. 72.

36 DoHA, *Submission 202*, Appendix D, p. 28.

5.27 SANE Australia commented to the Committee that programs that encourage help-seeking as soon as possible such as MindMatters, KidsMatters and the Headspace Youth Mental Health Initiative are also showing encouraging results.[37]

5.28 The Department of Veterans' Affairs (DVA) has informed the Committee of programs run for veterans and their families such as At Ease mental health awareness campaign which focuses on increasing awareness and education about the importance of mental health and self help management strategies, and The Right Mix health and alcohol promotion strategy that provides information to assist with choices around alcohol consumption and opportunities to reduce alcohol-related harm in the veteran community.[38]

5.29 Queensland Alliance also highlighted the VicHealth *Mental Health Promotion Framework* as a local example of a strategy that acknowledges the complexity and context of mental health issues for individuals.[39]

5.30 A strong feeling presented by submitters and witnesses was that DoHA and the programs implemented and funded under the NSPS did not adequately focus on raising public awareness about suicide through a coordinated approach, and that the Commonwealth Government had not taken a lead role in such matters to date.[40]

5.31 DoHA made the following comments:

> I will just say that the work plan – or what we call the action framework for what we and ASPAC (Australian Suicide Prevention Advisory Council) are doing does not have a specific heading around community awareness at the moment. I suppose it is not on our agenda to take froward in that respect. Clearly issues about reducing stigma and promoting help seeking – those kind of issues – are right there on the agenda and it overlaps with those issues.[41]

5.32 RANZCP commented that while there were some good campaigns that focus on suicide prevention, '…these are rarely supported by meaningful ongoing community supports other than crisis telephone lines'. They argued that suicide prevention awareness campaigns should not only focus on prevention, but also increase community awareness regarding treatment and support options, including the role of different mental health practitioners, in order to be beneficial for consumers, carers and their families.[42]

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37 SANE Australia, *Submission 97*, p. 3.

38 DVA, *Submission 215*, [p. 3]

39 Queensland Alliance, *Submission 122*, p. 3.

40 For example, Ms Jenna Bateman, Mental Health Coordinating Council, *Committee Hansard*, 3 March 2010, p. 1.

41 Ms Colleen Krestensen, DoHA, *Proof Committee Hansard*, 18 May 2010, p. 44.

42 RANZCP, *Submission 47*, p. 15.

5.33 The Kentish Regional Clinic recommended that a 'public awareness program is developed which directly addresses the issue of suicide and is not "hidden" under any other name and is treated as a stand alone issue'.[43]

Media guidelines and reporting

5.34 DOHA has told the Committee that as part of NSPS activities, the Commonwealth Government has worked with the media to improve the communication of key messages about mental illness and suicide prevention, in particular to develop media reporting guidelines through the MindFrame initiative that reduce the stigma of mental illness, encourage help-seeking and reduce copycat suicide.[44] The Committee received a significant amount of comment regarding media guidelines for the reporting of suicide.

5.35 The Suicide is Preventable submission notes that the way a suicide is reported can influence increases or decreases in suicide rates:

> 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…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.[45]

5.36 The MindFrame initiative was developed in 2000 and is funded through the NSPP. MindFrame is the primary source of guidance for media professionals and those who interact with the media. MindFrame aims to 'encourage responsible, accurate and sensitive media representation of mental illness and suicide, and to advocate on behalf of community concerns about media depictions that stigmatise mental illness or promote self-harm'.[46]

5.37 The key elements of the MindFrame initiative include: the Hunter Institute's MindFrame resources for media and other professionals; the SANE Australia Stimgawatch which monitors the Australian media to ensure accurate and respectful representation of mental illness and suicide; and the National Media and Mental Health Group which brings together media representatives with mental health professionals and the Commonwealth to develop strategies for improving media understanding and reporting of suicide and mental illness.[47]

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43 Kentish Regional Clinic, *Submission 40*, p. 7.

44 DoHA, *Submission 202*, p. 74

45 See Suicide is Preventable, *Submission 65*, p. 89.

46 DoHA, *Submission 202*, p. 37.

47 DoHA, *Submission 202*, p. 37.

5.38 The Committee was told by various witnesses that the MindFrame initiative is a well respected, important, and successful collaboration between the Australian Government, mental health advocates and the media industry 'to de-stigmatise mental illness and to influence public discussions about suicide and self harm'.[48]

5.39 DoHA also outlined two studies of the Media Monitoring Project to track reporting of suicide and mental illness in the Australian media, the first in 2000-01 and the second in 2006-07. The second study found a significant improvement in the quality of media reporting of these matters.[49]

> As a result of this engagement and the guidelines developed voluntarily with the media sector, Australia has seen significant improvements in both the quality of media reporting in these areas and the volume of publicly reported suicide cases. For example, recent research has shown that, between 2000-01 and 2006-07, there was a twofold increase in the number of media reports about suicide. Importantly, the study found that the quality of those reports also improved greatly, with significant reductions in the use of inappropriate language, details of method and images of the location or the body of the deceased and significant improvements in the provision of help-seeking information'.[50]

5.40 A tension has developed, however, between the recognised need to ensure responsible and accurate media representation of mental illness and suicide, and to increase public awareness and knowledge about the incidence of suicide in Australia.[51]

5.41 For example, the SA Coroner related the lack of public awareness about suicide to underreporting in the media, noting that 'the media is very nervous about the risk of copycatting and as a result…it (suicide) tends to be underexposed in the popular press'.[52] Similarly, SPA expressed concern that media guidelines could be 'interpreted as not to refer to suicide at all or to avoid suicide reporting' and that any reporting about suicide, including information about research, is avoided by popular media.[53]

5.42 Professor Patrick McGorry from Orygen Youth Health Research Centre told the Committee that underreporting of suicide in the media is linked to the stigma that exists within the community, and may impede efforts to reduce rates of suicide:

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48 Professor Ian Webster, *Submission 239*, p. 9; See also Ms Barbara Hocking, SANE Australia, *Committee Hansard*, 24 March 2010, p. 47.

49 DoHA, *Submission 202*, p. 38.

50 Ms Georgie Harman, *Committee Hansard,* 1 March 2010, p. 66.

51 DoHA, *Submission 202*, p. 75.

52 Mr Mark Johns, *Proof Committee Hansard,* 4 May 2010, p. 1; See also Consumer Advisory Group NSW, *Submission 85*, p. 15.

53 Dr Michael Dudley, SPA, *Committee Hansard,* 1 March 2010, p. 32; SPA, *Submission 121*, p.63.

> I think the fundamental problem with the suicide issue in Australia is the tremendous taboo and silence that surrounds it still. That is evident in…the issue of the media guidelines….
>
> But no-one has measured the death toll that arises from not talking about suicide and not reporting it in an active way, in the way that we report on the road toll…[54]

5.43 Similarly Mrs Jennifer Allen from Youth Focus Inc. argued that the restrictions on the media, and on educators, in discussing suicide could further the associated stigma:

> So I do understand why the media is nervous about addressing the issue of suicide, but not to talk about it all, pretty much, I think only reinforces the belief that it is wrong to talk about suicide. It makes people feel like they are alone…When we go into schools at the present time, we cannot mention the word suicide and we certainly cannot talk about self-harm event thought that is what we really need to do, because there is a lot of fear around: "Gosh, you're going to actually create it; you're going to encourage people to go and try self-harm". But how can we break down those stigmas if we are not actually hitting it head on?[55]

5.44 While recognising that some styles of reporting could result in "copy cat" acts or increased suicide, the Suicide is Preventable submission also argued that appropriate reporting can help to reduce incidences of suicide, citing evidence that '(r)eporting 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'.[56]

5.45 Ms Barbara Hocking noted therefore that 'we have to keep with our message that media presentation should be done responsibly and balanced against the public's right to know'.[57] The Committee was also told that the NCSRS have identified the need to more effectively 'communicate the positive actions being undertaken and the true state of suicide prevention' as a key area for future investigation, with a view to 'develop a communications strategy in consultation with the Mindframe Initiative. This strategy will ensure accurate, non-sensationalised information is provided to the media and all key stakeholders'.[58]

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54 Professor Patrick McGorry, Orygen Youth Health Research Centre, *Committee Hansard,* 4 March 2010, p. 79.

55 Mrs Jennifer Allen, Youth Focus Inc., *Committee Hansard,* 31 March 2010, p. 21.

56 Suicide is Preventable citing Australian Government, *Mindframe National Media Initiative,* 2006; and J. Purkis et al 'Changes in Media reporting of Suicide in Australia between 2000/01 and 2006/07', *Crisis: Journal of Crisis Intervention & Suicide*. 2009, vol. 30, no. 1, pp. 25-33.

57 Ms Barbara Hocking, SANE Australia, *Committee Hansard,* 24 March 2010, p. 48

58 NCSRS, *Submission 229,* p. 19.

5.46 Similarly, Orygen Youth Health Research Centre noted the intention and importance of media guidelines for the reporting of suicide, however recommended that the MindFrame initiative and current media reporting practices should now be reviewed to ensure that public discussion about suicide is not being inhibited. In particular, Orygen Youth Health Research Centre recommended that:

> Social networking sites such as My Space and Facebook are the means by which young people communicate. Such communication should not be discouraged; rather, healthy ways of using the internet for communication and information sharing need to be found and promoted. Such investigations need to form part of a national suicide prevention research agenda and the findings should inform a review of the current practice around media reporting.[59]

A National Suicide Awareness Campaign

5.47 A number of submitters and witnesses recommended to the Committee that a well-funded, long-term, national community awareness, anti-stigma and suicide prevention campaign should be developed and implemented.[60] The Suicide is Preventable submission recommended that a five-year national anti-stigma and suicide prevention awareness program (with a minimum budget of $10 million per year) was required 'to address existing community knowledge deficits and attitudes towards suicide'.[61]

5.48 Lifeline Australia suggested that such campaign should focus on reducing stigma by encouraging safe, open discussions of suicide, providing the Australian community with awareness about suicide warning signs, and providing information about options for seeking and providing help.[62]

5.49 It was strongly argued by submitters that there should also be a focus on overcoming public misunderstandings about suicide in an effort to reduce stigma.[63] Submissions noted the success of other health promotion and social awareness campaigns, including those for heart disease, breast cancer, diabetes, smoking related illnesses, HIV/AIDS, road trauma and Beyondblue which have made these issues

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59 Orygen Youth Health Research Centre, *Submission 82*, [p. 7].

60 For example Suicide Prevention Taskforce, *Submission 59*, pp.7-8; Suicide is Preventable, *Submission 65*, p. 135.

61 Suicide is Preventable, *Submission 65*, p. 134.

62 Lifeline Australia, *Submission 129*, p. 12.

63 Inspire Foundation, *Submission 101*, [pp 7 & 15]; SPA, *Submission 121*, p. 11.

'visible'.[64] As noted by one submitter these awareness campaigns 'also provide basic information to the community such as early warning signs and where to seek help'.[65]

5.50 The Committee was advised that in order to be effective, such a campaign must be sustained over time, well-funded, appropriately resourced and delivered through innovative and targeted mediums, including through new technology, to ensure comprehensive coverage.[66]

5.51 Mr Jeff Kennett, Chairman of Beyondblue told the Committee:

> You do not want a campaign just because it is an easy recommendation; you would want a campaign because you know that it was going to be consistently delivered – not just a media campaign but a campaign that is backed up by people who are out in the field, going to the town hall meetings and talking to media – for 10 years. It is a hard ask, and then you have to have people who are absolutely committed to it and for the right reasons.[67]

5.52 Recognising the complex social, cultural, economic, psychological and familial factors that can contribute to suicide, SPA identifies the need for a suicide awareness campaign to 'engage with and form connections with other relevant social agenda issues, including homelessness, bullying, and substance abuse (drugs and alcohol), and the impacts of ongoing challenges such as the global financial crisis and climate change'.[68]

5.53 SPA also recommended to the Committee that a way in which to address the social stigma associated with suicide, without glamorising suicide itself, is to give suicide a 'face' and encourage the personal stories of those involved in suicide prevention or postvention, including suicide attempt survivors and those bereaved by suicide.

> Maybe a way to demystify suicide is by telling real stories of how suicide affects people or an awareness of why suicide occurs in the first place? I think there is a tendency to want to ignore the specific grief and loss from suicide and I think these truths are not made apparent on a societal level…
>
> The topic of suicide needs to be taken out of the shadows. Make the people who die this way, come alive by telling their stories. Make them more than a statistic. Doing so would help to alleviate the unspoken sense of shame about [this] way of death…[69]

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64 For example, SPA, *Submission 121*, p. 45.

65 Frances, *Submission 18*, p.2;

66 Beyondblue, *Submission 48*, p.1; Suicide Prevention Taskforce, *Submission 59*, p. 6; *Committee Hansard*, Wednesday 31 March, p. 3.

67 Mr Jeff Kennett, Beyondblue, *Committee Hansard*, Thursday 4 March, p. 27.

68 SPA, *Submission 121*, p. 46.

69 SPA, *Submission 121*, p. 20.

Examples of suicide awareness programs

5.54 The Committee was directed to the LivingWorks program SuicideTALK as an example of life-promotion and suicide prevention activities for communities.[70] LLNH also submitted that feedback received for the LivingWorks, ASIST and safeTALK programs, Building Personal Resilience workshops and Seasons for Growth Adult workshop has clearly demonstrated a need for these programs, with participants grateful for the knowledge and skills they attained.[71]

5.55 Many submissions and witnesses referred the Committee to an overseas example of an 'exemplary' suicide awareness and prevention strategy: the *Choose Life: a national strategy and action plan to prevent suicide in Scotland,* developed as part of the *National Programme for Improving Mental Health and Wellbeing in Scotland*.[72]

5.56 Launched in December 2002, *Choose Life* is a ten year plan aimed at reducing suicides in Scotland by 20 per cent by the year 2013. The objectives of *Choose Life* include:

- Promoting greater public awareness raising and encouraging people to seek help early; and
- Supporting the media in reporting of suicide.[73]

5.57 The *Choose Life* website is designed to be a central portal of information about suicide prevention in Scotland, and helps to raise awareness among the general public about when and how to seek and provide support, and to correct misconceptions about suicide. The *Choose Life* strategy also includes the national 'Suicide. Don't hide it. Talk about it.' campaign which specifically targets the stigma associated with suicide. This campaign includes advertising and information materials, as well as advice about speaking to someone who may be suicidal.

5.58 The *Choose Life* strategy identifies that in order to reduce rates of suicide, action must take place across areas of disadvantage in society, including eradicating poverty, addressing social exclusion and inequality, and improving health and education opportunities.[74]

5.59 The *Choose Life* strategy particularly aims to reduce suicide and improve awareness about suicide and mental health from a community perspective. There are

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70 Lifeline Australia, *Submission 129*, pp 12-13

71 LLNH, *Submission 8*, p. 5.

72 Mr Jeffery Cheverton, Queensland Alliance, *Committee Hansard*, 2 March 2010, p. 21; MHCA, *Submission 212*, p. 10.

73 Choose Life: the national strategy and action plan to prevent suicide in Scotland, *About Choose Life*, http://www.chooselife.net/AboutChooseLife/AboutChooseLife.asp (accessed 2 June 2010)

74 Scottish Executive, *Choose life: A national strategy and action plan to prevent suicide in Scotland*, 2002, p. 14, Available: http://www.chooselife.net/web/FILES/Choose_Life.pdf

Local Choose Life Plans in 32 local areas, each implemented under the supervision of local Choose Life Coordinators.[75]

5.60 The Committee was also told that the US Air Force Suicide Prevention Program demonstrates the potential effectiveness of a comprehensive suicide prevention strategy that aims to reduce stigma within a community:

> the program's implementation was associated with a 33 per cent reduction in risk for suicide. Importantly, training was embedded in a whole-of-community strategy that targeted stigma (making it 'career enhancing' to seek help). It aimed to strengthen social networks, increase help-seeking behaviours and improve understanding of mental health. The initiative had an early intervention focus to identify problems before they escalated to potentially include suicide risk. It adopted community based, stress management strategies alongside medical services. Leadership support from all levels of the organisation was enlisted.[76]

Targeted awareness-raising programs

5.61 The Committee also heard strong evidence supporting the need for awareness-raising to be targeted to high-risk groups and communities that requires the consideration of particular sensitivities, including young people, people in rural and remote areas, men, Indigenous populations, the LGBTI and CALD communities.[77]

Young people

5.62 SPA told the Committee that a range of mental health issues and disorders present during adolescence and young adulthood.[78] Further, the Inspire Foundation refers to an 'almost-two-fold increase in rates of intentional self-harm, the increase of female youth suicide in 2007, and the even higher levels of male youth suicide' as evidence of the need to target efforts to reduce stigma and encourage help-seeking among young people.[79]

5.63 Inspire Foundation also presented to the Committee views from young people that community attitudes and stigma remained a major barrier in their help-seeking

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75 MHCA, *Submission 212*, pp 10-11; Choose Life: the national strategy and action plan to prevent suicide in Scotland, *Local Action Plans*, http://www.chooselife.net/xLCLP/LCLP_Home.asp (accessed 2 June 2010)

76 Lifeline Australia, *Submission 129*, p. 30.

77 See for example Suicide is Preventable, *Submission 65*, p. 19; SPA, *Submission 121*, p. 43

78 AMA, *Submission 65*, p. 3 citing Suicide Prevention Australia, *Position Statement on Mental Illness and Suicide*, 2009, http://suicidepreventionaust.org/PositionStatements.aspx#section-12

79 Inspire Foundation, *Submission 101*, p. 9.

behaviour.[80] In further evidence, it was highlighted to the Committee that the Office for Youth's report on the State of Australia's Young People national survey identified that social considerations including fear, embarrassment, stigma, confidentiality and self-perception created barriers that inhibited young people from seeking help with 'only one-fifth of teenagers with mental health problems seeking professional support'.[81]

5.64 As explained by the Inspire Foundation, the internet is 'a way of life' for young people, and the Committee particularly acknowledges the Inspire Foundation's ReachOut.com which 'looks to the internet for health promotion and prevention' and aims to 'provide young people with access to and online community and trusted information'.[82]

5.65 The Committee also notes research conducted by the Inspire Foundation, 'Breaking the Digital Divide', which found that many youth service providers 'lack the skills and confidence to provide support to young people using technology', and 'have a poor understanding of the role technology plays in young people's lives'. Recognising this, the 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'.[83]

People in rural and regional Australia

5.66 The Australian Medical Association told the committee:

> In Australia, rates of suicide and suicide attempts are higher in rural and remote populations, with very remote regions having suicide rates more than double that of major capital cities...social stigma appears to be a major inhibiting factor to seeking help in rural and remote communities...[84]

5.67 The Committee also repeatedly heard stories of stigma and concerns about confidentiality as a particular barrier to help-seeking in rural and remote communities. This was recognised in addition to a shortage of medical and health professionals in rural areas.

> Even where appropriate services are available, there may be a reluctance to seek help because it is seen as a sign of weakness...confidentiality cannot always be guaranteed in small communities to the same extent it can in the city and this is a major disincentive to seek help...[85]

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80 Inspire Foundation, *Submission 101,* [pp 19-20].

81 WA Commission for Children, *Submission 103,* [p.2]

82 Inspire Foundation, *Submission 101,* pp 22 & 25-26

83 Inspire Foundation, *Submission 101,* pp 25-26

84 AMA, Submission 55, p. 4.

85 HCRRA, *Submission 46;* [p.2]

> They (callers from regional and country areas) often report being afraid that others in their small communities 'find out' eg. 'My boss is the doctor and everyone says I'm strong and reliable', 'My friends might see me if I go to the doctors'...[86]

Men

5.68 The Committee heard a great deal of evidence that the incidence of suicide in men outnumbers suicide in women, and that men are more reluctant to seek help.[87]

5.69 For this reason, it was presented to the committee that there is a particular need to increase awareness and understanding about suicide among men in order to change attitudes towards seeking help.

> Given that 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...it is essential that the concept of 'help-seeking' is normalised among Australian men – starting at school and continuing across the lifespan.[88]

Indigenous Australians

5.70 The Committee heard that efforts to raise awareness about suicide in Indigenous communities will require particular cultural sensitivity. Ms Laurencia Grant from the Mental Health Association of Central Australia told the committee:

> The other issue is that suicide is a recent problem for Indigenous people here…it seems that it has been difficult for Aboriginal people to fit suicide into their cultural understanding.[89]

5.71 Ms Grant described to the committee the Life Promotion program that she manages, which aims to encourage discussion about suicide in Indigenous communities:

> Life Promotion…began to focus on developing resources that would be useful to work with Aboriginal people on the issue of suicide. Suicide Story is a training resource that was developed over time through this program and as a result of input from local people…It was driven from awareness that we needed to listen to how Aboriginal people understood this problem and what they were currently doing to support one another.[90]

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86 SOS Survivors of Suicide Bereavement Support Association Inc., *Submission 106*, [p. 1]

87 Beyondblue, *Submission 48*, p.8; Inspire Foundation, *Submission 101*, [p. 13]

88 SPA, *Submission 121*, p. 52.

89 Ms Laurencia Grant, Mental Health Association of Central Australia, *Proof Committee Hansard*, 17 May 2010, p. 3.

90 Ms Laurencia Grant, Mental Health Association of Central Australia, *Proof Committee Hansard*, 17 May 2010, p. 3.

CALD communities

5.72 A number of submitters told the committee that stigma around suicide is a particular issue in CALD communities and 'is a significant barrier to seeking help by those who may need suicide interventions and prevents family members left behind from being able to seek help within their own community…[91]

5.73 According to Multicultural Mental Health Australia (MMHA), the high degree of stigma that is associated with suicide and mental health in some cultural and religions communities can lead to 'shame', and social rejection for a person who has attempted suicide or bereaved persons, which can have further consequences for these individuals. This social pressure could result in, for example, family conflict or breakdown.[92]

5.74 The Public Advocacy Centre also submitted that people from refugee or non-english speaking backgrounds in Australia 'are likely to have come from countries where investigations of deaths may be conducted in an entirely different way to the model that Australia has inherited from the UK', and may therefore have a very different view about coronial processes, police and the criminal justice system.[93]

LGBTI communities

5.75 The committee has heard that it is also necessary to provide culturally sensitive and culturally specific support in order to improve suicide prevention and awareness in the LGBTI community.

5.76 SPA told the Committee that health and community services do not always have the appropriate awareness and training to deliver programs and health promotion to this group, and received the following personal story:

> Obviously, for me the counsellor or service I am dealing with needs to be open to my sexuality…My sexuality is not something I am prepared to hide in order to access help. This needs to be taken into account across all services. They need to be open to a variety of backgrounds and the staff need to leave their prejudices at the door.[94]

Issues for consideration

5.77 The Committee heard from a number of submitters that the use of internet-based technologies to increase public awareness about suicide could enable access to

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91 MMHA, *Submission 93*, [p. 11]. See also TMHC, *Submission 76*, [p. 3]; Australian Federation of International Students, *Submission 135*, p. 2.

92 MMHA, *Submission 93*, p. 6.

93 Public Interest Advocacy Centre, *Submission 34*, p. 12.

94 SPA, *Submission 121*, p. 50.

'hard to reach' groups, and could be of particular benefit in targeting young people.[95] The Committee particularly notes the work of the Inspire Foundation with ReachOut.com and Research Pro in this area. The Committee also heard that the internet enables the opportunity for convenient and anonymous access to information and support, including for those in geographically isolated areas.[96]

5.78 The Committee also received some concern about the incidence of 'cybersuicide' (attempted or completed suicide influenced by the internet), and the risk of young people seeking attention or recognition by referring to suicide and suicide ideation online.[97] Submitters noted that this risk of "glamorising" suicide must be managed carefully.

5.79 DOHA further told the Committee that there are some significant risks associated with efforts raise awareness about suicide:

> It is imperative to emphasise that, in the area of suicide prevention, there is the capacity to do harm – to unintentionally cause harm to those bereaved by suicide or even increase rates of suicide…[98]

5.80 SANE Australia also raised concerns that 'some well-intentioned projects to "raise awareness" have the capacity to engender anxiety, stress and thoughts of suicide and self harm'.[99] It was seen as important that efforts to raise community awareness and deliver a public message about suicide should be considered carefully, and there should be clarity about what that message should be, in order to avoid any adverse effects.[100]

5.81 The Committee further examined the fear that by raising awareness about suicide that it could become "normalised" or "glamorised", and considered as an acceptable thing to do. However, Lifeline explained to the committee:

> The clear evidence now is that talking about suicide does not people at risk of suicide, as long as the discussion and the conversation is done in a sensitive and careful way, that we are not sensationalising suicide, we are not glorifying it, we are not glamorised in it, because there is certainly nothing glamorous about it, but that it is spoken about in terms of how we keep people safe, that the impact of suicide is incredibly negative on family

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95 For example Suicide is Preventable, *Submission 65*, p. 135; Inspire Foundation, *Submission 101*, p. 22; Mr David Crosbie, MHRC, *Committee Hansard*, 1 March 2010, p. 21.

96 Suicide is Preventable, *Submission 65*, p. 135; See also Beyondblue, *Submission 48*, p.1.

97 See Suicide is Preventable, *Submission 65*, p. 88; Ms Barbara Hocking, SANE Australia, *Committee Hansard*, 24 March 2010, p. 50.

98 Ms Georgie Harman, DoHA, *Committee Hansard*, 1 March 2010, p. 66.

99 SANE Australia, *Submission 97*, p. 10.

100 Ms Colleen Krestensen, DoHA, *Committee Hansard*, 18 May 2010, p. 44; Mr Jeff Kennett, Beyondblue, *Committee Hansard*, 4 March 2010, p. 25.

> and friends and that every life is worth living and as a society we must do everything we can to help a person living and to find reasons to live….[101]
>
> The emphasis needs to be on normalising human experience, including misery, and normalising help-seeking and creating a community that promotes help-seeking.[102]

5.82 Professor McGorry from Orygen Youth Health Research Centre used the example of reporting road tolls:

> We do not report the road toll in a sensationalist way; we report it factually. We show the actual damage that is done to people's lives and to the lives of survivors.[103]

5.83 Similarly, the Inspire Foundation recommended that, like the release of statistics of road tolls that raises the public and political attention regarding road deaths, regular public reporting of statistics about suicide could help raise awareness about the extent of suicide in Australia and reduce stigma.[104]

5.84 Ms LeonieYoung from Beyondblue recommended that one way to overcome the risk of glamorising suicide in an awareness-raising campaign would be to avoid calling it a suicide prevention antistigma campaign. Referring to advice she had received during involvement in a campaign to reduce petrol sniffing in the Northern Territory, Ms Young explained:

> We had some funding for petrol sniffing, and she absolutely decried calling it 'petrol-sniffing' prevention or 'suicide prevention'. She said it is like a club; if you call it that, people will want to be part of it.[105]

5.85 It has been further submitted to the Committee that while there may be possible risks and social adjustment associated with raising awareness and attempting to increase public discussion about suicide, these risks must be considered against the impacts of stigma, that will continue to exist if the Australian public remain 'silent' on the issue:

> This silence around suicide inhibits our ability to teach people what to do when faced with a suicidal crisis, including where and how to seek effective help…To break this silence we believe we need to create not only an

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101 Ms Dawn O'Neil, Lifeline Australia, *Committee Hansard,* 1 March 2010, pp 11-12.

102 Mr Alan Woodward, Lifeline Australia, *Committee Hansard,* 1 March 2010, p. 12

103 Professor Patrick McGorry, Orygen Youth Health Research Centre, *Committee Hansard,* 4 March 2010, p. 79.

104 Inspire Foundation, *Submission 101,* [p. 15]

105 Ms Leonie Young, Beyondblue, *Committee Hansard,* 4 March 2010, p. 26; See also Professor Robert Donovan, Ministerial Council for Suicide Prevention, WA, *Committee Hansard,* 31 March 2010, p. 7.

> awareness of suicide but also a safe environment to talk openly and debate the issues…[106]
>
> Very well-meaning people say things that are inappropriate. There is risk, and we do need to be cognisant of that. But I think silence breeds stigma and stigma breeds silence and we have to break through that and be able to talk about suicide in a way that encourages people to understand it better, to seek help and to become more informed.[107]

Conclusion

5.86 The Committee notes the extensive evidence received about the stigma that exists around suicide in Australia, particularly as a result of a lack of public awareness and understanding about suicide and its risk factors.

5.87 The Committee further recognises that this stigma can have a detrimental impact on people's help-seeking behaviour, and the process of recovery for people who have attempted or considered suicide, or bereaved persons.

5.88 The Committee notes the considerable effort in recent times to increase mental health literacy in the Australian public through initiatives such as Beyondblue. The committee also notes programs and projects initiated through the NSPS such as Headspace.

5.89 The Committee considers that a national suicide awareness campaign which appropriately avoids stigmatising or sensationalising suicide, developed in consultation with community groups, would be beneficial in raising the profile of the issue of suicide and encouraging help-seeking behaviour by those at risk.

5.90 The Committee recognises that a national suicide awareness campaign should be a long-term and ongoing project that will require the commitment of significant resources for development, implementation and evaluation.

5.91 The Committee notes that risks associated with "normalising" or "glamorising" suicide must be carefully managed, and close consultation with stakeholder groups will be necessary.

Recommendation 17

5.92 The Committee recommends that the Commonwealth government fund a national suicide prevention and awareness campaign that provides information to all Australians about the risks and misconceptions of suicide, and advice on how to seek and provide help for those who may be dealing with these issues. This campaign should utilise a range of media, including television, radio, print

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106 Ms Joanne Riley, SPA, *Committee Hansard,* 1 March 2010, p. 29

107 Ms Susan Beaton, Lifeline Australia, *Committee Hansard,* 1 March 2010, p. 12

and online, and other methods of dissemination in order to best reach the maximum possible audience. This campaign should also create links with efforts to alleviate other public health and social issues, such as mental health, homelessness, and alcohol and drug use.

Recommendation 18

5.93 The Committee recommends that the development of a national suicide prevention and awareness campaign should recognise the risks of normalising and glamorising suicide, and draw on wide consultation with stakeholders and a solid evidence base.

Recommendation 19

5.94 The Committee recommends that a national suicide prevention and awareness campaign, once developed, should operate for at least 5 years, and with adequate and sustained resources. This should include the provision of additional resources, support and suicide awareness training for health care professionals.

5.95 The Committee notes the evidence received regarding media practices for reporting suicide, and particularly the MindFrame initiative. The Committee recognises evidence of the important contribution of MindFrame media guidelines in ensuring the accurate and respectful reporting of mental health and suicide.

5.96 It is the Committee's view that the media has a critical role in raising community awareness and reducing stigma associated health and welfare issues such as suicide. The Committee therefore encourages that issues associated with the reporting of suicide and guidelines such as those of MindFrame are well-identified throughout the media industry, including in the education and training of media workers. The Committee welcomes initiatives such as the SPA Life Awards which recognise organisations or individuals in print and non-print media who accurately and effectively report matters associated with suicide, and contribute to public awareness and education about suicide prevention.[108]

5.97 However, the Committee is concerned by suggestions from witnesses that the media may avoid the reporting of suicide and related issues including such as research, and this lack of media reporting may inhibit public discussion of suicide.

5.98 The Committee notes evidence of a need to identify better and more "active" ways to report and inform the Australian public about suicide, including the appropriate use of mainstream news media, the internet and social networking sites.

5.99 The Committee also recognises suggestions to provide better information to the Australian public about the extent of suicide in an effort to raise awareness. The Committee considers that the release of national suicide statistics, on a biannual basis

108 SPA, *Awards*, http://suicidepreventionaust.org/Awards.aspx (accessed 22 June 2010)

could be useful to focus the attention of governments and the public on the incidence of suicide in the community. This would also present an opportunity for targeted dissemination of information about the services and support that are available to those who may be affected.

Recommendation 20

5.100 The Committee recommends that the Mindframe guidelines and current media practices for the reporting of suicide are reviewed. Research should be undertaken to determine the most appropriate ways to better inform the Australian public about suicide through the media, including mainstream news reporting, as well as through internet and social networking sites.

Recommendation 21

5.101 The Committee recommends that national figures on suicide should be released to the Australian public, at a minimum, biannually, in an effort to raise community awareness about suicide, and should be provided together with information about available services and support.

5.102 The Committee recognises the evidence received regarding the particular circumstances and needs of high-risk groups, notably young people, people in rural and remote areas, men, Indigenous populations, LGBTI and CALD communities.

5.103 The Committee notes suggestions for reaching young people through schools and via the internet. The committee also recognises the need to ensure that culturally appropriate services and information are available to Indigenous and CALD communities, and that the dissemination needs of men, people in rural and remote areas and the LGBTI community are identified in order to best target these high-risk groups.

5.104 It is the Committee's view, therefore, that the development of a national suicide prevention and awareness campaign should also identify the most effective, culturally sensitive, and situation appropriate methods to encourage awareness and understanding about suicide within these groups.

Recommendation 22

5.105 The Committee recommends that a national suicide prevention and awareness campaign should include a targeted approach to high-risk groups, in particular young people, people in rural and remote areas, men, Indigenous populations, lesbian, gay, bisexual, transgender and intersex people and the culturally and linguistically diverse communities. This approach should include the provision of culturally sensitive and appropriate information and services.

CHAPTER 6

TARGETED PROGRAMS AND UNIVERSAL INTERVENTIONS

Introduction

6.1 This chapter will deal with term of reference (f) the role of targeted programs and services that address the particular circumstances of high risk groups. While the terms of reference specifically mention Indigenous youth and rural communities, many other high risk groups in the community were highlighted during the inquiry. These high risk groups include men, people who attempt suicide or self harm, children and young people, people bereaved by suicide, people with mental illness, LGBTI people as well as CALD people.

6.2 The Committee also received evidence regarding universal interventions, telephone services, 'suicide hotspots' and access to means of suicide. The appropriate balance between programs and projects aimed at the whole community and those targeted at high risk groups was also discussed.

Universal, selective and indicated interventions

6.3 Suicide prevention interventions were generally categorised as universal (directed at the entire population), selective (targeting groups at high risk) and indicated (aiming to identify and treat individuals at risk). DoHA stated that it funded over $5.2 million during 2008-09 to projects which took a universal approach to suicide prevention. In particular DoHA highlighted universal interventions to improve media coverage of suicide and mental health (Mindframe initiative) and to embed mental health promotion in school communities (Mindmatters and Kidmatters programs).[1]

6.4 There was broad support for a diverse approach to suicide prevention initiatives which addressed Australians universally, as well as the particular circumstances of groups identified as being at high risk. The Suicide is Preventable submission argued that a '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'.[2]

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1 DoHA, *Submission 202*, p. 36.

2 Suicide is Preventable, *Submission 65*, p. 16.

6.5 However some submissions had a preference for either targeted or universal approaches to suicide prevention. Orygen Youth Health Research Centre argued for '… a more targeted approach whereby a greater proportion of funded activity specifically targets those most vulnerable to suicide'. They stated:

> We believe that there is an urgent need for suicide prevention activity to actively target people known to be at high risk in such a way that reduced suicidal behaviour is a measurable outcome… We advocate that more attention be given at a national level to evidence-based, targeted interventions addressing those at risk during peak periods of risk, with general health and associated mental health services being the most obvious (although not the only) channels for intervention.[3]

6.6 Lifeline Australia acknowledged that targeted programs have an important role in any suicide prevention strategy but noted that there are limitations and dangers with an over-reliance on this approach. In particular they emphasised that restricting suicide vigilance to high risk groups could mean other individuals at risk could be overlooked.[4]

Universal interventions

Telephone support services

6.7 Lifeline Australia highlighted the significant role their organisation played in the area of suicide prevention. The Lifeline national helpline receives approximately 450,000 calls each year with 5.8 per cent of these calls involving a high risk of suicide. 3 to 4 calls each year are from someone who has already initiated an act of suicide.[5] They emphasised large part suicide affects those calling their service:

> Lifeline has recently undertaken analysis of the calls to 13 11 14 where a high risk of suicide is identified. This analysis found that 76.2% of these calls related to the caller's suicidality, 7.6% bereavement after suicide and 16.8% of calls concerned another person's suicide risk. This indicates that 13 11 14 is not only used by people considering suicide, but that it provides a vital role to support third party care givers. Almost two thirds (64.8%) of the suicide-related calls were from women and 35.0% were from men. More than half of the calls about current suicide thoughts (59.1%) also mentioned prior suicide behaviour, which places these callers at a much higher suicide risk. [6]

6.8 A key barrier identified for clients accessing the Lifeline telephone services was call costs. Lifeline noted that callers from mobile phones make up more than half

3 Orygen Youth Health Research Centre, *Submission 82*, p. 5.

4 Lifeline Australia, *Submission 129*, p. 55.

5 Lifeline Australia, *Submission 129*, p. 33.

6 Lifeline Australia, *Submission 129*, p. 33.

of all their calls and frequently they pay higher call costs.[7] Similarly Boystown described call costs as 'immediate barriers to accessing assistance' to the Kids Helpline they provide. They also noted a trend towards children and young people preferring mobiles and handheld devices to access assistance. Mr John Dalgleish stated:

> Currently, if any young person uses a landline to call the 1800 number that we have, that call is free. If they use a mobile—and, now, around 62 per cent of our telephone contacts are by mobile—unless they are on the Optus network, which also includes Vodafone, they have to pay for that call.[8]

6.9 The Psychotherapy and Counselling Federation of Australia also commented:

> …young people and those who are socially disadvantaged with mobile phone access only may not have enough credits to call and/or stay on the phone. There currently is no provision for crisis services to take mobile calls without cost. A dedicated line to a national Suicide Prevention service with a free number would be of great benefit.[9]

6.10 Smaller community organisations told the Committee they often received the overflow calls to the major telephone services when the capacity of these services to take calls could not keep up with the demand. Mr Darrin Larney noted that:

> The demand on Lifeline, Kids Helpline, MensLine and all of the services that are currently in place is huge. They do not necessarily have the facilities or perhaps the infrastructure to be able to cope with the number of calls that they are getting. So we by default get a significant amount of the overflow.[10]

6.11 A major recommendation of the Lifeline Australia submission was that the main Lifeline 13 11 14 helpline be officially mandated and funded as an essential suicide intervention service. They noted that currently:

> The National Suicide Prevention Strategy in Australia contains no direct reference or mandated role for Lifeline 13 11 14 – despite the widespread usage, promotion and referral to the service in the community generally, and by health care professionals.[11]

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7 Lifeline Australia, *Submission 129*, p. 35.

8 Mr John Dalgleish, Boystown, *Committee Hansard*, 2 March 2010, p. 9.

9 Psychotherapy and Counselling Federation of Australia, *Submission 72*, p. 5.

10 Mr Darrin Larney, SOS Survivors of Suicide Bereavement Support Association, *Committee Hansard*, 2 March 2010, p. 39.

11 Lifeline Australia, *Submission 129*, p. 37.

Access to means and suicide hotspots

6.12 The removal of access to means used for suicide is important in the management of the care of individuals at risk of suicide and changes to general access to dangerous means have been recognised as an effective policy in suicide prevention at the population level.[12] However DoHA has noted that most access to means interventions 'lie outside the area of influence for health departments'.[13]

6.13 On the unrevised ABS figures from 2007 more than half of all deaths recorded as suicide were the result of hanging (including strangulation and suffocation). Poisoning by drugs was used in 12 per cent of suicides and poisoning by other methods, including by motor vehicle exhaust accounted for another 12 per cent. Suicides using firearms made up 8.9 per cent of deaths.[14] The Suicide is Preventable submission noted that despite the large number of suicides by hanging, this method of suicide is difficult to prevent as the '…means for hanging are readily available and it is infeasible to restrict access to all the materials that could be used'.[15]

6.14 Other areas for restricting access to means were also discussed. For example RANZCP recommended that access to paracetamol should be reduced through specific legislation.[16] Professor Joan Ozanne-Smith of NCIS told the Committee that a number of suicides had been recently recognised as using helium and a plastic bag and that a simple regulatory control could reduce these types of suicide.[17] Mr John Dalgleish of Boystown also noted that the preferred methods of suicide of young people are different from adults. He stated:

> In our data we identified that many of the drugs that young people stated that they could access were prescription drugs, often prescribed for depression, anxiety and psychosis. Educational programs needed to be conducted to raise awareness of the risks involved in allowing uncontrolled access to these drugs by young people.[18]

Suicide hotspots and the Gap

6.15 Both in Australia and overseas specific places or landmarks have been recognised as a result of the high number of completed and attempted suicides which take place at that location. One 'suicide hotspot' that received considerable attention during the inquiry is the Gap, an ocean cliff in eastern Sydney. The inquiry received evidence from Ms Dianne Gaddin regarding the suicide of her daughter at the Gap in

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12 Keith Hawton and Kees van Heeringen, 'Seminar: Suicide', *The Lancet* 2009, 373, p. 1377.

13 DoHA, *Submission 202*, p. 41.

14 DoHA, *Submission 202*, p. 11.

15 Suicide is Preventable, *Submission 65*, p. 81.

16 RANZCP, *Submission 47*, p. 17.

17 Professor Joan Ozanne-Smith, NCIS, *Committee Hansard*, 4 March 2010, p. 49.

18 Mr John Dalgleish, Boystown, *Committee Hansard*, 2 March 2010, p. 2.

2004.[19] Ms Gaddin described the regular occurrence of suicides at the Gap as a 'national disgrace':

> I cannot understand why nothing has ever been done to prevent suicides at any of the hotspots in Australia. There is conclusive evidence from both the UK and New Zealand, showing that when there are steps to make access to hotspots difficult, that the suicide rate drops significantly. There is also anecdotal evidence to show that when this is done, it does not follow that a person would seek somewhere else.[20]

6.16 The Committee also received a submission from the Woollahra Municipal Council which covers Watson Bay where the Gap is located. The Council has developed a Gap Park Masterplan in consultation with residents, mental health providers, local police and relevant stakeholders. The plan would involve infrastructure modifications such as purpose built fencing, improved lighting and closed-circuit television (CCTV) coverage and on site telephone support to Lifeline and signage of messages of hope and support. Additionally the plan would include measures to practical coping and resilience skills to improve mental health in the community through provision of workshops and a mental health resource kit.[21] The Committee understands the Woollahra Council application for $2.1 million in funding was recently rejected.

6.17 DoHA stated that, together with ASPAC, it had been 'examining the evidence behind restricting access to suicide ‘hot spots’ such as bridges or clifftops known to be frequently used suicide locations'. It noted that funding physical infrastructure to reduce access is outside of the scope of the NSPP program, but 'funding advice on reduction of access to means in this way is within the remit of the NSPS'. They stated:

> Work is currently underway to provide guidelines for local government authorities and others with responsibility for infrastructure development on the evidence and best practice methods behind reduction of deaths by jumping through restricting access.[22]

6.18 The Suicide Prevention Taskforce argued:

> In terms of local government involvement, suicide prevention efforts are largely ad hoc and reactive to a suicide cluster and focussed on physical barriers at known suicide sites. However, there is no evidence of a coordinated national response through the Local Government association or other peak bodies.[23]

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19 Ms Diane Gaddin, *Submission 225*, p. 3.

20 Ms Diane Gaddin, *Submission 225*, p. 3.

21 Woollahra Municipal Council, *Submission 12*, p. 2.

22 DoHA, *Submission 202*, p. 41.

23 Suicide Prevention Taskforce, *Submission 59*, p. 4.

Firearms

6.19 DoHA stated that over time there has been change in the methods of suicide reported. Following the gun restrictions introduced after the Port Arthur deaths in 1996, there was a decline in deaths due to this means but this has reversed more recently.[24] SPA noted that access to firearms in rural and remote areas is an issue of concern 'given that the high lethality of such methods may convert many attempts into completed suicides as a consequence of the presence of a firearm'.[25]

Alcohol and drugs

6.20 The role of alcohol and drug abuse in completed suicides was frequently mentioned during the inquiry. Alcohol or substance abuse disorders are often comorbid with other conditions which have an increased risk of suicide.[26]

6.21 Alcohol and drugs were seen as significant risk factors for impulsive suicides, particular in Indigenous communities. Dr Julia Butt from the Indigenous team at the National Drug Research Institute (NDRI) told the Committee:

> In the Indigenous community and certainly in other sectors of Australian society, impulsive suicide becomes a much greater risk, and that is often in the context of alcohol and other drug use. It is much more difficult to predict; it is much more difficult to respond to.[27]

6.22 The Committee also received a submission from the Kimberley Aboriginal Law and Culture Centre which noted that a high level of correlation had been found between drug and alcohol use and the high incidence of suicide in the Kimberley. They were urgently seeking the implementation of a Kimberley Regional Alcohol Management Plan as 'alcohol and drugs are the principal drivers of suicide' in their region.[28]

6.23 The Alcohol and other Drugs Council of Australia noted research by the NDRI which identified alcohol-related suicides as the third-leading alcohol-related cause of death for males and alcohol-related suicide attempts as the fifth most common cause of hospitalisation for females in Australia.[29]

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24 DoHA, *Submission 202*, p. 11. However, conflicting evidence was received on this issue. For example National Coalition for Gun Control, *Submission 241*, p. 2 & Dr Samara McPhedran and Dr Jeanine Baker, *Submission 30*, p. 2.

25 SPA, *Submission 121*, p. 53.

26 Suicide is Preventable, *Submission 65*, p. 62.

27 Dr Julia Butt, NDRI, *Committee Hansard*, 31 March 2010, p. 41.

28 Kimberley Aboriginal Law and Culture Centre, Submission 2, pp 2-3.

29 Alcohol and other Drug Council of Australia, *Submission 49*, p. 5.

Targeted programs

6.24 The LIFE Framework documents identified a number of groups as higher risk of suicide. These include:

> ….men aged 20-54 and over 75, men in Aboriginal and Torres Strait Islander communities, people with a mental illness, people with substance use problems, people in contact with the justice system, people who attempt suicide, people in rural and remote communities, gay and lesbian communities, and people bereaved by suicide.[30]

6.25 Some of these groups at higher risk were recognised in the DoHA submission as receiving funding under the NSPP.

Men

6.26 Broadly, male suicides account for around three quarters of all suicide deaths in Australia. The Committee was often told during the inquiry that men make up the majority of completed suicides because they usually choose more lethal means (ie hanging and firearms). Men were seen as being less adept than women in seeking help and assistance, putting them at greater risk of suicide. DoHA noted that 'the vulnerability of separated and divorced men, particularly those involved in custody disputes and negotiated settlements, has been raised as a key factor' in the increased numbers of male deaths.[31]

6.27 The DoHA summary of 2008-09 NSPP expenditure indicates nine projects focused on men as a population group at higher risk of suicide with approximately $2.2 million spent. DoHA outlined several projects funded under the NSPP which are 'aimed specifically at providing support and reducing suicidal behaviour amongst men, given the high proportion of male suicides, and the specific characteristics of help-seeking behaviour that are often attributed to men'.[32]

6.28 The Committee received evidence regarding several programs which targeted men at risk of suicide. The Australian Men's Sheds Association seeks to provide men with safe, supportive environments in which they can work on projects '…which give them a sense of purpose, which contribute to self-esteem and which help men to resume their rightful place as useful and productive members of their community'. The Association noted these activities provide valuable suicide protective factors.[33] Mr Mort Shearer told the Committee that the Men's Sheds were a good way to sidestep

30 DoHA, *LIFE: A framework for prevention of suicide in Australia*, 2007, p. 32

31 DoHA, *Submission 202*, p. 53.

32 DoHA, *Submission 202*, p. 54.

33 Australian Men's Shed Association, *Submission 57*, p. 3.

the stigma of suicide prevention and mental health '…because a lot of men are not keen on pursuing their own health issues'.[34]

6.29 The OzHelp Foundation suicide prevention activities are workplace based in the (predominantly male) building, construction and mining industries. The OzHelp Foundation provides a number of support based programs, often on-site, focusing on early intervention and prevention.[35] The OzHelp Foundation indicated there was considerable unrecognised demand for mental health and support services for men:

> Every Tradies Tune-up event that we run on site is booked out. Every time we are in the van, guys openly talk about what is going on for them. That disproves this idea that they will not seek help and will not talk about their issues. It is about finding the ways that they will talk about their issues, because they will; it is just creating the right environment to do so.[36]

6.30 The Inspire Foundation also noted the opportunities they were exploring to access young men via internet and gaming forums. Ms Kerry Graham said their organisation was undertaking research to understand how young men seek help and how they use technology as well as how to use that overlap.[37]

6.31 SPA argued that it was essential that the concept of 'help-seeking' is normalised among Australian men. In particular they highlighted the potential of sporting clubs, recreational clubs, workplaces and other organisations more generally to construct supportive social networks in places where men of all ages frequent in an attempt to lessen harmful behaviours and practices.[38]

6.32 Given the much higher rates of male deaths the Private Mental Health Consumer Carer Network Australia argued '… men must be a more highly targeted group for suicide promotion strategies'.[39] Similarly the Freemasons Foundation of Men's Health noted the relatively few targeted suicide prevention programs and services for men and supported the development of interventions in a number of areas. These included:

- emotional literacy of boys;
- improved depression diagnosis and treatment for men;
- support services for men experiencing significant life stress, especially relationship breakdown and employment problems; and

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34 Mr Mort Shearer, Men's Sheds Association, *Committee Hansard*, 3 March 2010, p. 66.

35 OzHelp Foundation, *Submission 86*, p. 5.

36 Mr Glenn Baird, OzHelp, *Committee Hansard*, 1 March 2010, p. 39.

37 Ms Kerry Graham, Inspire Foundation, *Committee Hansard*, 1 March 2010, p. 49.

38 SPA, *Submission 121*, p. 52.

39 Private Mental Health Consumer Carer Network Australia, *Submission 10*, p. 3.

- routine depression and suicide screening for the seriously ill, particularly heart disease patients.[40]

Indigenous communities

6.33 Of the 2,472 deaths registered across Australia in 2008 where the deceased person was identified as being of Aboriginal or Torres Strait origin, 103 (74 male/29 female) were coded as Intentional self-harm [Suicide].[41] This proportion of suicide deaths is significantly higher than the average in the Australian population. Many submitters noted that Indigenous suicides are often not effectively identified by authorities, which suggests a significant level of underreporting also exists. SPA noted that the ABS does not currently report suicides by children under 14 years, which are extremely rare in the general community but in recent decades have been increasingly reported in some Indigenous communities.[42]

6.34 It was observed that suicide was not common in traditional Indigenous society and is considered a relatively recent phenomenon. However by the 1980's '…the situation had become endemic in some Aboriginal communities and in the past decade suicide has become a significant contributor to premature Aboriginal mortality'.[43]

6.35 The summary of 2008-09 NSPP expenditure for groups at higher risk of suicide stated 16 projects directed at Indigenous communities were funded for approximately $3.6 million. DoHA highlighted two projects which focus on Indigenous youth.

> A project which focuses on Indigenous youth is the Yiriman Project coordinated by the Kimberley Law and Aboriginal Cultural Centre in Western Australia. The project runs youth activities with support from senior cultural men and has established links with local agencies such as cultural activities and camps that build strong relationships, self identity and confidence in young people. Further, the Something Better project funded through the Queensland Police-Citizens Youth Welfare Association aims to assist and support young indigenous people in a number of Aboriginal communities in Queensland who are at risk of suicide through sporting activities outside of their community by a suitably trained and dedicated local person.[44]

6.36 The MHCA emphasised that Indigenous youth are the most 'at-risk' group in Australia for suicide. They recommended that the Commonwealth Government should invest in the development of a series of Indigenous Suicide Response Workshops 'to

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40 Freemasons Foundation for Men's Health, *Submission 52*, p. 1.

41 ABS, Causes of Death, 2008, p. 53.

42 SPA, *Submission 121*, p. 53.

43 Australian Indigenous Psychologists Association, *Submission 102*, p. 4; Mental Health Association of Central Australia, *Submission 100*, p. 1.

44 DoHA, *Submission 202*, p. 51.

gain an accurate picture of what Aboriginal communities see as the problem, and to develop possible solutions to inform future Indigenous specific suicide prevention strategies, particularly amongst Indigenous youth'.[45]

6.37 Lifeline Australia noted that Indigenous communities 'are often in a constant state of grief and loss, through deaths, separation, addictions, disease and children being taken into care'.

> Vulnerability to suicide is common in Indigenous communities that are in a constant state of stress. In this environment, it is difficult to locate people in families or communities who are available, and free enough of their own stresses, to give their full attention to a suicidal person.[46]

6.38 The inability of Indigenous remote communities to access people with suicide prevention training or mental health services was highlighted during the inquiry. The high turnover of public sector and community services staff in remote Indigenous communities means suicide intervention and prevention skill training needs to be delivered on a regular basis. The Indigenous team of the NDRI commented that most suicide prevention training in WA does not address whole community risks factors, impulsive suicidality and '…has little time dedicated to the needs, strengths and struggles of Indigenous communities'.[47] The Mental Health Council of Central Australia stated:

> Few mental health service providers are located in remote communities in Central Australia. Depending on the severity of the injuries, suicide attempts are commonly dealt with on communities rather than transporting people to hospital in town…
>
> The system of monitoring suicidal people or people at risk of suicide who live remotely or in town camps is inadequate. Any expectation that this could be done effectively by the already over-stretched mental health service or the SEWB branch of the Aboriginal health service is unrealistic. In remote communities, mental health specialists are visiting services[48]

6.39 The importance of consultation and engagement with Indigenous communities and recognition of the differences between Indigenous groups in developing responses to suicides and attempted suicides was emphasised by many submissions.[49] For example DoHA noted that it '…recognises the need to gain advice on suicide prevention and mental health issues in Aboriginal and Torres Strait Islander

45 MHCA, *Submission 212*, p. 6.

46 Lifeline Australia, *Submission 129*, pp 35-36.

47 Indigenous team of NDRI, *Submission 105*, p. 2.

48 Mental Health Association of Central Australia, *Submission 100*, p. 2.

49 For example, Mr John Dalgleish, Boystown, *Committee Hansard*, 2 March 2010, p. 6.

communities from representatives of those communities who also hold expertise in mental health and suicide prevention'.[50]

6.40 Central Australian Aboriginal Congress (Congress) provided the inquiry with an article on proposed guidelines for effective family support and counselling programs targeting bereavement and suicide prevention in Central Australian Indigenous communities. This suggested:

> The cornerstone of any effective local Aboriginal bereavement and suicide prevention services will be the employment of senior Aboriginal people in the delivery of intervention programs. We need to build meaningful and sustainable local Aboriginal employment pathways for senior Aboriginal community members as family support workers, bereavement counsellors, and crisis response team members.[51]

6.41 Congress reported that the threat of suicide '…is now used as a threat by some young people to get attention and access to money for alcohol and other drugs from other community members'. The Indigenous team of the NDRI also noted '…in some areas suicide appears to have taken on martyrdom symbolism as a consequence of disempowerment'.[52] A number of submissions also noted a high level of correlation between drug and alcohol abuse and the high incidence of suicide in Indigenous communities.[53]

6.42 SPA argued that 'in developing and implementing Indigenous suicide prevention strategies, it is important to recognise that no ‘quick fix’ solution exists to the complex web of underlying sociocultural and economic problems and conditions found to greatly contribute to increased occurrences of at-risk individuals and endemic rates of suicide and self-harm among Indigenous peoples'.[54]

6.43 During the inquiry the Committee visited the Perth offices of the Understanding & Building Resilience in the South West Project. One component delivered was workshops based on the 'Map of Loss' which was used for both Indigenous and non-Indigenous clients to teach how to self-diagnose their emotional state and to develop skills to manage their emotions.

Clusters

6.44 Indigenous communities were identified as being particularly vulnerable to clusters of suicides. SPA commented:

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50 DoHA, *Submission 202*, p. 45.

51 Central Australian Aboriginal Congress, *Submission 19*, p. 4.

52 Indigenous team of NDRI, *Submission 105*, p. 1.

53 For example, Kimberley Aboriginal Law and Culture Centre, *Submission 2*, p. 2.

54 SPA, *Submission 121*, p. 53.

> In rural and remote Aboriginal areas, suicide deaths often spark clusters of suicides... 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)'….[55]

6.45 Mr Clinton Shultz of the Australian Indigenous Psychologists Association noted the strong community connections amongst Indigenous people meant the impact of a suicide was more widespread. He stated:

> If there is a suicide in a community, that impacts on everybody in the community, which then has that flow-on effect of constant grief, constant loss, without the services to deal with that, which then can lead to the formation of clusters.[56]

6.46 Ms Leonore Hanssens, researcher into Indigenous suicide stated in her submission:

> Suicide contagion, particularly behavioral contagion is endemic particularly substance abuse, and familial contagion appears to be universal in most Indigenous communities, even the urban settings. This contagion results in imitative suicides which then produce suicide clusters. When suicide occurs in such close knit communities the 'reach of news' is widespread and is quickly communicated, which also spreads the contagion. [57]

6.47 Ms Leonore Hanssens noted the timely reporting of suicides in Indigenous communities could allow effective postvention actions to be taken to reduce the risk of further suicides occurring. These could include interventions to 'reduce alcohol availability in certain situations (during 'sorry business' related to suicide or sudden unexpected deaths), increase policing in certain jurisdictions, increased mental health personnel, increase in grief and trauma counsellors and critical incident debriefing in postvention support'.[58]

A separate strategy

6.48 The Indigenous Team of the NDRI observed there was '…an acute and chronic need for targeted programs that address the circumstances of Indigenous Australians'. These included holistic services, improved mental health services, integration of alcohol and other drug and mental health services, community and

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55 SPA, *Submission 121*, p. 27.

56 Mr Clinton Shultz, Australian Indigenous Psychologist Association, *Committee Hansard*, 2 March 2010, p. 70.

57 Ms Leonore Hanssens, *Submission 83*, p. 2.

58 Ms Leonore Hanssens, *Submission 83*, p. 3.

government services capable to responding to whole of community risk factors and intervening to prevent suicide 'contagion', and services and community interventions which are capable of responding to impulsive suicide behaviour.[59]

6.49 There was also discussion during the inquiry whether the unique circumstances of Indigenous communities in relation to suicide required a separate suicide prevention strategy rather than simply targeted programs. The Australian Indigenous Psychologists Association stated that despite clear differences in the needs of Indigenous and non-Indigenous communities '…Aboriginal suicide continues to be addressed under the same framework as the general population by national suicide prevention strategies…[and] Aboriginal initiatives continue to be adapted from existing non-Aboriginal models, which are based on non-Aboriginal understandings of suicide, health, healthcare and risk profiles'.[60] Ms Leda Barnett commented:

> I think it would be better to have strategies that are specific for Indigenous populations and perhaps even a strategy for Aboriginal people and a strategy for Torres Strait Islanders, separate ones. I think the benefits of that are because the contexts are so different...[61]

Children and Young People

6.50 While suicide accounts for only a small proportion of all deaths it accounts for a much greater proportion of deaths within specific age groups. In 2008, 24 per cent of all male deaths aged 15-24 years were due to suicide.[62] The ABS does not report suicide for people under 15 years of age due to the small number and the sensitivities around suicide, however the latest *Causes of Death* included the following:

> There was an average of 10.1 suicide deaths per year of children under 15 years over the period 1999 to 2008. For boys, the average number of [s]uicides per year was 6.9, while for girls the average number was 3.2.[63]

6.51 Ms Angela Ritchie from the Commission for Children and Young People and the Child Guardian (CCYPCG) Queensland noted there had been a changing approach to the intentionality for children. She stated that in past there were questions about the capacity of a child to understand the consequences and irreversibility of their actions but '…increasingly the research literature is suggesting that children do know enough to contemplate suicide…'.[64]

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59 Indigenous team of NDRI, *Submission 105*, p. 3.

60 Australian Indigenous Psychologists Association, *Submission 102*, p. 7.

61 Ms Leda Barnett, Australian Indigenous Psychologists Association, *Committee Hansard*, 2 March 2010, p. 65.

62 ABS, *Causes of Death, 2008*, 2010, p. 48.

63 ABS, *Causes of Death, 2008*, 2010, pp 64-65.

64 Ms Angela Ritchie, CCYPCG Queensland, *Committee Hansard*, 2 March 2010, p. 56.

6.52 DoHA noted that the youth focused projects funded under the NSPP 'tend to centre on building resilience and developing coping strategies and support networks for young people to increase the number of protective factors for suicide amongst vulnerable youth'.[65] The DoHA summary of 2008-09 NSPP expenditure for groups at higher risk of suicide indicated 25 projects directed at young people received approximately $4.5 million.

6.53 The role of schools and teachers was emphasised in managing the impact of suicide by children and young people. SPA recommended the introduction of 'mandatory suicide (and attempted suicide) postvention guidelines across all Australian educational institutions and schools…'.[66] A key schools program funded in the NSPP was the Mind Matters initiative delivered by Principles Australia. This is a national mental health, promotion, prevention and early intervention program delivered in 3000 Australian secondary schools.[67] Also funded under the NSPP was Peer Support, a national peer led program which fosters the mental, physical and social wellbeing of young people and their community by supporting positive cultural change within schools.[68]

6.54 Mr John Dalgleish of Boystown also highlighted the benefit of placing at risk youth in social enterprises and vocational training to develop protective factors and resilience. He stressed the importance of 'community engagement strategies around employment and psychological support which are critical to divert young people from suicidal behaviour'.[69]

6.55 The risk of familial and imitative contagion for children and young people was highlighted by the CCYPCG Queensland. The Commission's child death review had found 42 per cent of young people who completed suicide did so after the suicide, or attempted suicide of a friend, family or community member.[70] Ms Angela Ritchie from CCYCPG Queensland noted this data '…reinforces the importance of detailed suicide prevention and postvention guidelines being put in place' to support children when suicides take place.[71] The CCYPCG Queensland also outlined their preliminary findings that many children and young people had contact with a variety of human service agencies prior to their suicide including educational institutes, police, child safety, health and mental health services and the youth justice system.[72]

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65 DoHA, *Submission 202*, p. 50.

66 SPA, *Submission 121*, p. 59.

67 DoHA, *Submission 202*, Appendix D, p. 25.

68 DoHA, *Submission 202*, p. 51.

69 Mr John Dalgleish, Boystown, *Committee Hansard*, 2 March 2010, p. 2.

70 CCYCPG Queensland, *Submission 99*, p. 3.

71 Ms Angela Ritchie, CCYCPG Queensland, *Committee Hansard*, 2 March 2010, p. 54.

72 CCYPCG Queensland, *Submission 99*, p. 21.

Bullying and cyber-bullying

6.56 The NSW Legislative Council General Purpose Standing Committee report into bullying and young people acknowledged the problematic relationship between bullying and suicide. SPA highlighted the report's recommendations to the Committee including better assistance to schools to identify effective anti-bullying programs, better training for teachers, that the State education department seek annual feedback from young people on anti-bullying initiatives, protocols for schools to report on their anti-bullying polices and a greater research focus on cyber-bullying.[73] Boystown also noted 'a high correlation between suicidality and cyberbullying and even face-to-face bullying'.[74]

6.57 The internet was seen as both a blessing and curse in relation to suicide prevention for children and young people. A number of witnesses and submitters noted some internet websites included inappropriate information about suicide including instructions for those who intend to attempt suicide.[75] On the other hand some recognised that social networking and mobile phones decreased the social isolation for children and young people.

6.58 The Inspire Foundation emphasised the positive role internet and communication technologies had played in their activities such as ReachOut.com. They recommended that these technologies be seen as 'enablers of young people's mental health and wellbeing and an important setting in which a spectrum of interventions can be undertaken'. The Inspire Foundation commented:

> The Internet is accessible, anonymous, engaging and informative, providing a space where young people can feel empowered and confident to talk about sensitive issues… ICT therefore offers significant potential as a tool and setting for mental health promotion and suicide prevention for all young people…[76]

headspace initiative

6.59 The Suicide is Preventable submission stated that help seeking and help pathways for young people at risk of suicide can be limited.[77] Although not funded through the NSPP, DoHA noted the headspace initiative which, through 30 shopfronts, '…provides access for youth to general practitioners and allied health professionals with skills and experience in alcohol and drug treatment and mental health, as well as access to other social and vocational support services'.[78] The APGN

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73 SPA, *Submission 121*, p. 58.

74 Mr John Dalgleish, Boystown, *Committee Hansard*, 2 March 2010, p. 12.

75 For example, Mr John Dalgleish, Boystown, *Committee Hansard*, 2 March 2010, p. 11.

76 Inspire Foundation, *Submission 101*, p. 23.

77 Suicide is Preventable, *Submission 65*, p. 76.

78 DOHA, *Submission 202*, p. 51.

commented that the '…headspace model delivers more than collocated services, with provision of youth specific education and training to headspace providers, and development of local referral pathways so that care providers are linked and the youth people presenting do not fall between the cracks'.[79]

People who attempt suicide or self harm

6.60 The programs directed to those who have attempted suicide have been addressed in the section in Chapter 4 dealing with discharge, follow up, coordination of care and stepped accommodation. However it was also recognised that many of those who attempt suicide or self harm do not present to hospital, medical care or mental health care.[80]

6.61 Self-harm was distinguished from attempted suicide during the inquiry as a form of behaviour in its own right. The Suicide is Preventable submission commented that self harm could 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'.[81]

6.62 The table summary of 2008-09 NSPP expenditure grouped people who had previously attempted suicide or self harmed with people with a mental illness. 33 projects were funded for approximately $2.9 million.[82]

6.63 DoHA noted data on hospital admissions which indicated around 30,000 admissions to public hospitals each year 'with one-and-a-half to twice as many admissions of females as admissions of males'.[83] It noted that not every person who attempts suicide would necessarily be admitted to hospital. The results of the National Survey of Mental Health and Wellbeing in 2007 showed that:

> …13.3% of Australians aged 16-85 years have, at some point in their lives, experienced some form of suicide ideation, 4.0% had made a suicide plan and 3.3% had attempted suicide. This is equivalent to over 2.1 million Australians having thought about taking their own life, over 600,000 making a suicide plan and over 500,000 making a suicide attempt during their lifetime…
>
> In the 12 months prior to interview, 2.4% of the total population or just over 380,000 people reported some form of suicidality. Of these, 2.3% or around

79 AGPN, *Submission 213*, p. 11.

80 Lifeline Australia, *Submission 129*, p. 29.

81 Suicide is Preventable, *Submission 65*, pp 33-34.

82 DoHA, *Submission 202*, p. 43.

83 DoHA, *Submission 202*, p. 55.

> 370,000 people experienced suicidal ideation, 0.6% or 91,000 made suicide plans and 0.4% or 65,000 made a suicide attempt.[84]

6.64 The MHCA emphasised that 'every suicide attempt is serious and warrants attention'. They stated:

> Because men tend to choose more lethal means than women, it is more likely to result in a fatal outcome… however, this does not of itself make an attempt any less serious in the first instance.[85]

6.65 Lifeline noted research which indicated those with prior suicidal behaviour had 'over 30 times the risk of people in the general population'.[86] They emphasised the need for follow-up services for those who had previously attempted suicide as well as outlining the operation of their Lifeline Suicide Crisis Support Program.[87] Lifeline Australia also highlighted that those who have attempted suicide and their families have different ongoing support needs than those bereaved by suicide. They argued that to 'try and place those bereaved by suicide with those who have had someone close to them attempt suicide in the same support groups will not cater to their unique circumstances'.[88]

People with mental illness

6.66 While the suicide of a person is often a complex event with many interrelated factors, one of the most common and significant contributing factors is mental illness. The strong associations between mental illness and suicide include persons with clinical depression, bipolar disorder, schizophrenia, alcohol and other substance use disorders, borderline personality disorder, and behavioural disorders in children and adolescents.[89] The MHCA outlined the results of the National Survey of Mental Health and Wellbeing which indicated that people with mental illness are much more likely to have serious suicidal thought than other people (8.3 per cent compared to less than 1 per cent).[90] The Survey also found 73.4 per cent of people who reported making a suicide attempt had used mental health services in the previous 12 months.

6.67 SANE Australia highlighted the increased risk of suicide for people with mental illness particularly bipolar disorders and schizophrenia. They stated:

> Suicide is the pre-eminent cause of death for people with bipolar disorder, with a lifetime risk of 15% (compared to approximately 1% in the general

84 DoHA, *Submission 202*, p. 58.

85 MHCA, *Submission 212*, p. 13.

86 Lifeline Australia, *Submission 129*, p. 55.

87 Lifeline Australia, *Submission 129*, p. 55.

88 Lifeline Australia, *Submission 129*, p. 22.

89 SPA, *Submission 121*, p. 56.

90 MHCA, *Submission 212*, p. 7.

> population). It is estimated that around one in eight of all suicides (12%) are by people with bipolar disorder. Of those who die by suicide, it is estimated that 60% have received inadequate treatment.
>
> Suicide is a prominent cause of death for people with schizophrenia. Suicidal ideation is common, experienced by 68% of those with this diagnosis. Over 40% attempt suicide at least once, and WHO calculates the lifetime risk of suicide for people with schizophrenia at 10-13% (compared to approximately 1% in the general population). As with bipolar disorder, research indicates that suicide is more likely to occur in those who are not receiving adequate treatment.[91]

6.68 However evidence received during the inquiry suggested that the relationship between mental illness and suicide is complex. The Committee heard many stories of people who had completed suicide who exhibited no sign of mental health issues or had any previous contact with mental health services.[92] SPA commented that:

> Many people who experience mental illness do not display suicidal thoughts or behaviour and not everyone who takes their own life can be said to be mentally ill – that is, a person does not need to have a mental illness for suicide risk to still be present.[93]

6.69 Professor Patrick McGorry argued that the link between mental illness and suicide has been underestimated in Australia. He believed that '…90-plus per cent of people who successfully complete suicide have been suffering from an untreated, partially treated or poorly treated mental health problem or mental illness'.[94] Similarly Professor Robert Goldney stated:

> Thus Population Attributable Risk studies demonstrate that by far the most impact on suicidal behaviours could be made by ensuring the optimum management of mental disorders. That is where the bulk of suicide prevention measures should be focussed: on boosting existing Mental Health services and facilities, rather than developing parallel services purportedly addressing suicidal behaviour specifically.[95]

6.70 SANE Australia emphasised that mental illness was the primary risk factor for suicide in all demographic groups and this was an attribute subject to intervention.

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91 SANE Australia, *Submission 97*, p. 2.

92 For example Mr Jeffery Cheverton, Queensland Alliance, *Committee Hansard*, 2 March 2010, p. 15; Mr Darrin Larney, SOS Survivor of Suicide Bereavement Support Association Inc., *Committee Hansard*, 2 March 2010, p. 29.

93 SPA, *Submission 121*, p. 56.

94 Professor Patrick McGorry, Orygen Youth Health Research Centre, *Committee Hansard*, 4 March 2010, p. 80.

95 Professor Robert Goldney, *Submission 51*, p. 4.

They argued this approach '…was our best opportunity to reduce suicidal behaviour across the board'.[96]

Rural and remote areas

6.71 An AIHW report on mortality in rural, regional and remote areas found that deaths by suicide in regional areas were 20-30 per cent higher than in major cities.[97] While death rates for females in remote areas appeared similar to those in major cities the rate of suicide for males in remote and very remote areas were around 1.7 and 2.6 times as high. DoHA noted this analysis was supported by QSR data as well as information produced by the NCIS which indicated that deaths by suicide were highly associated with remoteness, with rates of sucide significantly higher in remote and very remote areas (20.7 and 21.8 deaths per 100,000 respectively).[98].

6.72 The challenges for residents in rural and remote areas in accessing health care and mental health care as well as retaining mental health professionals was frequently highlighted.[99] Many submissions and witnesses indicated a number of other interrelated reasons for these higher rates of suicide in regional, rural and remote areas.[100] These included:

- the pressures on rural communities and farmers of prolonged severe drought conditions and adverse economic conditions leading to financial difficulties, bankruptcy and the loss of family farms;
- the shrinking of rural communities and increased social isolation;
- traditional attitudes of stoicism and independence discouraging help-seeking behaviour;
- the lack of confidentiality and medical privacy in small communities; and
- easier access to lethal means of suicide such as firearms.

6.73 DoHA outlined several NSPP funded projects in rural and remote areas which focus on 'on community capacity building and gatekeeper training, which helps maximise use of scarce community resources'. The 2008-09 NSPP summary of expenditure for groups at high risk of suicide indicated 11 projects received approximately $1.9 million.[101]

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96 SANE Australia, *Submission 97*, p. 3.

97 AIHW, *Rural, regional and remote health: a study on mortality*, 2nd edition, 2007, pp 201-202.

98 DoHA, *Submission 202*, p. 47.

99 For example, Salvation Army, *Submission 142*, p. 29.

100 For example, HCRRA, *Submission 46*, p. 2.

101 DoHA, *Submission 202*, p. 48.

6.74 An example was the Rural Alive and Well project delivered by the Southern Midlands Council in Tasmania, which aimed to build resilience and capacity of men, their families and the community to react to challenging life experience with a specific focus on suicide.[102]

6.75 In the area of mental health DoHA also outlined the Mental Health Services in Rural and Remote Areas (MHSRRA) Program which 'will fund non-government organisations up to $91 million for the delivery of mental health services by appropriately trained mental health care workers in communities that would otherwise have little or no access to mental health services'. DoHA noted that workers employed under the MHSRRA program will have access to adapted suicide prevention training to 'enhance the capacity of primary care workers in rural and remote Australia to work with clients who are suicidal'.[103]

6.76 The *Mental Health Support for Drought Affected Communities* initiative was also mentioned by the AGPN as a program '… building the capacity of rural and remote drought affected communities to respond to the psychological impact of drought'. The initiative provides community outreach and crisis counselling for distressed individuals and communities in drought affected rural and remote areas as well as raising community awareness and providing education and training to enable health workers and community leaders to recognise and respond to the early warnings of emotional stress.[104]

Access to services

6.77 The lack of access to services in rural, regional and remote areas was seen to increase the risk of suicide for people in those areas. Professor Ian Hickie described this as an area where ' the health system have let people down to the greatest degree'. He noted that older farmers who are seeking help will have great trouble accessing help through the lack of primary care services and through lack of additional allied health services.[105]

6.78 Lifeline Australia commented on the feedback they had received:

> People who wrote about their experience with suicide and living in rural and remote areas expressed that often help is not available in the local town, forcing people to either travel to major centres, or wait for a scheduled time when relevant professionals travel to a town from a major centre. In some cases, this delay may be too late. Frustration was also expressed about long

102 DoHA, *Submission 202*, Appendix D, p. 13.

103 DoHA, *Submission 202*, p. 48.

104 AGPN, *Submission 213*, p.10.

105 Professor Ian Hickie, BMRI, *Committee Hansard*, 1 March 2010, p. 61.

> waiting lists, and often having no alternatives for the suicidal person's care.[106]

6.79 The AMA emphasised that in rural and remote areas a local GP is '…likely to be the only provider of mental health services….'. They recommended practical support for these GPs including: opportunities for education and professional development on issues of rural and remote suicide; a database of risk factors and recall system for patients considered at risk of suicide; professional and peer support programs for general practitioners particularly for those likely to be sole provider of mental health services in smaller rural and remote communities.[107]

6.80 The Australian Institute of Family Studies noted that stoicism is seen as an important concept that regulates access to help in rural areas. They stated:

> In the case of farmers, stoicism may arise from a crucial imperative to fulfil the farming role, as the number of workers on a farm is often small, and time off for illness would have a significant impact on productivity. As such, men perceive taking practical steps, remaining optimistic and getting on with the job as the most useful strategies to deal with problems[108]

6.81 Professor Brian Kelly noted that while GPs were important for suicide prevention in rural and remote areas other health providers such as community nurses were also critical points of contact. He noted '…it has been very important for us to work with the sort of agencies that have day-to-day contact with people in isolated circumstances'.[109] SPA also argued that individuals in rural, remote and regional areas such as Rural Financial Counsellors, support workers, teachers, sports coaches, and small businesspeople '…should 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.[110]

6.82 The Suicide is Preventable submission recognised that the development of online communication would enhance timely access to suicide prevention interventions and support services and this would particularly benefit people living in regional, rural and remote areas.[111]

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106 Lifeline Australia, *Submission 129*, p. 20.

107 AMA, *Submission 55*, p. 5.

108 Australian Institute of Family Studies, *Submission 80*, p. 7.

109 Professor Brian Kelly, *Committee Hansard*, 3 March 2010, p. 14.

110 SPA, *Submission 121*, p. 50.

111 Suicide is Preventable, *Submission 65*, p. 22.

Lesbian, gay, bisexual, transgender and intersex (LGBTI) people

6.83 LGBTI people were identified as a high risk group for suicide in research. The Suicide is Preventable submission noted that '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 per cent higher'.[112] Suicide by LGBTI people is likely to be underreported as sexual orientation or gender identity may not necessarily be widely known at the time of death. Issues relating to sexual preference may also be avoided by authorities or not acknowledged by family members of the deceased. However the DoHA LIFE Research document comments that same-sex orientation is a risk factor for nonfatal behaviour and ideation, especially amongst adolescents and young people, however 'based upon results of (scarce) studies conducted to date, completed suicide rates do not appear to be increased among the gay and lesbian populations'.[113]

6.84 MHCA noted the lack of information regarding suicide and LGBTI people but commented it was clear that 'the stigma and discrimination experienced by GLBT(I) youth is likely to seriously impact on their mental health, increasing their chances of experiencing social isolation and family rejection'. They commented:

> The evidence also suggests that most suicide attempts by GLBT(I) people occur while still coming to terms with their sexuality and/or gender identity, and often prior to disclosing their identity to others … or, for transgender individuals, before engaging in any gender-related treatment, such as counselling or therapy.[114]

6.85 The MHCA recommended further research be conducted to understand the exact nature and extent of mental health issues impacting GLBT youth as well as the extent of suicide and attempted suicide within these groups.

Access to appropriate services

6.86 A number of LGBTI organisations considered that the priorities and needs of LGBTI people had not been recognised in government policy relating to mental health and suicide such as the NSPS or by related organisations such as Beyondblue.[115]

6.87 The Gay & Lesbian Counselling Service of NSW noted that LGBTI individuals face challenges such as overt and subvert homophobia in accessing services and have needs that are not specific to the general population. They stated:

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112 Suicide is Preventable, *Submission 65*, p. 76.

113 DoHA, *LIFE:Research and evidence in suicide prevention*, 2008, p. 67.

114 MHCA, *Submission 212*, p. 25.

115 Lesbian and Gay Solidarity Melbourne, *Submission 37*, p. 1; Gender Agenda, *Submission 112*, p. 6; Ms Gabi Rosenstreich, National LGBT Alliance, *Committee Hansard*, 3 March 2010, p. 58.

> Targeted programs are of great importance as people and groups have specific needs to be met and programs have to find the right audience. For instance, some gay and lesbian people in rural areas have little contact with the 'gay community' and can feel cut off, isolated and unable to identify with anything – they just don't fit.[116]

6.88 The National LGBT Health Alliance noted there were complex factors relating to the access of LGBTI people to services. Ms Gabi Rosenstreich stated:

> We also know that current initiatives are not working for these populations and that the rates remain really high. We know that that has something to do with the lack of acknowledgement of social determinants and the pure invisibility of these communities. We know that it has something to do with the lack of targeted services and resources and that LGBT people tend not to use mainstream services. They fear discrimination and sometimes they experience discrimination if they use them. Often if they do use them they hide the fact that they are dealing with issues of sexuality or gender identity, which means they are not getting effective care.[117]

6.89 Gender Agenda also highlighted the lack of discrete services and information for sex and gender diverse people. They noted that not all sex and gender diverse people were comfortable 'accessing services designed for meet specific needs of gays and lesbians'.[118]

6.90 A state study conducted by the Tasmanian Government identified key health and well-being issues for the LGBTI population including '…a lack of support networks and a sense of 'community', the need for access to support services during the critical 'coming out' life stage for individuals, the impact of homophobia/transphobia ranging from underlying apprehension to violence and bullying, and discrimination and ignorance by health workers resulting in reduced access to health services'.[119]

6.91 SPA noted studies which support 'the proposition that GLBT(I) people utilise the internet as a primary means of learning more about sexuality and gender identity, as well as a way to connect with peers through participation in online communities and social networks'.[120]

> The difficulty is in effectively identifying same-sex-attracted youth, because of course they do not talk about it openly often, and so often they suffer in silence or the issues are kept within the family.[121]

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116 Gay & Lesbian Counselling Service of NSW, *Submission 81*, pp 3-4.

117 Ms Gabi Rosenstreich, National LGBT Alliance, *Committee Hansard*, 3 March 2010, p. 58.

118 Gender Agenda, *Submission 112*, p. 16.

119 Tasmanian Government, *Submission 244*, p. 9.

120 SPA, *Submission 121*, p. 55.

121 Professor Nick Allen, *Committee Hansard*, 4 March 2010, p. 84.

Elderly LGBTI people

6.92 Dr Jo Harrison highlighted for the Committee the lack of recognition of the needs of elderly LGBTI people in aged care and mental health support as well as suicide prevention activities. She commented:

> Older GLBTI people are at an increased risk of social isolation and lack of support networks compared to non-GLBTI people. They are also less likely to approach services for support until the point of desperation, due to fear of homophobic retribution and abuse.[122]

6.93 The GLBTI Retirement Association (GRAI) emphasised the majority of older LGBTI people '…have grown up in an environment where they have had to hide their sexual orientation… [many] have been subjected to overt discrimination, prejudice and violence'. They noted the apprehensions of LGBTI people regarding entering aged care facilities.[123]

People bereaved by suicide

6.94 The Committee was told that grief is greatly exacerbated in suicide survivors, who report that feelings of stigmatisation, shame and embarrassment sets them apart from those who grieve a non-suicidal death.

6.95 Those bereaved through a suicide death of a significant other had a fivefold increased suicide risk compared to the rest of the population. Suicide deaths can also spark clusters of suicides where the suicide or attempted suicide of one person may trigger suicidal behaviours in others.[124]

6.96 The summary of 2008-09 NSPP expenditure indicated 12 projects were funded for those bereaved by suicide for approximately $3.4 million.[125] DoHA told the Committee that in '…the five year period 2006-07 to 2010-11 over $18m will have been expended on suicide bereavement projects…'. This was equivalent to 17.5 per cent of total NSPP allocation over that period.[126]

6.97 DoHA also highlighted a number of bereavement programs funded under the NSPP. These included:

> StandBy Bereavement Response Service is an active 24-hour postvention service which provides support and assistance for those affected by suicide,

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122 Dr Jo Harrison, *Submission 24*, p. 1.

123 Gay, Lesbian, Bisexual, Trans and Intersex Retirement Association (GRAI), *Submission 67*, p. 2.

124 Suicide is Preventable, *Submission 65*, p. 79.

125 DoHA, *Submission 202*, p. 43.

126 DoHA, *Submission 202, Responses to questions on notice from hearing 1 March 2010*, p. 4.

> as well as management of the bereavement circumstance. It coordinates local services, agencies and individuals to form a referral pathway to support to people bereaved by suicide.
>
> The Hope for Life suicide bereavement support project run by the Salvation Army provides support for persons bereaved by suicide through a telephone help line, website, online and face to face suicide prevention gatekeeper training, and a resource kit for frontline Salvation Army staff dealing with people who are bereaved by suicide.
>
> The Active Response Bereavement Outreach Model is a pro-active model of postvention which focuses on early engagement of those bereaved, including Indigenous people, within the Perth metropolitan area
>
> Support for people bereaved by suicide within rural and metropolitan Victoria is available through the Support after Suicide Service coordinated by Jesuit Social Services.[127]

6.98 The Suicide is Preventable submission noted that a National Suicide Bereavement Strategy had been completed in 2006 but had not been released by government. DoHA provided the Committee with information on this matter. In 2005 a National Bereavement Reference Group (NBRG) was established to oversee the development of national activities targeting people bereaved by suicide, including exploring options for national coordination of suicide bereavement activities. While the NBRG membership included a range of experts in postvention, DoHA stated that the NBRG 'did not provide jurisdictional representation at senior levels'. In 2006 DoHA contracted a provider to undertake a the National Activities on Suicide Bereavement Project regarding a range of activity in line with the purposes of the NBRG, however the contract not require the provision of a national suicide bereavement strategy for consideration.

6.99 While the report produced has not been publicly releasd DoHA stated it has used the report 'as a practical guide in taking forward significant activity targeted for those bereaved by suicide'. They noted:

> To achieve genuine engagement with States and Territories, any national strategy requires involvement of States and Territories in scoping the need for, development of and endorsing of the strategy. The NBRG did not offer this level of input and so was not able to formally recommend the final outline for a national bereavement strategy that was put to it.[128]

6.100 One of the issues raised during the inquiry was the most appropriate way to offer assistance to bereaved families following a suicide. For example coroners' offices often include a counselling service who offer personal support to those involved in coronial processes, including those bereaved by suicide. However the Committee heard these services were often under resourced.

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127 DoHA, *Submission 202*, p. 52.

128 DoHA, *Submission 202, Responses to questions on notice from hearing 1 March 2010,* p. 3.

6.101 Wesley Misson told the Committee that as a result of community demand Wesley LifeForce has in partnership with the Penrith Suicide Prevention and Support Network established a suicide bereavement self help support group in the Penrith area of Sydney. The group aims to provide emotional, psychological and moral support for its members.[129]

6.102 Jesuit Social Services recommended that the feasibility of establishing a National Postvention Consultancy Service be investigated. This service would provide resources and secondary consultation to professionals, communities or organisations working with the suicide bereaved. They noted:

> People bereaved by suicide are at increased risk of suicide and face significant barriers to effective care. There is an urgent need to increase the availability of care to the suicide bereaved through the provision of more specialist services that provide individual counselling, group-work and intensive outreach services. These services must be provided by professional counsellors expert in dealing with both grief and trauma and be free of charge. They also must have the ability to provide long-term support to clients.[130]

6.103 The ACT Government also recommended that consideration be given to providing a scheme to assist counselling and support to those bereaved by suicide which does not link bereavement counselling with mental illness as well as increasing the number of bulk billing clinics providing counselling to those bereaved by suicide.[131]

Commemoration and memorials

6.104 The importance of assisting those bereaved by suicide work through their grief was highlighted during the inquiry. For example SPA commented that encouraging people to tell their stories regarding those lost to suicide can also serve as an effective outlet for grief and may assist in the individual healing process.[132]

6.105 The Committee received evidence regarding the Salvation Army's *Hope for Life National Lifekeeper Memory Quilt.* The quilt initiative was designed as a memorial to people who have died by suicide and serves as creative outlet for survivors' grief as well as a visual reminder of those lost to suicide. The Salvation Army stated:

> The clear messages emanating from this initiative are that many families need an opportunity to grieve openly and share with others. Sensitive rituals are very important in the grieving process and families need to know that

129 Wesley Mission, *Submission 138*, p. 6.

130 Jesuit Social Services, *Submission 78*, p. 6.

131 ACT Government, *Submission 44*, p. 3.

132 SPA, *Submission 121*, p. 19.

> they are not alone and that they have the support of a concerned community.[133]

6.106 Similarly Wesley Mission noted the Wesley LifeForce Memorial Day Services were community events to 'enable those who have been impacted by suicide to have a place to come together in the 'spirit of comfort and hope…'. They stated:

> The LifeForce Memorial Day Services are important postvention activities which not only support those bereaved by suicide but also raise awareness and the public profile of the issue of suicide thereby working to reduce the stigma associated with suicide by publicly acknowledging the surrounding the subject.[134]

Culturally and linguistically diverse people (CALD)

6.107 The effect of moving to a new country can vary for each person depending on a range of social, economic, environmental and personal factors. Different cultures can also have different understandings and reactions to suicide.[135] Both these factors are relevant to Australia because of its culturally and linguistically diverse population. In the 2006 Census, almost 44 per cent of Australian were born overseas or had at least one parent born overseas. Around 15 per cent of Australians speak a language other than English at home. [136]

6.108 The Transcultural Mental Health Centre (TMHC) pointed to research which indicated migrant populations had a higher risk of suicide.[137] Similarly the MHCA commented that while '…suicide rates tend to reflect the rates of suicide in the country of origin, existing evidence suggests that the average suicide rate for migrants is consistently *higher* in Australia than in the country of origin'.[138] The LIFE factsheet for people from CALD backgrounds lists a number of risk factors for immigrants including: decreased in socioeconomic status; social isolation and lack of support; separation from families, friends and culture; and language and cultural barriers to accessing mental health services.[139]

6.109 In addition to migrants, the large number of international students studying in Australia was also identified as a CALD community with a higher risk of suicide.[140]

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133 Salvation Army, *Submission 142*, p. 10.

134 Welsey Mission, *Submission 138*, p. 6.

135 DoHA, *LIFE: Research and Evidence in Suicide Prevention*, 2007, p. 39.

136 TMHC, *Submission 76*, p. 1.

137 TMHC, *Submission 76*, p. 1.

138 MHCA, *Submission 212*, p. 28.

139 DoHA, *LIFE*: *Factsheet 20, Suicide pre Suicide prevention and people from culturally and linguistically diverse (CALD) backgrounds*, 2007, p. 2 http://www.livingisforeveryone.com.au/LIFE-Fact-sheets.html (accessed 30 April 2010)

140 Australian Federation of International Students, *Submission 135*, p. 2.

The Psychotherapy and Counselling Federation of Australia noted that international students were a group at risk who frequently experience extreme isolation, are often not provided with counselling and welfare services by educational institutions and are not eligible for Medicare funded services.[141] The MHCA also outlined a number of CALD sub-groups which had been identified as having a heightened risk of suicide. These includes the elderly; asylum seekers and refugees; male immigrants in rural and remote areas and women.

6.110 Stigma issues were highlighted as particularly difficult for CALD communities where there were often '…high levels of stigma surrounding mental health issues'. [142] This was seen as preventing early recognition of mental health issues which were a risk for suicide and discouraging help-seeking behaviour.

6.111 MHCA noted that a lack of coordination exists between multicultural community services and mental health services which 'hampers efforts to address suicide in CALD communities'. MMHA highlighted the language barriers faced by people from CALD backgrounds and recommended a multilingual telephone crisis and counselling service similar to the Lifeline model to assist these CALD consumers and carers when faced with suicide.[143] The Ethnic Communities Council of Western Australia noted a lack of culturally competent, culturally responsive, and culturally and linguistically appropriate mental health and suicide prevention services for CALD consumers.[144] The TMHC recommended targeted and collaborative suicide prevention activities in line with the NSW Multicultural Mental Health Plan 2008-12 which include '…improving the use of interpreters and translators, stigma reduction campaigns, developing mental health literacy and resources particularly for new and emerging communities'.[145]

6.112 Only one NSPP program specifically mentioned CALD communities as a targeted group. The Reducing Suicide and Traumatic Aftermath in Culturally Diverse Communities in Tasmania provided by the Migrant Resource Centre focuses on reducing the suicide risk and increasing the capacity to respond to suicide crises within CALD communities and CALD individuals.[146] DoHA also highlighted another project which focuses on young people from refugee backgrounds. The NEXUS Project coordinated by the Queensland Program of Assistance to Survivors of Torture aims to promote well being and resilience building in refugees aged 12-24 in Brisbane

141 Psychotherapy and Counselling Federation of Australia, *Submission 72*, p. 8.

142 TMHC, *Submission 76*, p. 3.

143 MMHA, *Submission 93*, p. 5.

144 Ethnic Communities Council of Western Australia, *Submission 36*, pp 3-4.

145 TMHC, *Submission 76*, p. 7.

146 DoHA, *Submission 202, Appendix D*, pp 13-14.

and Toowoomba by increasing three of the major protective factors for suicide: connectedness, locus of control and perceived academic performance.[147]

Prisoners

6.113 Suicide and self harming behaviour in prisons has been a significant issue in Australia. In particular, the increase in Aboriginal deaths in prison in the 1980s led to the Royal Commission into Aboriginal Deaths in Custody. Prisoners and those in custody were identified as an important group with an increased at risk of suicide during the Committee's inquiry. For example the Tasmania Government stated that among '…a ten per cent sample of men who presented at prison health services in March - April 2008, 25 per cent exhibited suicide and self-harm behaviour…'.[148]

6.114 The Victorian Institute of Forensic Mental Health stated:

> It is… undeniable that people in prisons generally have poor health and mental health profiles and include vulnerable groups that traditionally have the highest risk of suicide – eg. young males, the socially disenfranchised and isolated, people with substance use problems and those who have previously displayed suicidal behaviours. In addition, the psychological impact of imprisonment and the daily stressors associated with the prison environment are challenging to even the most robust of prisoners.[149]

6.115 SPA noted that suicide attempts by those in prison are significantly higher than in the general population. They noted that many who die through suicide within '…the first 24 hours of confinement tend to be charged with minor, non-violent alcohol and/or drug-related charges, with many of these individuals being acutely intoxicated at the time'.[150] Mr Michael Barnes, the Queensland Coroner stated that hanging points in prison cells and '…resulting suicide by hanging continue to be a blight on correctional services'.[151]

6.116 The time following release from prison was also seen as a period of increased risk for former prisoners.[152] Ms Jenna Bateman from the Mental health Coordinating Council commented:

> Studies suggest that the initial adjustment period after release is a time of extreme vulnerability, particularly for men. On return to the community, variables associated with suicide, such as hopelessness, significant loss, social isolation, lack of support and poor coping skills, are especially

147 DoHA, *Submission 202*, p. 51.

148 Tasmanian Government, *Submission 244*, p. 10.

149 Victorian Institute of Forensic Mental Health, *Submission 125*, p. 5.

150 SPA, *Submission 121*, p. 42.

151 Mr Michael Barnes, *Proof Committee Hansard*, 18 May 2010, p. 53.

152 Suicide is Preventable, *Submission 65*, p. 80; Dr Andrew Campbell, Richmond Fellowship of NSW, *Committee Hansard*, 3 March 2010, p. 35.

> significant for this group. An Australian study of recently released prisoners found that in the immediate six-month post release period the suicide rate is three times higher than in the general population.[153]

6.117 Mental Health ACT is currently undertaking a quality improvement program to provide follow-up to those people released from prison who have been identified as having a mental health problem by a follow up contact within seven days of release from prison.[154] Boystown also noted the benefits of their program *Participate in Prosperity*, designed to give vocational training and other support to young people coming from detention centres and prisons.[155]

The elderly

6.118 Despite a reduction in overall suicide rates, RANZCP expected the number of suicides among older men to rise given they constitute a fast growing segment of the population. They stated:

> Suicide rates reach a second peak (after the 25-44 age group) in older men aged over 85 years. Men aged 75 years and over remain a high risk group. Contributing factors in old age suicide may include physical or economic dependency, mental and/or physical health problems, chronic pain, grief, loneliness, alcoholism or carer stress.[156]

6.119 The Salvation Army also saw an increasing need to target resilience programs and suicide prevention programs to elderly people.[157] Similarly Professor Brian Draper considered suicide in old age remained a neglected topic. He commented that the circumstances leading up to a suicide attempt in old age frequently involve '…declining health including chronic pain, in combination with social isolation, lack of social support, and evolving depression & hopelessness'. He noted:

> Suicide is likely to be under-reported in the elderly with GPs and other doctors being more likely to record deaths in frail elderly as being due to natural causes to avoid stigma for families and possibly in some circumstances to cover up assisted suicides. There is an issue of overlap with euthanasia but this would affect less than 10% of late life suicides.[158]

6.120 Professor Draper noted that the NSPS had been developed out of a youth suicide strategy and had '…yet to fully grasp a lifespan approach other than in the

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153 Ms Jenna Bateman, Mental Health Coordinating Council, *Committee Hansard*, 3 March 2010, p. 3.

154 ACT Government, *Submission 44*, p. 7.

155 Mr Dean Brunker, Boystown, *Committee Hansard*, 2 March 2010, p. 5.

156 RANZCP, *Submission 47*, p. 17.

157 Salvation Army, *Submission 142*, p. 35.

158 Professor Brian Draper, *Submission 13*, p. 1.

words used' and 'few specific strategies targeting older people have been implemented'.[159]

6.121 The AMA noted that elderly people are likely to have established relationships with medical practitioners, including a GP. They suggested that this '…offers a significant opportunity for suicide prevention, including the identification of those elderly people who may be at an increased risk of suicide'. They recommended awareness raising amongst medical professionals to highlight the risk of suicide in the elderly.[160]

6.122 The Committee received a number of personal submissions from elderly people highlighting the challenges, indignities and lack of choices frequently faced by those nearing the end of their lives. The submissions received often made valid and persuasive arguments that this area of policy should be reviewed. While the Committee has made a decision not to focus on the issue of euthanasia in the inquiry it has noted this topic has attracted significant interest.

Other groups

6.123 A number of other groups were also identified as being at increased risk of suicide or attempted suicide during the inquiry, including the long term unemployed[161] and junior doctors. [162]

Victims of childhood physical and sexual abuse

6.124 Adults Surviving Child Abuse highlighted that research studies from Australia and overseas '…consistently demonstrate that adult survivors of child abuse and neglect are at risk of a range of mental health problems, such as depressive and anxiety disorders, substance abuse, eating disorders, post-traumatic stress disorders and suicidality'.[163] The Suicide is Preventable submission also stated:

> 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.[164]

6.125 A joint submission by the Alliance of Forgotten Australians (AFA) and Care Leavers of Australia Network (CLAN) recalled the Committee's inquiry into the *Forgotten Australians*. The inquiry found that care leavers were subjected to emotional, physical and sexual abuse and this lead to a range of major health and

159 Professor Brian Draper, *Submission 13*, p. 2.

160 AMA, *Submission 55*, p. 3.

161 Psychotherapy and Counselling Federation of Australia, *Submission 72*, p. 8.

162 AMA, *Submission 55*, p. 4.

163 Adults Surviving Child Abuse, *Submission 216*, p. 1.

164 Suicide is Preventable, *Submission 65*, p. 21.

mental health problems including depression, anxiety, post-traumatic stress disorders, drug and alcohol problems. The anecdotal evidence received during that inquiry showed an abnormally large percentage of suicides among care leavers.[165] The Committee recommended that Commonwealth and State Governments, in providing funding for health care and in the development of health prevention programs (including suicide prevention), recognise and cater for the health needs and requirements of care leavers.[166]

Conclusion

Telephone support services

6.126 Telephone crisis and support services provide vital assistance to those who may be at risk of suicide. These services have the advantage of being available to almost all callers at anytime regardless of their location. However as telecommunications technology changes, consumers are moving to mobile and wireless devices which incur increased call costs. The Committee was concerned to hear that the cost of calls could be restricting access to telephone support services for people in need. The Committee considers access to crisis telephone support and counselling a critical component of suicide prevention activity in Australia. The services provided by Lifeline, Kidsline, Mensline and the other telephone services should be available at minimal cost to the user. The Committee considers that steps should be taken to ensure access to these services is maintained and not inhibited by cost disincentives.

Recommendation 23

6.127 The Committee recommends that the Commonwealth government ensure telecommunications providers provide affordable access to telephone and online counselling services from mobile and wireless devices.

6.128 The Committee recognises the important work done by the volunteers of Lifeline Australia. The proposal made to mandate Lifeline as a toll-free national crisis telephone support service has considerable merit. The implementation of a national crisis line to assist people at risk of suicide should be independently assessed.

Recommendation 24

6.129 The Committee recommends that the Commonwealth government commission an implementation study for a national toll-free crisis support telephone service to assist those at risk of suicide.

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165 Joint Submission by AFA and CLAN, *Submission 139*, p. 1.

166 Senate Community Affairs References Committee, *Forgotten Australians: A report on Australians who experienced institutional or out-of-home care children*, 2004, p. 95

Access to means

6.130 Submissions received by the Committee made it clear there is strong evidence for restricting access to means as a suicide prevention activity. Possible areas to reduce access to the means of suicide cover a number of policy areas and may require whole of government action to initiate reform.

6.131 The Committee does not see adequate reason for the NSPP to be unable to fund infrastructure and other projects for the purposes of suicide prevention at 'suicide hotspots'. In particular the Committee considers that NSPS funding should be available to implement changes at locations such as the Gap in Sydney. These interventions should be completed after appropriate assessment, be evidence based and according the best practice guidelines being prepared by DoHA.

Recommendation 25

6.132 The Committee recommends that the National Suicide Prevention Program include funding for projects to reduce access to means of suicide and prevention measures at identified 'suicide hotspots'. These interventions should be evidence based and in accordance with agreed guidelines.

Men

6.133 The Committee notes the comparatively low number of projects and level of expenditure focused on men as a population group at higher risk of suicide. While men at risk of suicide are also covered by other targeted programs such those aimed at rural and remote areas the Committee considers this should be given greater priority in the future given the proportion of men who complete suicide.

Recommendation 26

6.134 The Committee recommends that the National Suicide Prevention Program should increase the funding and number of projects targeting men at risk of suicide.

Indigenous communities

6.135 The possibility of a separate suicide prevention strategy for Indigenous communities was discussed during the inquiry. The high impact of suicide on Indigenous communities suggests a separate strategy is justified. A risk exists that the creation of a separate strategy could create a disincentive for people in Indigenous communities to access mainstream suicide prevention support services. However in the view of the Committee, a separate strategy would assist Indigenous communities by targeting specific suicide prevention services and programs to the unique characteristics and features of these communities. This Indigenous suicide prevention strategy should form part of the overall NSPS.

6.136 Suicide clusters were identified as a phenomenon which disproportionately affects Indigenous people. In the view of the Committee the potential for government

and community services to rapidly react to suicides in Indigenous communities to reduce the risks of suicide clusters should be investigated.

Recommendation 27

6.137 The Committee recommends that the Commonwealth governments develop a separate suicide prevention strategy for Indigenous communities within the National Suicide Prevention Strategy. This should include programs to rapidly implement postvention services to Indigenous communities following a suicide to reduce the risk of further suicides occurring.

Children and young people

6.138 The Inspire Foundation has demonstrated that the internet and communication technology can be a significant means to assist children and young people. However the online environment can also have negative influences on children. The Committee is concerned by the links between bullying and cyber-bullying and suicidal behaviour by young people. The Committee notes the current Joint Select Committee on Cyber-Safety is focusing on the issue of cyber-bullying. The Committee anticipates the inquiry will be able to address this topic in greater detail.

6.139 The Committee recognises the valuable work done in secondary schools around Australia by teachers and other school staff who assist young people through the Mind Matters initiative. However the Committee was concerned the availability of this program was dependent on the willingness of school staff to participate. More should be done to promote the benefits of this program and other young focused suicide prevention programs to schools.

6.140 The Committee was also impressed by the important work being undertaken by the Queensland Commission for Children and Young People and the Child Guardian in studying the factors influencing child deaths. The fact that Australian children complete suicide is a terrible tragedy, but this does not mean that public agencies and policy makers should not acknowledge these events occur. The Committee recognises there are additional sensitivities with finding and recording child suicides. Care and tact should be taken where the recording of low incidence numbers in particular areas could impact on the privacy of bereaved families. However the reluctance by the ABS to track child suicides by those under 15 years of age does not encourage official acknowledgement of this important issue or assist policy makers to develop preventative measures.

Recommendation 28

6.141 The Committee recommends that the Australian Bureau of Statistics and other public agencies which collect health data record and track completed suicides and attempted suicides of those under 15 years of age.

People who have attempted suicide or self harmed

6.142 In the programs funded under the NSPP there did not appear to be an emphasis on community based support groups for those who had attempted suicide or self harmed. It was recognised during the inquiry that it may not be appropriate for this group to access the community support which exists for other people affected by suicide. The personal stories the Committee received from people who had attempted suicide indicated that some with this history would benefit from access to community based support groups.

Recommendation 29

6.143 The Committee recommends that targeted programs be developed to provide community support group assistance for people who have attempted suicide and those who self harm.

People with mental illness

6.144 There are strong linkages between suicide and mental illness. Programs which seek to diagnose and treat mental illness undoubtedly also operate to reduce the rates of suicide and attempted suicide in the community. However many who take their own lives will not be mentally ill or will have previously used mental health services. The Committee has previously inquired into mental health services in Australia and recommended that services and support for the mentally ill need to be increased.[167] The evidence received during this inquiry has reiterated the need for mental health services to be widely accessible and adequately resourced.

Recommendation 30

6.145 The Committee recommends that additional resources be provided by Commonwealth, State and Territory governments to mental health services. These services are recognised as functioning to reduce the rate of suicide and attempted suicide in Australia.

People in regional, rural and remote areas

6.146 The lack of access to health and mental health care services was seen as a key risk factor for people living in regional, rural and remote areas. Community resilience was seen as a key factor in reducing suicides. It was recognised that suicide prevention training should be directed to people who are in regional, rural and remote areas and have day-to-day contact with those who may be at risk.

167 Senate Community Affairs Committee, *Towards Recovery: mental health services in Australia*, 2008.

Recommendation 31

6.147 The Committee recommends that additional 'gatekeeper' suicide awareness and risk assessment training be directed to people living in regional, rural and remote areas.

Lesbian, gay, bisexual, transgender and intersex

6.148 The Committee supports the Suicide is Preventable submission recommendation that LGBTI people be recognised as a higher risk group in suicide prevention strategies, policies and programs, and that funding for targeted approaches to prevent suicide in LGBTI communities be made available.[168]

Recommendation 32

6.149 The Committee recommends that lesbian, gay bisexual, transgender and intersex people be recognised as a higher risk group in suicide prevention strategies, policies and programs, and that funding for targeted approaches to assist these groups be developed.

People bereaved by suicide

6.150 The personal impact of suicide on people with close relationships with deceased is enormous. During the inquiry the Committee received evidence regarding a range of programs and projects to support people bereaved by suicide. However it also received evidence from those bereaved by suicide who experienced difficulty in finding and accessing assistance. In the view of the Committee there could be more coordination and consistency amongst the various programs and projects intended to assist people bereaved by suicide. The Committee supports the SPA recommendation for the development and promotion of a National Suicide Bereavement Strategy with a commitment by government to long-term funding and improved transparency and coordination.[169]

Recommendation 33

6.151 The Committee recommends that the Commonwealth, State and Territory governments together with community organisations implement a national suicide bereavement strategy.

Prisoners

6.152 An identified gap in the suicide prevention programs and assistance directed to prisoners was during the time following release. The Committee considers a NSPP targeted program or project to assist those who have been recently released from jail should be assessed the next time funding is allocated.

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168 Suicide is Preventable, *Submission 65*, p. 29.

169 SPA, *Position Statement on Suicide Bereavement and Postvention*, May 2009, p. 12.

Recommendation 34

6.153 The Committee recommends the development of a National Suicide Prevention Program initiative targeting assistance to people recently released from correctional services.

CHAPTER 7

SUICIDE RESEARCH

Introduction

7.1 This chapter will deal with term of reference (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.

NSPS suicide research

7.2 DoHA outlined three research projects which the Commonwealth Government had provided funding towards:

- the WHO Suicide Trends in At-Risk Territories study from 2008 -2010 to investigative preventative interventions across various countries, cultures and population sub groups within the Asia-Pacific region;
- University of Sydney case-control studies of suicides and attempted suicide in young adults in NSW commenced under a National Health and Medical Research Council (NHMRC) project grant; and
- the completed Australian National Epidemiological Study of Self-Injury project which aimed to determine the prevalence and nature of self-injury amongst the Australian population.[1]

7.3 In 2008 AISRP at Griffith University became a National Centre of Excellence in Suicide Prevention (NCESP) under the NSPS.

The purpose of the NCESP is to:

- provide advice on evidence-based best practice suicide prevention activity to inform the NSPP workplan, commencing with the ATAPS program, but also in relation to other activity, such as population health approaches to suicide prevention through school-based activity;
- offer direct support to agencies contracted by DoHA to undertake new and emerging suicide prevention activities, particularly where this pertains to selective interventions to individuals who have attempted suicide or self-harm;
- provide a quarterly critical literature review outlining recent advances and promising developments in research in suicide prevention, particularly where this can help to inform national activities;

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1 DoHA, *Submission 202*, pp 64 -66.

- provide advice on improving approaches to evaluation of suicide prevention activities and on the development of evaluation frameworks for new projects, such as the ATAPS suicide prevention project and other identified areas of the NSPS workplans; and
- provide advice on the implications of existing suicide prevention data and on issues around the credibility of suicide data.[2]

A focus on the evaluation of interventions

7.4 A number of the main suicide prevention organisations and others emphasised that Australia currently did not have a set of priorities for research into suicide and no systemic process for developing research priorities. Many submitters cited an article in *Crisis: Journal of Crisis Intervention & Suicide* which examined research priorities in suicide prevention in Australia. This article concluded:

> Well-conducted intervention studies are necessary to inform the suite of suicide prevention activities to be undertaken under the LIFE Framework. At present, we know very little about what works and what doesn't work in suicide prevention.
>
> Given the limited knowledge regarding which interventions might be efficacious, it would seem reasonable for attention to be paid to studies that assess the efficacy of the full spectrum of suicide prevention interventions (universal, selective, and indicated) and/or evaluate suicide prevention policies, programs, and services.[3]

7.5 This study of suicide prevention research also supported equal focus be placed on research into both suicide and attempted suicide. In relation to target groups for research it stated that young people were the most commonly researched and prioritised, as well as those with mental health problems and those who have attempted suicide and self harm. However it argued:

> It would seem premature, however, to prioritise only these groups over others, particularly since, as noted above, we know so little about what works and what doesn't work in terms of suicide prevention for *any* target group.[4]

7.6 The *Crisis* article reflects an earlier international systematic review of suicide interventions in 2005 which could only identify two prevention strategies for which

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2 DoHA, *Submission 202*, p. 64; AISRP, *Submission 237*, p. 109.

3 Jo Robinson et al, 'Research Priorities in Suicide Prevention in Australia; A Comparison of Current Research Efforts and Stakeholder-Identified Priorities', *Crisis: Journal of Crisis Intervention & Suicide*, 2008, vol. 29, no.4, p. 188.

4 Jo Robinson et al, 'Research Priorities in Suicide Prevention in Australia; A Comparison of Current Research Efforts and Stakeholder-Identified Priorities', *Crisis: Journal of Crisis Intervention & Suicide*, 2008, vol. 29, no. 4, p. 188.

there was evidence of effectiveness: educating physicians to detect, diagnose and manage depression and restricting access to lethal methods of suicide. The review did not reject other strategies as ineffective but found these interventions need more evidence of efficacy.[5]

7.7 The focus on the evaluations of interventions was widely supported. For example Lifeline Australia stated that in its experience there does not appear to be a mechanism to assess the efficacy of trials/pilot programs and if these should be implemented nationally as a sustainable funded service. Similarly SPA noted:

> …Australia's suicide and suicide prevention research agenda should more effectively emphasise and adopt the principle and practice of evaluations of specific suicide-related interventions, policies, programs and services.[6]

7.8 The MHCA argued:

> Unless measures are put in place to ensure that programs and policies are working, we will continue to see precious resources going to antiquated systems and failed programs; programs that have failed for many years to make significant inroads in reducing suicide rates, especially in high risk groups and communities. [7]

7.9 However there appeared to have been a lack of such evaluations of suicide prevention activities in the previous years. Associate Professor Jane Pirkis outlined research undertaken which reviewed the 156 projects funded under the original NSPS. While the organisations which received funding for these projects were contractually obligated to evaluate '…in practice the evaluations were methodologically too weak to contribute much to the evidence base regarding what works and what doesn't work in suicide prevention'.[8] Similarly AISRP highlighted that despite a broad range of programs funded by the Commonwealth and States only 60 per cent included an effectiveness evaluation component and none of those evaluated the impact of the interventions on the actual suicide rate.[9]

Difficulties assessing suicide interventions

7.10 It was acknowledged during the inquiry that evaluations of the effectiveness of suicide prevention inventions and initiative posed a numbers problems for

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5 Associate Professor Jane Pirkis, *Submission 27*, p. 1; J Mann et al, 'Suicide prevention strategies: a systematic review', *Journal of the American Medical Association*, 2005, vol. 294, p. 2064.

6 SPA, *Submission 121*, p. 61.

7 MHCA, *Submission 212*, op. 5.

8 Associate Professor Jane Pirkis, *Submission 27*, p. 1; A Heady et al, 'A review of the 156 local projects funded under Australia's National Suicide Prevention Strategy: overview and lessons learned', *Australian e-journal for the Advancement of Mental Health*, 2006, vol. 5, no. 3, p. 247.

9 AISRP, Submission 237, pp 106-107.

researchers. For example Orygen Youth Health Research Centre stated that while suicide and its associated sequelae represent a significant health problem it is a rare event '… which means that large numbers of participants are required for intervention studies to have sufficient power to enable meaningful conclusions to be drawn'. They suggested suicide research would benefit from the development of research networks which would facilitate the development of multi-site studies.[10]

7.11 Associate Professor Jane Pirkis also described the problems for researchers seeking to evaluate suicide interventions. Suicide prevention activities are usually not amenable to the 'gold standard' of randomised control trials. She argued that there needed to be recognition that '… some interventions, by their very nature, will not be amenable to randomised controlled trials but that we must apply the most rigorous designs that we can'.[11] AISRP also suggested that while controlled randomised trials were not always feasible in the domain of suicide prevention research '…other sound evaluation designs could be used, e.g. quasiexperimental designs using control groups'.[12]

7.12 The ethical issues of researching suicide prevention were also raised. The Suicide is Preventable submission stated that ethics committee approval processes would generally prohibit research involving any person who may be demonstrating suicidal behaviour.[13] SPA emphasised there was a paucity of evidence regarding what interventions work in suicide prevention but also noted these studies were difficult to complete. They commented:

> Ethical concerns arise with recruiting actively suicidal participants to intervention studies (e.g. antidepressant pharmacotherapy, psychotherapy) or alternatively excluding them from interventions… There are also major statistical problems with demonstrating a reduction of suicide, though these are not insurmountable…[14]

Disseminating research

7.13 The LIFE Communications project delivered by Crisis Support Services '…aims to improve the effectiveness of suicide and self-harm prevention activities in Australia by providing access to the latest information and shared learnings from the NSPS in suicide prevention, intervention and postvention'.[15] Components of the project include providing access to the LIFE suite of resources and access to the latest information activities and resources in suicide prevention. From June 2009 to

10 Orygen Youth Health Research Centre, *Submission 82*, p. 3.

11 Associate Professor Jane Pirkis, *Submission 27*, p. 3.

12 AISRP, *Submission 237*, p. 108.

13 Suicide is Preventable, *Submission 65*, p. 128.

14 SPA, *Submission 121*, p. 60.

15 DoHA, *Submission 202*, p. 63,

September 2009, 674 hard copies of the LIFE resource were distributed. Between June 2009 to October 2009 there were over 16,300 visits to the LIFE website.[16]

7.14 However there were some concerns raised during the inquiry about the dissemination of research. The Salvation Army had concerns that suicide research information was '…not readily accessible to practitioners within the health and welfare sectors'. They perceived a need to ensure that research was '… synthesised and incorporated into salient messages disseminated through mediums that will reach the front line staff who are working with people at risk of suicide'.[17]

7.15 In the area of suicide prevention Dr Erminia Colucci argued there was 'too much separation between academia and services'.[18] This was supported by Professor Colin Tatz who described the dissemination of suicide research material was 'frankly, dismal' noting that '…lay people don't read articles in *Australasian Psychiatry*; nor do many of the health professionals, educators and community workers who seek to prevent suicide'.[19] Psychotherapy and Counselling Federation of Australia members also reported that current research was inadequate and hard to access.[20]

7.16 The Integrated Primary Mental Health Service of North East Victoria also noted that statistical information about suicide is not routinely made available for clinical staff within their own geographical environment and contexts. They commented:

> As a service, we are often frustrated with a lack of clarity around accurate regional suicide statistics, and how to access them…. Improved dissemination of these statistics would be immensely helpful in supporting our delivery of evidenced-based mental healthcare.[21]

Resource Centre

7.17 Lifeline stated that 'Australia currently lacks a systematic formal mechanism for identifying, enabling and communicating information about best practice'. They proposed the creation of a best practice registry similar to one currently operating in the United States, the Suicide Prevention Resource Centre (SPRC).[22] The SPRC was established in 2002 and '…supports suicide prevention with the best of science, skills and practice to advance the United States National Strategy for Suicide Prevention (NSSP)'. It includes a best practice registry for suicide prevention to identify, review,

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16 DoHA, *Submission 202, Appendix D*, p. 23.

17 Salvation Army, *Submission 142*, p. 42.

18 Dr Erminia Colucci, *Submission 77*, p. 1.

19 Professor Colin Tatz, *Submission 16*, p. 1.

20 Psychotherapy and Counselling Federation of Australia, *Submission 72*, p. 9.

21 Integrated Primary Mental Health Service of North East Victoria, *Submission 26*, pp 3&6.

22 Lifeline Australia, *Submission 129*, pp 67-68.

and disseminate information about best practices that address specific objectives of the NSSP.[23]

7.18 SPA also argued that in many cases the information distributed on 'best practice' suicide prevention, intervention and postvention strategies is outdated. They stated it was essential for 'best practice' standards and accreditation for all service delivery and training. SPA recommended the development of an independent suicide prevention accreditation and standards agency 'to manage the accreditation and evaluation of suicide prevention service delivery, training and programs'.[24]

Gaps in research

7.19 Several submissions which discussed specific groups who were at risk of suicide also identified gaps in the research about these groups. For example, MHCA noted that the research priorities study 'revealed that, of 209 published journal articles and 26 funded grants undertaken between 1999 and 2006, none specifically targeted CALD populations ... Only 2% of people conducting suicide prevention research were identified as targeting CALD peoples.[25] Similarly the Victorian Institute of Forensic Mental Health argued that while there had been considerable research in suicide and prevention for prisoners in the 1990s little attention had been given to this issue in the past decade. They stated:

> With the number of prisoners in Australia increasing at unprecedented levels, it is vital that research into suicide and self harming behaviour within the criminal justice system be conducted to inform Government decision making. Specific issues in relation to women, the personality disordered and people with a multi-cultural background are specific areas that require close investigation.[26]

7.20 Ms Leonore Hanssens commented:

> There is 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 accelerating dramatically.[27]

7.21 SPA listed a number of gaps in suicide and suicide prevention research including the coordination and communication between sectors and services to prevent individuals 'falling through the gaps'. They suggested mapping these gaps

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23 Available at www.sprc.org (accessed 30 April 2010)

24 SPA, Submission121, pp 48 & 51.

25 MHCA, *Submission 212*, p. 31.

26 Victorian Institute of Forensic Mental Health, *Submission 125*, p. 7.

27 Ms Leonore Hanssens, *Submission 83*, p. 3.

'may assist in better addressing them…'. They also suggested research into the lived experience from those affected by suicide and those who provide services to them. [28]

7.22 A wide range of other potential research areas were identified by SPA during community consultations including: the impact on professionals of suicide by patients; vicarious trauma on first responders and others who work closely with suicide; evaluations of completed suicide by persons refused admission to psychiatric care and following hospital discharge; practices of detention and seclusion within mental health facilities; inadequacies in assessment and response to people at risk of suicide; effectiveness of anti-depressants in suicide prevention; use of new media and internet in suicide prevention; impact of global wide scale events such as the global financial crisis; and the relationship between economic disadvantage and suicide.[29]

7.23 AISRP proposed two specific research projects. The first a study to assess the effectiveness of intensive case management on outcomes for suicidal psychiatric patients in the post discharge period. The second was a model of treatment for suicidal behaviour which offers an alternative to hospital-based care. The aim of the 'Life House' project is to develop an alternative to hospital-based care that can provide a comprehensive range of services (including community based psycho-social rehabilitation) for individuals who are suicidal.[30]

Funding

7.24 Funding for research and evaluation of suicide prevention activities was identified as coming from two sources. The first was Commonwealth, State and Territory health departments which provide resources for internal or external evaluation of particular suicide prevention activities they have funded. Associate Professor Jane Pirkis commented:

> Contracts awarded by health departments provide for evaluations of a range of often large and complex initiatives, but the evaluations tend to be constrained (e.g., the intervention is often well under way by the time the evaluation is commissioned, making it difficult to gather baseline information).[31]

7.25 The second source of research funding was academic granting bodies such as the NHMRC and the Australian Research Council (ARC). Associate Professor Jane Pirkis stated that grants from these organisations are '…investigator-driven and peer reviewed, so they are typically very strong methodologically, but the funding is usually limited so the interventions they test tend to be fairly small in scale'.[32]

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28 SPA, *Submission 121*, pp 61-62.

29 SPA, *Submission 121*, p. 62.

30 AISRP, *Submission 237*, pp 210 – 214.

31 Centre for Rural and Remote Mental Health Queensland, *Submission 27*, p. 3.

32 Associate Professor Jane Pirkis, *Submission 27*, p. 3.

7.26 Prior to 2006 the scope of the NSPP did not allow funding of research projects. DoHA commented that while 'the capacity for funding research directly through the NSPP is limited, there are other sources of funding available to support research into suicide prevention and related areas'. DoHA provided a table summarising NHMRC funding of mental health, suicide and substance abuse. This table indicated that the NHMRC research funding for suicide has fluctuated but had not increased at the same level as research for mental health and substance abuse. NHMRC mental health research funding had steadily increased from $7.5 million in 2000-01 to $28.9 million in 2006-07. In contrast, funding for suicide research was $0.96 million in 2000-01 and had fallen to $0.58 million by 2006-07.[33]

7.27 The Australasian Society for Psychiatric Research analysed previous NHMRC research grants to determine the relative proportion of NHMRC funding provided for research focusing on suicide prevention strategies. In 2010 they found no NHMRC research grants for suicide prevention research and little funding in previous years had been directed to suicide and its prevention (in either project grants or fellowships). They recommended priority funding be set aside for suicide in subsequent NHMRC rounds.[34]

7.28 RANZCP also highlighted that the NHMRC research expenditure on the issue of suicide was considerably less than other social problems and diseases with similar mortality rates such as breast cancer, skin cancer and road traffic accidents.[35] They recommended better collaboration between Commonwealth and State governments to fund research into suicide prevention and the appointment of an expert body to oversee all suicide prevention research linked to academic institutions. [36]

7.29 Professor Joan Ozanne-Smith commented that the current focus of research, research funding and organisational committees and their structures is on mental health. She noted '…people taking a different perspective have been excluded from some of these national processes'.[37] Dr Erminia Colucci also sought to bring the lack of specific funding for suicide research to the attention of the Committee. She noted that suicide researchers such as herself must apply for general mental health, community and health promotion grants which give them '…little chance to ever get our hands on these grants because other topics are usually favoured'.[38]

7.30 Other witnesses commented on the lack of funding for research centres for suicide. Mr Sebastian Rosenberg from the BMRI contrasted the resources available for alcohol and drug research to those available to research suicide:

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33 DoHA, *Submission 202*, p. 67.

34 Australasian Society for Psychiatric Research, *Submission 20*, pp 1-2.

35 RANZCP, *Submission 47*, p. 11.

36 RANZCP, *Submission 47*, p. 23.

37 Professor Joan Ozanne-Smith, NCIS, *Committee Hansard*, 4 March 2010, p. 48

38 Dr Erminia Colucci, *Submission 77*, p. 1.

> …when it comes to comparing and contrasting developments in the alcohol and drug sector, is this purposive investment in independent research centres which are able to operate as an engine to gather and validate information to inform public debate and to inform, frankly, public spending. That makes a huge difference to being able to make astute decisions about what works and what does not work in alcohol and drugs.[39]

7.31 Mr David Crosbie of the MHCA contrasted the federal funding of research centres in relation to drugs and addiction. He stated:

> We have a real lack of a bringing together of the researchers who are trying to do work in this area and creating the kinds of economies of scale and the kind of capacity that is needed to actually say what is happening in mental health in this country at the moment.[40]

Conclusion

7.32 A consistent message that the Committee received during the inquiry was that there is limited evidence regarding which suicide prevention interventions are effective and consequently there is an urgent need for research in this area. However many submissions and witnesses also acknowledged that the evaluation of suicide prevention activities could be difficult and costly.

7.33 There does appear to be potential for Commonwealth, State and Territory governments, together with national research funding organisations, academic institutions and other organisations to cooperatively fund detailed evaluations of suicide prevention interventions. However these opportunities to pool funding for important research ultimately depend on the willingness of funding partners to participate.

7.34 The Committee considers a simpler approach would be to include funding in the NSPP for major evaluations of suicide prevention interventions. This would have the potential of allowing these large scale assessments to be tied into the individual project evaluations requirements which already exist for many projects funded under the NSPP.

Recommendation 35

7.35 The Committee recommends that the Commonwealth government provide funding in the National Suicide Prevention Program for research projects into suicide prevention, including detailed evaluations of suicide prevention intervention.

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39 Mr Sebastian Rosenberg, BMRI, *Committee Hansard*, 1March 2010, p. 57.

40 Mr David Crosbie, MHCA, *Committee Hansard*, 1 March 2010, pp 22 – 23.

7.36 There was general agreement that the LIFE suite of resources and materials were valuable for both suicide prevention researchers and service providers. However some service providers and community organisations who worked 'at the coalface' did not feel that research was being disseminated to them appropriately.

7.37 The Committee considers there is scope for the organisations which collect and distribute suicide research in Australia to be more proactive in both identifying research findings and then locating organisations and staff who may benefit from that research. These organisations include: the Life Communications project responsible for the LIFE suite of resources; the NCESP which publishes the bi-annual suicide prevention literature review; SPA which regularly creates position statements on aspects of suicide prevention; and the ABS and NCIS which collect and record suicide statistics.

7.38 The Committee supports the Lifeline Australia recommendation for the creation of a suicide prevention resource centre and best practice registry. In particular the Committee considers the sector would benefit from a research centre which would:

- function as source of reliable information for those seeking suicide prevention services such as training;
- identify and list evidence-based suicide prevention practices and programs, including community programs, training and service delivery;
- offer guidance to people seeking to develop and implement best practice activities;
- operate as a clearing house for collecting, listing and accessing standards that meet professional consensus-based criteria for best practice;
- provide a forum where practitioners and researchers can communicate and develop best practice in suicide prevention; and
- provide a forum for progressing research priorities in suicide prevention.[41]

Recommendation 36

7.39 The Committee recommends the Commonwealth government, as part of the National Suicide Prevention Strategy, create a suicide prevention resource centre to collect and disseminate research and best practice regarding suicide prevention.

41 Lifeline Australia, *Submission 129*, p. 68.

CHAPTER 8

THE NATIONAL SUICIDE PREVENTION STRATEGY

Introduction

8.1 This chapter will address term of reference (h) the effectiveness of the National Suicide Prevention Strategy (NSPS) in achieving its aims and objectives, and any barriers to its progress.

National Suicide Prevention Strategy

8.2 The current NSPS is a program under the COAG National Action Plan for Mental Health 2006-11. The 2006-07 Federal Budget committed the Commonwealth funding which included $62.4 million to expand the NSPP to $127.1 million between 2006-07 and 2011-12.[1] The five year goal of the NSPS is to reduce deaths by suicide across the population and among at risk groups and to reduce suicidal behaviour by:

> Adopting a whole of community approach to suicide prevention to extend and enhance public understanding of suicide and its causes;
>
> Enhancing resilience, resourcefulness and social connectedness in people, families and communities to protect against the risk factors for suicide; and
>
> Increasing support available to people, families and communities affected by suicide or suicidal behaviour.[2]

8.3 DoHA described the current NSPS as having four inter-related components. The first is the LIFE Framework which 'provides national policy for action based on the best available evidence to guide activities aimed at reducing the rate at which people take their own lives'.[3] The second was the National Suicide Prevention Strategy Action Framework which provides a time limited workplan for taking forward suicide prevention and investment. The Action Framework was developed in collaboration with ASPAC and '…will effectively steer the NSPS and NSPP' until 2011. The third, the National Suicide Prevention Program (NSPP), is the Commonwealth funding program for suicide prevention activities which is administered by DoHA. The final component was mechanisms to promote alignment with and enhance state and territory suicide prevention activities, particularly to progress the relevant actions of related national frameworks, such as the COAG

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1 DoHA, *Submission 202*, p. 27.

2 DoHA, *Submission 202*, p. 25.

3 DoHA, *Living is For Everyone (LIFE): A Framework for Prevention of Suicide in Australia*, 2007, p. 6.

National Action Plan for Mental Health 2006-2011 and the Fourth National Mental Health Plan 2009-14.[4]

Suicide prevention in Australia

Department of Health and Ageing

8.4 DoHA has primary responsibility for suicide prevention at the Commonwealth level but outlined the broad range of services and programs (usually in the area of mental health) which assist those at risk of suicide. They stated:

> Mental health services and programs, broader health initiatives such as indigenous health programs, and drug and alcohol support also comprise an important platform from which DOHA administered programs contribute to efforts to prevent suicide and support people at risk of suicidal behaviour. Other Government portfolios similarly administer a broad range of mainstream programs which contribute to supporting individuals at risk and protecting against factors which may be associated with suicidality.[5]

8.5 In the area of mental health services DoHA highlighted a recent review which indicated expenditure had increased to $1.9 billion in 2007-08. They noted that while only 1 per cent of funding is 'directly contributed to the NSPS, a large amount of funds are provided for programs and services which support suicide prevention efforts'.[6] These included mental health services under the MBS and programs such as ATAPS, training for mental health professionals, mental health promotion (including the National Depression Initiative), mental health programs funded for groups at high risk of suicide (such as indigenous specific mental health programs), early intervention programs (such as headspace) as well as programs for parents (perinatal Depression Initiative) and children (KidsMatter Early Childhood).[7] They also highlighted a range of supported telephone and web based crisis support and self help therapies. The investment in the National Drug and Alcohol Strategy was also highlighted as 'extremely relevant to suicide prevention efforts'.

> Broader investment in Indigenous health programs, including social and emotional wellbeing activities also contributes to suicide prevention efforts targeting Aboriginal people and Torres Strait Islanders.[8]

4 DoHA, *Submission 202*, p. 24.

5 DoHA, *Submission 202*, p. 21.

6 DoHA, *Submission 202*, p. 22.

7 DoHA, *Submission 202*, p. 22.

8 DoHA, *Submission 202*, p. 23.

Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)

8.6 The FaHCSIA submission also outlined a range of programs that, while not specifically focused on suicide prevention, also contribute collaterally to the prevention of suicide through promoting resilience and protective factors. They stated:

> FaHCSIA programs play a crucial role in providing early intervention services for individuals and families from high risk vulnerable groups. Many FaHCSIA programs aim to build individual and community resilience, which is core to suicide prevention. Programs also provide services that can ultimately reduce suicide risk and increase protective factors. Research suggests that being part of a cohesive and supportive family unit is an important protective factor for children and young people, helping them to better cope with any stressors or adversity they may encounter.[9]

8.7 In particular FaHCSIA funds Mensline Australia delivered by Crisis Support Services, an initiative which offers a range of services and programs to support men in managing family and relationship difficulties.[10]

Department of Veteran's Affairs (DVA)

8.8 DVA provides training for the peer support of veterans at risk of suicide through Operation Life offering ASIST to veterans or support provided through Family Relationship Centres to help families manage and resolve conflict.[11]

8.9 As part of an election commitment the Commonwealth Government committed to conducting a study that examines the broad issue of suicide in the ex-service community, including a number of specific cases of suicide over the last three years. The Suicide Study report conducted by Professor David Dunt, together with the Government's response, was publicly released on 4 May 2009. The recommendations cover a wide range of matters, including strengthening mental health programs, including suicide prevention, the use of experienced case coordinators for complex cases, and ensuring that administrative processes are more 'user-friendly'.

8.10 The Government allocated $9.5 million over four years to implement the recommendations in order to strengthen and improve the range of mental health services provided, particularly in relation to suicide prevention, to support the veteran community.[12]

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9 FaHCSIA, *Submission 211*, p. 5.

10 FaHCSIA, *Submission 211*, p. 14.

11 DoHA, *Submission 202*, p. 20.

12 DVA, *Submission 215*, p. 2.

8.11 DVA outlined a number of suicide prevention and mental health projects directed to the veteran community. These included Operation *Life*, a framework for action to prevent suicide and promote mental health and resilience across the veteran community. A major part of this framework included suicide prevention workshops as well as the provision of information on treatment services that are available to the veteran community. Also mentioned was the Veterans and Veterans Families Counselling Service (VVCS), a specialised national service that provides counselling and support to Australian veteran, peacekeepers, their families and eligible Australian Defence Force personnel.[13]

Other

8.12 Other areas noted included the role of the Department of Education, Employment and Workplace Relations (DEEWR) which administers a range of services to assist people with mental illness and those at risk of suicide. Another example was that Centrelink social workers referred 3,463 persons 'as a result of being at risk of suicide' and 30,650 more broadly with 'mental health issues'.[14]

States and Territories

8.13 The State and Territory governments have a range of suicide prevention strategies and programs.

8.14 The Queensland Government stated that it planned to finalise the *Queensland Government Suicide Prevention Action Plan* in 2010 following the previous strategies *Reducing Suicide: the Queensland Government Suicide Prevention Strategy 2003-2008* (QGSPS) and *Queensland Government Youth Suicide Prevention Strategy 1998-2003*. It noted that over the past 12 years the Queensland Government has allocated an annual budget of $2 million directly to cross-government suicide prevention initiatives.[15]

8.15 The NSW Government stated that it is in the process of developing a new NSW whole-of-government 5-year suicide prevention strategy which will follow on from the 1999 NSW Suicide Prevention Strategy: *we can make a difference*.[16]

8.16 The WA Ministerial Council for Suicide Prevention is an advisory body to the WA Minister for Mental Health. The Council has been given a mandate to oversee the implementation of the *WA State Suicide Prevention Strategy 2009-2013* which has been committed $15 million over four years.[17]

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13 DVA, *Submission 215*, p. 3.

14 DoHA, *Submission 202*, pp 20-21.

15 Queensland Government, *Submission 205*, p. 1.

16 NSW Government, *Submission 136*, p. 3.

17 WA Ministerial Council for Suicide Prevention, *Submission 70*, p. 1.

8.17 The SA Government noted that SA Health is developing a statewide suicide strategy '…that will focus on social justice, coordination, collaboration, partnerships and building on existing programs'.[18] The strategy will be released in late 2010.[19] The SA Government also outlined recent funding for several suicide prevention and support programs including to Beyondblue, SQUARE, Mental Health First Aid (delivered by Relationships Australia SA) and to Centacare Suicide Prevention Program ASCEND.[20]

8.18 The Victorian *Mental Health Reform Strategy 2000-2019 Because mental health matters* states a goal of the strategy is to:

> Renew our suicide prevention plan, *Next Steps: Victoria's suicide prevention action plan*, using the new national framework to strengthen our ability to identify and respond to risk factors and emerging trends in suicide behaviour and suicide prevention.[21]

8.19 In October 2009, the Tasmanian Government released *Building the Foundations for Mental Health and Wellbeing, a Strategic Framework and Action Plan for Implementing Promotion, Prevention and Early Intervention (PPEI) Approaches in Tasmania* (the Framework). A priority under the framework was the development of a Suicide Prevention Strategy for Tasmania. This has been commissioned and is due for completion in June 2010.[22]

8.20 The NT Government noted that the *NT Strategic Framework for Suicide Prevention* commenced in 2003. A NT Suicide Prevention Action Plan 2009 -2011 was launched in March 2009. The Plan provides a whole of Government response to guide directions in suicide prevention over the next three years. New funding of $330 000 has been allocated by the Department of Health and Families from January 2009 to June 2010 to progress a range of new initiatives including '…increased training programs in suicide prevention and self injury and the development of suicide and bereavement support resources'.[23]

8.21 The ACT Government indicated it had recently launched a new suicide prevention strategy *Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009-2014* which '…was strongly aligned to the LIFE Framework'.[24]

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18 SA Government, *Submission 208*, p. 6.

19 Dr Anthony Sherbon, Department of Health (SA), *Proof Committee Hansard*, 4 May 2010, p. 79.

20 SA Government, *Submission 208*, p. 8.

21 Department of Human Services (Victoria), *Victorian Mental health Strategy 2009-2019: Because mental health matters*, 2009, p. 13

22 Tasmanian Government, *Submission 244*, p. 4.

23 NT Government, *Submission 32*, p. 8.

24 ACT Government, *Submission 44*, p. 1.

Coordination and collaboration.

8.22 A criticism of the NSPS was that it had resulted in fragmented services for those at risk of suicide. The Suicide is Preventable submission argued that 'roles, responsibilities and accountabilities are poorly defined…there is no agency at a national or state/territory level with the mandate to address suicide and suicide prevention'.[25]

8.23 The Suicide is Preventable submission listed how responsibility for suicide was distributed:

- Mortality data collection – this is distributed across an array of organisations.
- Morbidity data – the AIHW 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 non-government organisations (NGOs) – many are parties to or supporters of this Submission.
- Advocacy – SPA
- Self-help groups and other support groups – small networks of community groups. [26]

8.24 Similarly, Lifeline Australia stated that despite the significant achievements of the NSPS, the 'execution of the strategy has often been fragmented and lacks a clear vision for how all levels of government, community stakeholders and consumers can work together in a co-ordinated way to think strategically, plan effectively and achieve good outcomes'. Lifeline Australia recommended the vertical integration of the NSPS by engaging all levels of government in strategic development and

25 Suicide is Preventable, *Submission 65*, p. 12.

26 Suicide is Preventable, *Submission 65*, p. 12.

implementation. It also noted the limited processes or structures for developing systematic, cross sector collaboration. They stated:

> While entities like Suicide Prevention Australia do provide forums for sharing of ideas, programs and research, more substantial collaborative structures and mechanisms are needed to work with governments, stakeholders, communities and consumers around planning, developing and implementing suicide prevention strategy.[27]

8.25 Professor John Mendoza also highlighted problems with service coordination between the programs funded by Commonwealth and the States and Territories. He stated:

> We have ridiculous overlaps and duplications of service, and then we have massive gaps. As one consumer that I work with regularly describes it, it is a lucky dip out there if you can get any access to mental health services. It is a really lucky dip if you get access to quality mental health services, ones that actually are effective. In this area, in relation to people experiencing suicide ideation and suicidal behaviour, it is even a greater lucky dip to actually score the sort of service that is going to work.[28]

8.26 Professor Graham Martin highlighted that there was the risk suicide prevention activities could be subsumed into the mental health agenda and '…lost as an issue'. He also commented on Commonwealth-State service provision coordination:

> Several programs in Far North Queensland were funded by the Commonwealth but nobody at the state level seemed to know much about them—what they were doing or how they were working. So there was then duplication, or attempts at duplication.[29]

8.27 DoHA noted that alignment between Commonwealth, State and Territory suicide prevention activities, coordinating investment and activities, was being progressed through the *Fourth National Mental Health Plan*.[30] This includes action to:

> 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.[31]

8.28 DoHA stated that '…effort has gone into jointly planning Australian Government suicide prevention investment with states and territories, particularly

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27 Lifeline Australia, *Submission 129*, p. 67.

28 Professor, John Mendoza, *Committee Hansard*, 1 March 2010, p. 103.

29 Professor Graham Martin, *Committee Hansard*, 2 March 2010, p. 81.

30 Ms Georgie Harman, DoHA, *Committee Hansard*, 1 March 2010, p. 65.

31 DOHA, *Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009–2014*, 2009, p. 36

under the COAG National Action Plan for Mental Health 2006-11 and work has begun towards a single national suicide prevention framework'.[32] However they acknowledged that efforts to align '…suicide prevention activity across the Commonwealth and with state and territory government investment in suicide prevention will continue to be both a priority and a challenge'.[33]

Governance and accountability

8.29 The Suicide is Preventable submission argued that the NSPS was not actually a 'national strategy'. They commented:

> 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.[34]

8.30 Similarly the Suicide Prevention Taskforce argued the LIFE Framework had served as a proxy for the NSPS. They said:

> The NSPS is not a national policy or strategy endorsed by all governments through COAG. It has never been endorsed by the Australian Health Ministers' Conference or other inter-government forum. Nor is it a whole-of-Commonwealth Government policy or strategy as it does not have the engagement in development or deployment of a whole-of-government strategy. It is a strategy developed by and deployed by the Commonwealth Department of Health and Ageing.[35]

8.31 The ACT Government noted there was confusion within the community concerning the status of the NSPS, specifically around whether or not there is a national strategy. They stated:

> Within the community, some view the Living Is For Everyone: a framework for prevention of suicide in Australia as 'the strategy'. However, the Commonwealth refers to this as a 'supporting resource'… The lack of clarity concerning the content of the National Suicide Prevention Strategy is a significant barrier to its successful implementation[36]

8.32 The ACT Government recommended that the Commonwealth provide greater leadership and guidance surrounding strategies for national suicide prevention by developing a clear strategy document which sets out actions to be implemented, an implementation strategy and mechanisms for consistent data collection.

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32 DoHA, *Submission 202*, p. 33.

33 DoHA, *Submission 202*, p. 75.

34 Suicide is Preventable, *Submission 65*, p.12.

35 Suicide Prevention Taskforce, *Submission 59*, p. 2.

36 ACT Government, *Submission 44*, p. 9.

8.33 Some considered the role of government departments was limiting suicide prevention activities. SPA commented that …previous instability of executive-level staffing arrangements within departments responsible for the oversight of the NSPS has also produced an environment that has not been entirely favourable to the development of a cohesive Australian suicide and suicide prevention research agenda.'[37] Similarly the Suicide Prevention Taskforce argued that 'changes in personnel, machinery of government and policy frameworks have impeded progress and outcomes'. They stated:

> 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.[38]

8.34 SPA commented that historically there had been broad support for the NSPS objectives. However they stated:

> In 2008, criticism was expressed by some suicide prevention sector stakeholders towards national suicide prevention policy settings. Feedback from the consultations undertaken as part of the independent evaluation of SPA clearly indicated a growing sense of frustration and malaise with regards to policy formulation and progress in Australia, including what was perceived by some members to be a disregard of the informed advice of experts, the evidence and/or the views of the sector and a continuing marginalisation of the issue of suicide prevention more generally…[39]

8.35 The Suicide Prevention Taskforce submission proposed a new national governance and accountability structure with four key organisations to implement a 'coordinated multi-strategy approach to suicide prevention'. One of the rationales for this approach was that suicide was not only a health issues and there were a number of sectors '… private, public and community - with a stake in suicide and suicide prevention'. In summary these proposed structure would be:

- A new coordinating body which would monitor the performance of subsidiary entities in the new structure and approve strategic priorities for suicide prevention
- A peak advocacy body to advocate on behalf of service providers and those affected by suicide.
- A suicide prevention council and resource centre which would develop information and resources for service providers, develop research strategy, and develop standards and accreditation.

37 SPA, *Submission 121*, p. 66.

38 Suicide Prevention Taskforce, *Submission 59*, p. 7.

39 SPA, *Submission 121*, p. 65.

- A national foundation in suicide prevention which would raise funding from a variety of sources and promote awareness.[40]

8.36 Similarly Lifeline Australia recommended the creation of a national organisation for suicide prevention independent of any specific government department.[41] Professor John Mendoza commented:

> …we have to invest in new structures, new infrastructure and invest in what is truly a national strategy, not one that has got the name 'National Strategy' but a national strategy that engages not only the other eight governments in Australia but the sector, the industries, the stakeholders who really want to see transformation in this area.[42]

8.37 The MHCA also linked better data collection in relation to suicide and attempted suicide with better governance and accountability.

> Robust accountability and transparency means removing the process whereby governments assess their own performances and measures, and giving this role to organisations that can provide genuine oversight and accountability of progress in reducing suicide in Australia.[43]

8.38 Professor Peter Bycroft argued that there were too many vested interests in control of the decision making process, in key positions of policy advice and in co-dependency relationships with DoHA. He recommended that the advisory bodies '… who are instrumental in decisions relating to priorities for policy, service provision and funding should be arms length from the Department and should not be dominated by either the medical/clinical professions or academics/researchers who are major beneficiaries of those funding decisions'.[44]

8.39 Professor Patrick McGorry recommended that an aspirational target should be set for the reduction in the rate of suicide in Australia. He noted this target may not be quick to achieve but it would '…really put pressure on us as a society to significantly reduce the suicide toll as we have been successful in doing in reducing the road toll over the last couple of decades'.[45] This is an approach that has been taken overseas. For example, *Choose Life: the national strategy and action plan to prevent suicide in Scotland* includes a target to reduce suicide by 20 per cent over ten years.[46]

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40 Suicide Prevention Taskforce, *Submission 59*, pp 9-11.

41 Lifeline Australia, *Submission 129*, p. 71.

42 Professor John Mendoza, *Committee Hansard*, 1 March 2010, p. 98.

43 MHCA, *Submission 212*, p. 5.

44 Professor Peter Bycroft, *Submission 41*, p. 9.

45 Professor Patrick McGorry, *Committee Hansard*, 4 March 2010, p. 80.

46 Scottish Executive, *Choose life: A national strategy and action plan to prevent suicide in Scotland*, 2002, p. 20.

8.40 Professor Graham Martin's comparison of national suicide prevention strategies noted that some overseas jurisdictions have decided on specific targets for reductions in suicide. He notes that this 'may be a two-edged sword, on one hand leading to criticism of the government for not achieving a goal, but it also may very well help with public perceptions, and the public ownership of, and commitment to, suicide prevention'.[47]

Evaluation of the NSPS

8.41 In 2005 the Commonwealth engaged Urbis Keys Young to conduct an independent evaluation of the NSPS. The evaluation found NSPS was '…widely supported and perceived as an appropriate and necessary strategy that addresses an ongoing community need'. However it also found that 'stronger evidence regarding the impact and outcomes of NSPS funded projects is required'.

8.42 DoHA noted that a full independent evaluation of the NSPS is planned for the 2010-11 financial year '…that will provide guidance on the currency and efficacy of the strategy that will inform the department's advice to government on any changes of direction or amendments to the strategy'. [48] The AISRP argued that evaluating the NSPS was problematic because of the inaccuracy of ABS data on suicides.[49]

Funding issues

8.43 DoHA stated that the Commonwealth has increased its annual allocation of funding for specific suicide prevention programs from $8.7 million in 2005-06 to $22.2 million in 2009-10 and that this forms part of a broader investment in mental health services and programs of $1.9 billion.[50] It stated '…investment by the Australian Government in suicide prevention has increased significantly over the last decade, and that there has been no reduction of effort despite the decline in official data on deaths by suicide'.[51]

47 Graham Martin, *National Suicide Prevention Strategies: A Comparison*, 2009, p.76. Paper prepared for DoHA.

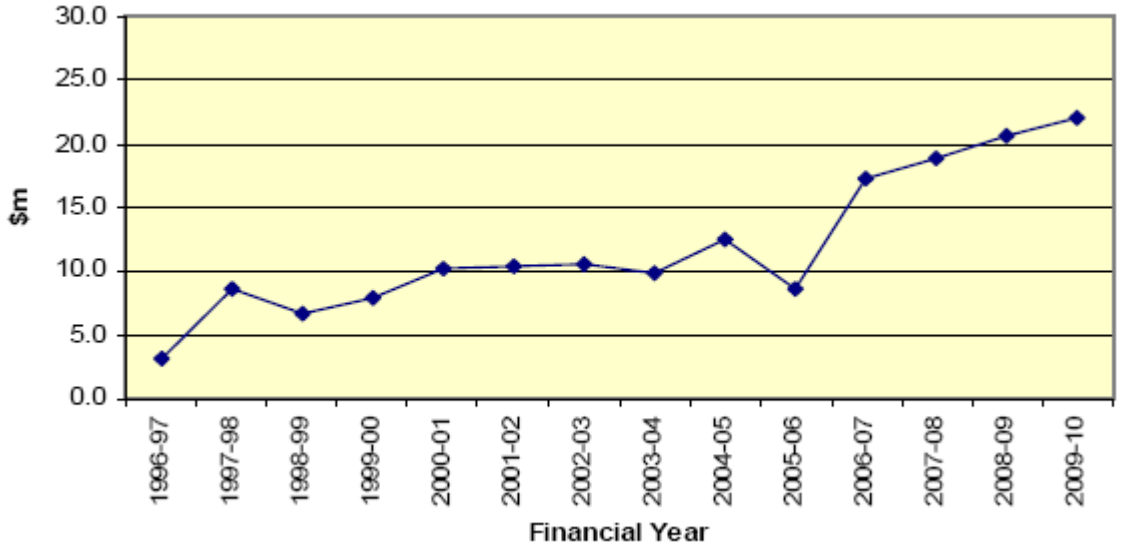
48 Ms Georgie Harman, DoHA, *Committee Hansard*, 1 March 2010, p. 66.

49 AISRP, *Submission 237*, p. 122.

50 DoHA, *Submission 202*, p. 2.

51 DoHA, *Submission 202*, p. 33.

Appropriations by Financial Year for National Youth Suicide Prevention Strategy (1996-97 to 1998-99 and NSPP (1999-00 to 2009-10)[52]



8.44 However the lack of resources available to implement the NSPS was often emphasised during the inquiry. For example Lifeline Australia stated that the 'financial resources allocated to implementing the strategy are meagre in relation to the scope of the problem…'.[53] The funding available for suicide prevention was compared to other issues which received greater levels of public funding such as road safety and cancer. RANZCP recommended that funding allocated to suicide prevention should be equivalent to that spent on events and/or illnesses with a similar mortality rate, for example breast cancer.[54]

8.45 The Suicide is Preventable submission stated there was also 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'.[55]

8.46 The approach of the funding projects under the NSPS was also criticised. The Suicide Prevention Taskforce stated that:

52 Extracted from DoHA, *Submission 202*, p. 33.

53 Lifeline Australia, *Submission 129*, p. 66.

54 RANZCP, *Submission 47*, p. 12.

55 Suicide is Preventable, *Submission 65*, p. 12.

> The NSPS approach to funding small scale projects has been likened to 'spreading confetti across the land'. While this approach of investing through small grants has developed some capacity in communities to respond to suicide, few projects have been sustained and even fewer evaluated.[56]

8.47 SPA recommended the funding priorities should be shifted '… from short-term small scale projects to longer-term investment in projects that derive sustainable outcomes and include a budget for evaluation of interventions as an evidence base against which to measure the ongoing effectiveness of the NSPS'.[57]

8.48 A number of organisations commented that the lack of certainty regarding funding cycles created problems for the organisations in maintaining staff as well as the credibility with clients to whom assistance was being directed. The ACT Government also noted there was a history of mental health programs developed on a pilot basis, where Commonwealth funding is withdrawn after an initial period despite positive evaluations. They noted this can have a significant impact on clients who lose services and for providers who become disillusioned or are unaware of services because of ongoing changes.[58]

8.49 This view was shared by many organisations which operated suicide prevention programs. The Integrated Primary Mental Health Service of North East Victoria emphasised:

> We cannot stress enough the need for long term funding for mental health skilled community workers. Grant funding is inappropriate. Short term projects are regarded cynically, '*How long are you lot going to be around?*'. We have learnt that workers need months to years to successfully be accepted and valued by a community.[59]

8.50 Mr Keith Todd from OzHelp stated:

> We lose good, quality people because they have family themselves. They are probably looking for another job nine months out. They have families to support and they have to take care of their own sustainability.[60]

8.51 Similarly, Ms Kerry Graham from the Inspire Foundation commented:

> … three-year funding contracts, which are set at the beginning, do not allow a great deal of flexibility to be highly responsive; and then, when you are getting to the end of your funding contract, you are putting most of your

56 Suicide Prevention Taskforce, *Submission 59*, p. 3.

57 SPA, *Submission 121*, p. 67.

58 ACT Government, *Submission 44*, p. 6.

59 Integrated Primary Mental Health Service of North East Victoria, *Submission 26*, p. 4.

60 Mr Keith Todd, OzHelp, *Committee Hansard*, 1 March 2010, p. 40.

> efforts into repositioning or demonstrating success, which is very important, as opposed to being as forward-thinking as you can be…[61]

8.52 Centre of Rural and Remote Mental Health Queensland stated:

> Sustainability presents a significant challenge for community based suicide prevention strategies. Pilot and seeding programmes that do not have a strategy for longer-term implementation often raise expectations and needs within communities that are then not met… With short term funding arrangements, many groups struggle to find new resources. Efforts to institutionalise programmes may compete with the time-consuming task of fund-raising during the later stages of projects…There is also a strong likelihood of a loss of momentum and the departure of key project staff.[62]

8.53 The Urbis Keys Young evaluation identified several aspects of the NSPS structure and processes that could be strengthened. This included understanding in the sector of '...funding processes and mechanisms to advise on the progress and outcomes of NSPS activities and projects (including evaluations of these projects)'.[63] During the course of the inquiry the Committee heard from some community organisations who felt their locally-based and long running programs had been excluded from consideration for public funding as they did not have the capacity to write complex competitive tenders.

8.54 DoHA told the Committee that following the open tender process for local community grants in 2006 'there was some concern from smaller organisations who were not as good at writing submissions as bigger organisations… worthwhile small projects felt they could not compete'.[64]

Conclusion

8.55 The Committee understands that work is being undertaken to produce a single national suicide prevention framework and DoHA has indicated that an independent evaluation of the NSPS has been scheduled for financial year 2010-2011.

8.56 In the opinion of the Committee the policy documents around the NSPS (the LIFE Framework resources and the National Suicide Prevention Action Framework) do not assist understanding of suicide prevention activities in Australia, particularly given the different strategies being conducted or developed by the State and Territory governments. There is an opportunity to simplify these policy documents and promote understanding of the NSPS and suicide prevention activities in Australia.

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61 Ms Kerry Graham, Inspire Foundation, *Committee Hansard*, 1 March 2010, p. 40.

62 Centre of Rural and Remote Mental Health Queensland, *Submission 31*, p. 6.

63 Urbis Keys Young, *Evaluation of the National Suicide Prevention Strategy – Summary Report*, 2006, p. 6.

64 Ms Colleen Krestensen, DoHA, *Proof Committee Hansard*, 18 May 2010, p. 34.

Recommendation 37

8.57 The Committee recommends that following extensive consultation with community stakeholders and service providers, the next National Suicide Prevention Strategy include a formal signatory commitment as well as an appropriate allocation of funding through the Council of Australian Governments.

8.58 The Committee is sympathetic to the views of many organisations and individuals who supported the joint Suicide is Preventable submission and the proposal that a new governance and accountability structure would assist the delivery of suicide prevention programs in Australia. However the Committee is also cautious to support the creation of several interrelated organisations which may divert resources from suicide prevention activities and programs.

8.59 The Committee was interested in the recent changes to responsibility for suicide prevention in WA. In that jurisdiction a Ministerial Council for Suicide Prevention has been charged with overseeing the implementation of the WA State Suicide Prevention Strategy which would be delivered by a non-government organisation.[65] The Committee considers that a greater role could possibly be taken by ASPAC and the various State and Territory Ministerial Councils for suicide prevention in developing policy and programs under the NSPS.

Recommendation 38

8.60 The Committee recommends that an independent evaluation of the National Suicide Prevention Strategy should assess the benefits of a new governance and accountability structure external to government.

8.61 The Committee accepts the recommendations made in many submissions that funding for suicide prevention programs, projects and research in Australia be substantially increased. The Committee recognises that many other public programs and welfare expenditure operate to limit or decrease the incidence of suicide and attempted suicide in Australia. In particular, a broad range of mental health services and programs which function to prevent or treat mental illness significantly contribute to reducing suicide and attempted suicide. Similarly many other government services and programs can also be seen as promoting recognised protective factors and limiting risk factors for suicide.

8.62 Nonetheless the funding for programs which could be described as at 'the pointy end' of suicide prevention is relatively limited ($22.2 million in 2009-10) when considered against even some of the lower financial cost estimates of suicide in Australia. Additional public funding directed to effective programs and projects in this area can literally be considered to be lifesaving. It is clear to the Committee that the

65 Mr Shawn Phillips, Ministerial Council for Suicide Prevention, *Committee Hansard*, 31 March 2010, p. 2.

public funding made available for suicide prevention is not proportionate to the personal, social and financial impacts of suicide in Australia.

8.63 The Committee also recognises the need to diversify the funding sources for suicide prevention. In the view of the Committee there is merit in the Suicide Prevention Taskforce proposal to establish a foundation to encourage other sources of funding for strategic priorities in research, advocacy and service provision.

Recommendation 39

8.64 The Committee recommends that the Commonwealth government double, at a minimum, the public funding of the National Suicide Prevention Strategy, with further increases to be considered as the research and evaluation of suicide prevention interventions develops.

Recommendation 40

8.65 The Committee recommends that the Commonwealth, State and Territory governments should facilitate the establishment of a Suicide Prevention Foundation to raise funding from government, business, community and philanthropic sources and to direct these resources to priority areas of suicide prevention awareness, research, advocacy and services.

8.66 The short term funding of programs and projects is an issue with which the Committee is familiar from previous inquiries. Clearly this approach to funding cycles allows government some flexibility to change priorities. However short term funding cycles can be enormously detrimental to the establishment and ongoing success of projects and programs. Short term funding cycles usually create additional administrative burdens for projects, disruption for clients and uncertainty for project employees.

Recommendation 41

8.67 The Committee recommends that, where appropriate, the National Suicide Prevention Program provide funding to projects in longer cycles to assist the success and stability of projects for clients and employees.

8.68 The most important measure of the effectiveness of the NSPS is whether it has reduced the number of suicides in Australia over the period of its operation. Unfortunately this measure has been obscured by changes to data collection and uncertainty regarding the underreporting of suicides. The situation will become clearer as revised data from the ABS is released over the coming years and trends will be identified. The Committee feels that an explicit and ambitious target for the reduction in the annual number of suicides should be included in the NSPS. This target would function to focus the attention and resources of government and the community on suicide prevention initiatives.

Recommendation 42

8.69 The Committee recommends that the Commonwealth government as part of a national strategy with State, Territory and local governments for suicide prevention set an aspirational target for the reduction of suicide by the year 2020.

CHAPTER 9

CONCLUSION

9.1 The impact of suicide extends beyond those who complete suicide and includes those bereaved by suicide and those who attempt suicide, as well as the broader community.

9.2 Accordingly, the Committee's inquiry has highlighted a number of overarching findings that were consistently raised in evidence. These are:

- the need for a single national suicide prevention strategy to clearly link the efforts of all levels of government as well as community organisations and an ambitious target for the reduction of suicide in Australia;

- the need for increased funding for both universal and targeted programs and projects, including the development of a separate suicide prevention strategy for Indigenous communities, to reduce the prevalence of suicide and suicide attempts in Australia;

- the need for better data collection methods to ensure accurate reporting of suicide in order to track rates of suicide and the success of prevention programs;

- the need for enhanced and customised suicide assessment, prevention and awareness training for frontline staff;

- the need for improved support for people who have attempted suicide, have suicidal ideation or received psychiatric care, including follow up support for those leaving care and affordable telephone crisis and counselling services;

- the need for increased community understanding and awareness, and improved media practices to reduce the stigma of suicide; and

- the need for direct and increased funding for research on suicide, particularly the evaluation of interventions to guide future suicide prevention activities.

9.3 Throughout its inquiry, the Committee was impressed by the work of many community organisations in preventing suicide and assisting those affected by it. Many of these organisations are not optimally funded but rather are supported by many volunteers who have a strong commitment to helping others.

9.4 The Committee also recognises the commitment of governments to respond to suicide in Australia, including the commitment of funding for programs and projects. Nevertheless, the Committee strongly considers that much more can done to reduce the number of Australians attempting and completing suicide. The Committee considers that one of the key areas for action should be ensuring that the development

and implementation of the next NSPS be prioritised, coordinated and aligned with action at all levels of government.

9.5 This report makes a number of recommendations that will allow for:

(a) a better understanding of economic costs of suicide to the Australian community;

(b) mechanisms to improve the accurate reporting of the prevalence of suicide in Australia;

(c) front line staff to be equipped with the skills and training in suicide prevention;

(d) enhanced procedures for the discharge of patients with the aim of providing ongoing support;

(e) a dedicated public awareness campaign, promoting greater community understanding of suicide with a particular focus for at-risk groups; and

(f) stronger research to provide more targeted interventions.

9.6 In 2006 the Commonwealth Government made a significant step to increase public support for suicide prevention. Based on the evidence received, the Committee considers that the time has arrived for a further commitment to efforts to prevent suicide in Australia. With appropriate funding, coordination and initiatives such as those outlined in this report, the Committee considers that there can be concrete changes made to reduce the number of suicide and attempted suicides, and to assist those affected by suicide in Australia.

Senator Rachel Siewert

Chair

APPENDIX 1

LIST OF PUBLIC SUBMISSIONS, TABLED DOCUMENTS AND ADDITIONAL INFORMATION AUTHORISED FOR PUBLICATION BY THE COMMITTEE

1	White Wreath Association Limited
2	Kimberley Aboriginal Law & Culture Centre (KALACC)
3	Protective Mother Alliance
4	Non-Custodial Parents Party (Equal Parenting)
5	Foss, Ms Marguerite
6	ACT Branch of Dying With Dignity
7	Hamilton, Mr Craig
8	Lifeline Newcastle & Hunter
9	Dawkins MLC, The Hon John
10	Private Mental Health Consumer Carer Network (Australia)
11	Quayle, Mr David
12	Woollahra Council
13	Draper, Professor Brian
14	NSW Commission for Children & Young People
15	Consumer Activity Network (Mental Health) Inc
16	Tatz, Professor Colin
17	Snow, Mr Jim
18	Frances
19	Central Australian Aboriginal Congress Inc
20	Australasian Society for Psychiatric Research (ASPR)
21	Lloyd, Mr Murray
22	Name withheld
23	Lodding, Ms Suzzanne
24	Harrison, Dr Jo
25	Peer Support Australia
26	Integrated Primary Mental Health Service of North East Victoria

27 Pirkis, A/Professor Jane

28 Compassionate Friends Victoria Inc

29 Jorm, Professor Anthony and Kitchener, Ms Betty

30 McPhedran, Dr Samara and Baker, Dr Jeanine

- Supplementary submission received 25.05.10

31 Centre for Rural and Remote Mental Health Queensland

32 Northern Territory Government

33 Tasmanian Council for Sexual & Gender Diverse People Inc

34 Creative Ministries Network

35 Nowra Family Support Services Inc

36 Ethnic Communities Council of WA

37 Lesbian and Gay Solidarity Melbourne

38 Name withheld

39 Name withheld

40 Kentish Regional Clinic Inc

41 Bycroft, Professor Peter

42 Choi, Mr Ching and Ruzicka, Dr Lado

43 Women's Health Victoria

44 ACT Government

45 Enterprising World International Limited T/A AfterShock and Rotary Community Corps of WA

46 Health Consumers of Rural and Remote Australia (HCRRA)

47 Royal Australian and New Zealand College of Psychiatrists (RANZCP)

48 beyondblue

49 Alcohol and other Drugs and Council of Australia

50 Community Action for the Prevention of Suicide Inc (CAPS)

51 Goldney, Professor Robert

52 Freemasons Foundation Centre for Men's Health

53 Freeman, Dr Adrienne

54 Incolink

55 Australian Medical Association (AMA)

56 Health Quality and Complaints Commission

57 Australian Mens Sheds Association (AMSA)

58 Suicide Safety Network (Central Coast Inc)

59 Suicide Prevention Taskforce & Suicide Prevention Australia Inc

60 Centre for Mental Health Research

61 Australian Press Council

62 Australian Research Council Discovery Project Team

63 Advocacy Disability Ethnicity Community (ADEC)

64 Page, Dr Andrew; Carter, Professor Greg; Taylor, Professor Richard; Dudley, Dr Michael; Morrell, Dr Stephen; Martin, Professor Graham and Hall, Professor Wayne

65 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

66 Australian Suicide Prevention Foundation

67 Gay, Lesbian, Bisexual, Trans and Intersex Retirement Association Inc.

68 Exit International

69 Whyte and Co Pty Ltd.

70 WA Ministerial Council for Suicide Prevention

71 Australian Christian Lobby

72 Psychotherapy and Counselling Federation of Australia

73 Mental Health at Work

74 Mental Health Council of Tasmania

75 O'Connor, Dr Manjula

76 Transcultural Mental Health Centre

77 Colucci, Dr Erminia

78 Jesuit Social Services

79 Victoria Mental Health Carers Network

80 Australian Institute of Family Studies

81 Gay and Lesbian Counselling Services of NSW

82 Orygen Youth Health Research Centre

83 Hanssens, Ms Leonore

- Supplementary submission received 21.05.10

84 National Coroners Information System

85 NSW Consumer Advisory Group – Mental Health Inc.

86 OzHelp Foundation

87 ACON

88 NSW Department of Health

89 United Synergies Ltd

90 Australian New Zealand Spinal Cord Injury Network

91 No Submission

92 Civil Liberties Australia

93 Multicultural Mental Health Australia

94 Dr Edward Koch Foundation Ltd

95 OzHelp Queensland Inc

96 COTA National

97 SANE Australia

98 BoysTown

99 Commission for Children and Young People and Child Guardian

- Supplementary submission received 25.03.10

100 Mental Health Association of Central Australia

101 Inspire Foundation

102 Australian Indigenous Psychologists Association

103 Commissioner for Children and Young People in Western Australia

104 Youth Focus

105 Indigenous Team of the National Drug Research Institute

106 SOS Survivors of Suicide Bereavement Support Association Inc.

107 Martin, Professor. Graham

108 Joint Epilepsy Council of Australia

109 Relationships Australia

110 Australian Christian Values Institute

111 Australian Bureau of Statistics

112 A Gender Agenda Inc

113 Kilkeary, Mr. Stephen

114 Davies, Reverend. George

115 FamilyVoice Australia

116 No Submission

117 Crisis Support Services Inc

118 Kimberley Mental Health and Drug Service

119 Tatz, Professor Colin

120 Marninwarntikura Fitzroy Women's Resource & Legal Centre;
Marra Worra Worra Aboriginal Corporation;
Nindilingarri Cultural Health; and
Kimberley Aboriginal Law and Cultural Centre

121 Suicide Prevention Australia

122 Queensland Alliance, Peak Body for the Mental Health Community Sector

123 Victorian Section of the College of Clinical Psychologists, Australian Psychological Society

124 The Richmond Fellowship of NSW

125 Victorian Institute of Forensic Mental Health

126 NSW Centre for Rural and Remote Mental Health

127 Catholic Women's League Australia Inc

128 Mental Health Coordinating Council

- Supplementary submission received 31.03.10

129 Lifeline Australia

130 The Way to Happiness Foundation

131 Harrison, Associate Professor James

132 Australian Psychological Society (APS)

133 Pharmacy Guild of Australia

134 Public Interest Advocacy Centre

135 Australian Federation of International Students (AFIS)

136 No Submission

137 Humanist Society of Victoria Inc

138 Wesley Mission

139 Care Leavers Network of Australia (CLAN) and Alliance for forgotten Australians

140 Victorian Doctors Health Program (VDHP)

141 United Synergies

142 Salvation Army

143 Australian Institute for Loss and Grief Pty Ltd

144 Wall, Ms Nicci

145 McCormack, Mr John

146 Kendrick, Ms Nancy
147 Sheedy, Mr Jim
148 Pryor, Mr Malcolm
149 Phelan, Mr Vincent
150 Ashton, Ms Cath
151 Fleming, Mr Graham
152 Garrity, Dr Alan
153 Watson, Ms Narelle
154 Cane, Mr Jared
155 Dinse, Mr Grant
156 Seccombe, Mr Ralph
157 Vickers-Willis, Mr Tony
158 Dimond, Mr John
159 Brunton, Ms Heather
160 O'Shea, Ms Louise
161 Neame, Mr Peter
162 Name withheld
163 Brown, Ms Janice
164 Killen, Mr Darrel
165 Schorel-Hlavka, Mr G H
166 Arthur, Ms Jeanne
167 Schulz, Mr Alex
168 Schulz, Mr David and Mrs Sandra
169 Watson, Dr Robert
170 Perron Mr Marshall
171 Balagengadaran Ms Valerie
172 Name withheld
173 Bradley Mr John
174 Harrison Ms Jan
175 Edge Mr John
176 Jacobs Mr Michael
177 Name withheld
178 Condon Mr Michael

179 Alvaro Mr Joe
180 Name withheld
181 Name withheld
182 McCormack, Ms Casey
183 March, Dr M
184 Mahar, Mr Keith
185 Ward, Ms Sharon
186 Gee, Mr Tony
187 Lotton, Mr M & Ms E
188 Nichols, Mrs J
189 McKensy, Ms Carolyn
190 Leon, Mr Ray
191 Eales, Ms Mic
192 Maple, Dr Myfanwy
193 Humphreys, Mr Andrew
194 Matherson, Ms Kate
195 Harbison, Ms Cathy
196 No Submission
197 Tilley, Mr James
198 Webb, Dr David
199 Morris, Mr Robin and Mrs Jennifer
200 Gender Centre Inc
201 National LGBT Health Alliance
202 Department of Health and Ageing
- Revised versions of Appendix A and Appendix D, received 17.05.10

203 Australian Federation of Aids Organisations
204 Rural Doctors Association of Australia
205 Queensland Government
206 Medicine With Morality
207 Joseph, Ms Rita
208 South Australian Government
209 Department of Forensic Medicine, Glebe NSW
210 Australian College of Mental Health Nurses

211 Department of Families, Housing,, Community Services and Indigenous Affairs

212 Mental Health Council of Australia

213 Australian General Practice Network (AGPN)

214 Northern Territory Government

215 Department of Veterans' Affairs

216 Adults Surviving Child Abuse

217 No Submission

218 Bond, Mr Graeme

219 Thompson, Ms Shirley

220 Storm, Ms Caroline

221 Dekker, Ms Muriel

222 Croll, Ms Barbara

223 Morgan, Mr Dylan

224 Strachen, Ms Patricia

225 Gaddin, Ms Dianne

226 WA Department of Health

227 Western Australian Aboriginal Advisory Council

228 Bennett, Professor Maxwell

229 National Committee for Standardised Reporting on Suicide (NCSRS)

230 Styles, Ms Pat A

231 Name withheld

232 Anti Depression Association of Australia

233 Webb, Dr Myfanwy

234 Mulligan, Ms Christine

235 Lukus, Mr Jake

235a Attachment to submission, 'Mapping Homophobia in Australia'

236 Name withheld

237 Australian Institute for Suicide Research and Prevention

238 Name withheld

239 AO Webster, Professor Ian

240 Spivey, Ms Margaret

241 National Coalition for Gun Control

242 Keep, Mr David

243 Lucire, Dr Yolande

244 Statewide & Mental Health Services, Department of Health & Human Services, Tasmania

245 South Australia Police

246 Name withheld

247 Iris Foundation

248 Phoenix Consulting

249 Carr, Ms Karen

250 General Practice Network Northern Territory

251 Survivors of Suicide (SOS) Support Group, Newcastle NSW

252 Rosen, Professor Alan

253 Joint Submission by Ms Catherine Keating, Ms Hanna Rosenthal, Ms Jacinta Wainwright and Ms Kate Bennett

254 Name Withheld

255 Driver, Ms Bev

256 Loft, Mr Ken and Ms Julianne

257 Berry, Ms Virginia

258 Club SPERANZA

Tabled Information

1. Australian Institute for Suicide Research and Prevention

- Documents on Suicide data in Queensland and Australia, tabled at public hearing 18.05.10

2. Australian Suicide Prevention Foundation

- 'Hold on to Life' documentation tabled at public hearing 04.03.10

3. General Practice Network NT

- Submission to the inquiry, tabled at public hearing 17.05.10

4. Hope, Mr Alastair

- Information provided at public hearing 31.03.10

5. Inspire Foundation

Documents tabled at public hearing 01.03.10

- Information on Mental Health and Information Communication Technology (ICT)
- 'Reach Out! The internet as a setting for mental health promotion and prevention', *Eisteach*, Burns, J, Durkin, L A and Nicholas, J., Spring 2008

6. Martin AOM, Professor Graham

- Paper: 'National Suicide Prevention Strategy: A Comparison', Martin, G. and Page, A., 2007, tabled at public hearing 02.03.10

7. Mission Australia

- 'national survey of young Australians 2009, key and emerging issues', tabled at public hearing 30.03.10

8. OzHelp Foundation

- Evaluation Audit: 'Tradies Tune Up', January 2010, tabled at public hearing 01.03.10

9. Tasmanian Council for Sexual & Gender Diverse People Inc

Documents tabled at public hearing 20.05.10

- Information on percentage of GLBTI people who have experienced assault based on sexual orientation
- Brochure on the Tasmanian Council for Sexual & Gender Diverse People

10. TimeOut

- Brochure about TimeOut House, tabled at public hearing 20.05.10

11. Webster, Professor Ian

- Article: 'Suicide rates in Australia: meta-analysis of rates and methods of suicide between 1988 and 2007', Large, M. & Nielssen, O., *Medical Journal of Australia*, April 2010, tabled at public hearing 04.05.10

Additional Information Received

1. Active Response Bereavement Outreach (ARBOR)

Additional information arising from public hearing 30.03.10

- 'Discussion Paper on a Statewide Aboriginal Suicide Postvention Project', prepared by Ugle, K., Glaskin, B., Dudgeon,P., and Hillman, S. June 2009, ARBOR
- Booklet: 'Supporting children after suicide: Information for parents and other care givers', October 2008
- 'An Active Postvention Program', Campbell F., Cataldie, L., McIntosh, J. and Millet., *Crisis*, 2004
- 'Changing the Legacy of Suicide', Campbell, F., *Suicide and Life-Threatening Behaviour*, June 1997
- 'Bereavement after Suicide', Jordan, J., *Psychiatric Annals*, October 2008
- Additional Information on the Postvention models received at the hearing
- Information and Support Pack: For those concerned about someone who is distressed or suicidal
- Information and Support pack: For those bereaved by suicide and other sudden death

http://www.mcsp.org.au/resources (accessed 11 June 2010)

- Clarification of evidence from hearing, received 23.04.10

2. ACT Government

Additional information provided at the public hearing 25.03.10

- ACT Mental Health Services Plan 2009-2014

http://health.act.gov.au/c/health?a=dlpubpoldoc&document=1636 (accessed 11 June 2010)

- Managing the Risk of Suicide: A suicide prevention strategy for the ACT 2009-2014

http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1266807908&sid= (accessed 11 June 2010)

- Building a Strong Foundation: A framework for promoting mental health and wellbeing in the ACT 2009-2014

http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1244685524&sid= (accessed 11 June 2010)

- Response to questions taken on notice at hearing, received 14.04.10

3. Australian College of Mental Health Nurses

- Responses to questions taken on notice at public hearing 24.03.10, received 03.05.10

4. Australian Institute for Suicide Research and Prevention

Additional information provided at public hearing 18.05.10

- 'Turning Points: An Extraordinary Journey Into the Suicidal Mind', De Leo, D., 2010
- 'Suicide Research: Selected Readings Volume 2', Sveticic, J., Anderson, K. and De Leo, D., May-October 2009
- 'Suicide in Queensland 2002-2004: Mortality Rates and Related Data', De Leo, D., Klieve, H. and Milner, A., 2006
- 'International Suicide Rates and Prevention Strategies', De Leo, D. and Evans, R., 2004

5. Australian Institute of Family Studies

Additional information from public hearing 24.03.10, received 01.04.10

- Article Review: 'The decline in Australian young male suicide', reviewed by Elly Robinson, *Family Relationships Quarterly*, Issue 5, 2007

http://www.aifs.gov.au/afrc/pubs/newsletter/n5pdf/n5e.pdf
(accessed 8 June 2010)

- 'Online Counselling, therapy and dispute resolution: A review of research and its application to family relationship services', *AFRC Briefing No.15*, E. Robinson, 2009

http://www.aifs.gov.au/afrc/pubs/briefing/b15pdf/bp15.pdf
(accessed 8 June 2010)

- 'Final Report-Mental Health Support Pilot Project', Family Court of Australia, August 2006

http://www.familycourt.gov.au/wps/wcm/resources/file/ebc70a45b5a3ceb/MH_Report2006.pdf (accessed 8 June 2010)

- Final Report-Integrated Client Service Delivery featuring Mental Health Support, January 2009

http://www.familycourt.gov.au/wps/wcm/resources/file/ebdce241f11fd22/ICSDP_Report_March2009_lowres.pdf (accessed 8 June 2010)

6. Beyondblue

- *Taking Care of Yourself and Your Family, A Resource Book For Good Mental Health*, Ashfield, J., November 2009, provided at public hearing 04.03.10

7. Billard Learning Centre

- Blank Page Summit on Suicide Communiqué, July 2009, received 30.11.09

8. Brain and Mind Research Institute

Additional information provided at public hearing 01.03.10

- 'Australian mental health reform: time for real outcomes', Hickie, I., Groom, G., McGorry, P., Davenport, T. and Luscombe, G., *The Medical Journal of Australia*, April 2005

http://www.mja.com.au/public/issues/182_08_180405/hic10810_fm.html (accessed 10 June 2010)

- Paper: 'Association between antidepressant prescribing and suicide in Australia, 1991-2000: trend analysis', Hall, W., Mant, A., Mitchell, P., Rendle, V., Hickie, I. and McManus, P., *British Medical Journal*, May 2003

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC154757/ (accessed 10 June 2010)

- 'Cardiovascular risk perception and evidence–practice gaps in Australian general practice (the AusHEART study)', Heeley, E., Peiris, D., Patel, A., Cass, A., Weekes, A., Morgan, C., Anderson, C. and Chalmers, J., *The Medical Journal of Australia,* March 2010

http://www.mja.com.au/public/issues/192_05_010310/hee10422_fm.html (accessed 10 June 2010)

- 'Fit for the future — a regional governance structure for a new age', Jackson, C., Nicholson, C. and McAteer, E., *The Medical Journal of Australia*, March 2010

http://www.mja.com.au/public/issues/192_05_010310/jac10846_fm.html (accessed 10 June 2010)

- 'National mental health reform: less talk, more action', Rosenberg, S., Hickie, I. and Mendoza, J., *The Medical Journal of Australia,* February 2009

http://www.qldalliance.org.au/resources/items/2009/06/282743-upload-00001.pdf (accessed 10 June 2010)

- 'Mental health expenditure in Australia: time for affirmative action', Hickie, I., Davenport, T. and Luscombe, G., *Australia New Zealand Journal of Public Health*, January 2006

- 'Sociodemographic correlates of antidepressant utilisation in Australia', Page, A., Swannell, S., Martin, G., Hollingworth, S., Hickie, I. and Hall, W., *The Medical Journal of Australia*, May 2009

9. Commissioner for Children and Young People in Western Australia

- 'Mental Health', *Issues Paper 3*, December 2009, received at public hearing 31.03.10

http://www.waamh.org.au/upload/downloadFiles/2009_12_Issues_paper_CCYP.pdf (accessed 11 June 2010)

10. Crisis Support Services

- Additional information arising from public hearing 25.03.10, received 20.04.10

11. Department of Health and Ageing

Additional information arising from public hearing 01.03.10

- 'National Suicide Prevention Strategy Evaluation Data Reporter (EDR) Tool: Instruction Guide', Department of Health and Ageing, 2007, received 08.04.10
- 'Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014', received 08.04.10

http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-f-plan09 (accessed 17 June 2010)

- Responses to questions on notice from public hearing 01.03.10, received 17.05.10

12. Gaddin, Ms Dianne

- Additional information received 27.12.09

13. General Practice Network NT

- DVD: 'Suicide Story: A training resource for indigenous people to help create suicide safer families and communities', Mental Health Association of Central Australia, March 2010, provided at public hearing 17.05.10

14. Hanssens, Ms Leonore

- 'Imitation and Contagion Contributing to Suicide Clustering in Indigenous Communities: Time-Space-Method Cluster Analysis', Hanssens, L., *Aboriginal and Islander Health Worker Journal*, June 2008
- 'The Search to Identify Contagion Operating Within Suicide Clusters in Indigenous Communities, Northern Territory, Australia', Hanssens, L., *Aboriginal and Islander Health Worker Journal*, October 2007
- 'Indigenous Dreaming: How Suicide in the Context of Substance Abuse has Impacted On and Shattered the Dreams and Reality of Indigenous Communities in Northern Territory, Australia', Hanssens, L., *Aboriginal and Islander Health Worker Journal*, December 2007

- 'Research into the Clustering Effect of Suicide Within Indigenous Communities, Northern Territory, Australia, Hanssens, L., *Aboriginal and Islander Health Worker Journal*, June 2007
- 'Clusters of Suicide... The Need for a Comprehensive Postvention Response to Sorrow in Indigenous Communities in the Northern Territory', Hanssens, L., *Aboriginal and Islander Health Worker Journal*, April 2008

15. Hawdon, Mrs Kathy and Mr Alan

- Additional information provided at public hearing 03.03.10

16. Hearing Voices Network Australia

Additional information provided at public hearing 30.03.10

- Hearing Voices Information Booklet

http://hvna.net.au/upfile/HVNA_Info_Booklet.pdf (accessed 11 June 2010)

- Report of Activities, March 2010
- Pamphlet on Voices Vic

17. Inspire Foundation

- 'Reach Out: Online Mental Health Promotion for Young People' Burns J., Ellis, L., Mackenzie, A. and Stephens-Reicher, J, *Counselling, Psychotherapy, and Health,* 2009, provided at public hearing 01.03.10

http://www.cphjournal.com/archive_journals/v5_1_171-186.pdf
(accessed 10 June 2010)

18. Lifeline Australia

- Additional information provided to the committee, received 07.04.10

19. Lifeline Hobart

- Additional information arising from public hearing 20.05.10, received 21.05.10

20. Mendoza, Professor John

- Paper: 'Estimating the Economic Cost of Suicide in Australia', Prepared by ConNetica Consulting for SPA, Lifeline, OzHelp, Inspire, Salvation Army, the Mental Health Council of Australia & the Brain and Mind Research Institute, University of Sydney, November 2009, provided at public hearing 01.03.10

21. MindMatters

Documents received at public hearing 04.05.10

- Fact sheet: 'World Health Organization Model for school mental health promotion', Adapted from WHO, 1994
- Information on MindMatters Professional Development Planning

22. National LGBT Health Alliance

- Additional information received at public hearing 03.03.10
- Response to a question on notice arising from hearing 03.03.10, received 18.05.10

23. NSW Consumer Advisory Group – Mental Health Inc

- Response to questions taken on notice at public hearing 03.03.10, received 12.04.10

24. NSW Department of Health

- Response to questions taken on notice at public hearing 03.03.10, received 10.06.10

25. Northern Territory Government

Additional information arising from public hearing 17.05.10, received 17.05.10

- 'Addressing Aboriginal mental health issues on the Tiwi Islands', Norris, G., Parker, R., Beaver, C. and van Konkelenberg, J., *Australasian Psychiatry*, July 2007
- 'Australia's Aboriginal Population and Mental Health', Parker, R., T*he Journal of Nervous and Mental Disease*, January 2010

26. Public Interest Advocacy Centre

- Paper: 'Inquest into the Death of Scott Ashley Simpson', provided at public hearing 03.03.10

27. Richmond Fellowship of NSW

- Media release: 'Early cannabis users three times more likely to have psychotic symptoms', University of Queensland, February 2010, received 24.03.10

28. Richmond Fellowship of Western Australia

- Annual Report 2008/2009

http://www.rfwa.org.au/images/stories/pdf/RFWA_2008-2009_Annual_Report.pdf (accessed 11 June 2010)

29. Salvation Army

- Booklet: 'Life Keeper Memories', Hope for Life, Suicide Prevention and Bereavement Support, provided at public hearing 04.03.10

30. SANE Australia

- Additional information received 02.02.10

31. SOS Survivors of Suicide Bereavement Support Association Inc

- 'Revisiting Impulsivity in Suicide: Implications for Civil Liability of Third Parties', Smith, A., Witte, T., Teale, N., King, S., Bender, T. and Joiner, T., *Behavioural Sciences & The Law*, November 2008

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2597102/
(accessed 11 June 2010)

32. Statewide & Mental Health Services, Department of Health & Human Services, Tasmania

Additional information arising from public hearing 20.04.10, received 11.06.10

- Correspondence with links to Tasmania's strategic framework *Building the Foundations for Mental Health and Wellbeing*
- Tasmanian Police Report of Death for the Coroner form
- Treasurers Instruction 709 – framework for the management of grant payments

33. Tasmanian Council for Sexual & Gender Diverse People Inc

- Additional information arising from public hearing 20.05.10, received 08.06.10

34. Webster, Professor Ian

- Additional information provided at public hearing 04.05.10

35. Wesley Mission

- Additional information provided to the committee on LifeForce Community Networks Project and Wesley LifeForce Training following public hearing 03.03.10, received by the committee 25.03.10

http://www.uq.edu.au/news/?article=20723 (accessed 9 June 2010)

36. WA Ministerial Council for Suicide Prevention

- Additional information on analysis of WA suicides referred to at public hearing 31.03.10, received 08.04.10
- Response to questions taken on notice at hearing, received 12.05.10

37. Youth Focus

Additional information provided at public hearing 31.03.10

- 'Connected', Youth Focus Newsletter, Issue 11, December 2009
- Progress Report, July 1 2009–December 31 2009
- Additional information received 31.03.10

APPENDIX 2

WITNESSES WHO APPEARED BEFORE THE COMMITTEE AT PUBLIC HEARINGS

Monday, 1 March 2010
Parliament House, Canberra

Committee Members in attendance

Senator Rachel Siewert (Chair)
Senator Claire Moore
Senator Sue Boyce
Senator Judith Adams

Witnesses

Lifeline Australia

Ms Dawn O'Neil, Chief Executive Officer
Ms Susan Beaton, National Advisor Suicide Prevention
Mr Alan Woodward, General Manager, Social Policy, Innovation, Research and Evaluation
Ms Brenda Barber, Lifeline Telephone Counsellor
Ms Madelin Fisher, Suicide Bereavement Support Facilitator

Mental Health Council of Australia

Mr David Crosbie, Chief Executive Officer
Ms Rachelle Irving, Director
Mr Simon Tatz, Director, Communications

Suicide Prevention Australia

Dr Michael Dudley, Chairperson
Mr Ryan McGlaughlin, Executive Officer
Ms Sara Maxwell, Research and Policy Development Coordinator
Ms Jo Riley, Board Member

Inspire Foundation

Ms Kerry Graham, Chief Executive Officer
Ms Cheryl Mangan, Research and Policy Manager

OzHelp Foundation

Mr Keith Todd, Executive Director
Mr Glenn Baird, Manager

Brain and Mind Research Institute

Professor Ian Hickie, Executive Director
Mr Sebastian Rosenberg, Senior Lecturer in Mental Health Policy

Department of Health and Ageing

Professor Jim Bishop, Chief Medical Officer
Ms Georgie Harman, First Assistant Secretary, Mental Health and Chronic Disease Division
Ms Collen Krestensen, Assistant Secretary, Mental Health and Suicide Prevention

Department of Families, Housing, Community Services and Indigenous Affairs

Ms Deborah Winkler, Branch Manager, Mental Health and Autism

Adjunct Professor John Mendoza

Tuesday, 2 March 2010
Queensland Parliament, Brisbane

Committee Members in attendance

Senator Rachel Siewert (Chair)
Senator Claire Moore
Senator Sue Boyce
Senator Judith Adams
Senator Mark Furner

Witnesses

Boystown

Mr John Dalgleish, Manager
Mr Dean Brunker, Program Manager, Employment, Education and Training

Queensland Alliance, Peak Body for the Mental Health Community Sector

Mr Jeff Cheverton, Executive Director
Ms Georgina Lawson, Sector Development Worker
Ms Jude Bugeja, State Councillor
Mr Jorgen Gullestrup, Queensland OzHelp

White Wreath Association

Ms Fanita Clark, Chief Executive Officer
Mr Peter Neame, Research Officer

Community Action for the Prevention of Suicide Inc (CAPS)

Ms Carla Pearse, Chief Executive Officer
Mr Peter Annand, President

SOS Survivors of Suicide Bereavement Support Association Inc.

Ms Myvanwyn Camp, President
Mr Darrin Larney, Executive Officer

Dr Edward Koch Foundation
Ms Dulcie Bird, Executive Officer

Anti-Depression Association of Australia

Mr David Cameron-Hands
Ms Carol McLoughlin

Commission for Children and Young People and Child Guardian, Queensland

Ms Angela Ritchie, Manager Child Death Review

Australian Indigenous Psychologists Association

Ms Leda Barnett, Psychologist
Mr Clinton Schultz, Psychologist

Professor Graham Martin

Queensland Health

Dr Aaron Groves, Executive Director, Mental Health Directorate

Wednesday, 3 March 2010
New South Wales Parliament, Sydney

Committee Members in attendance

Senator Rachel Siewert (Chair)
Senator Claire Moore
Senator Sue Boyce
Senator Judith Adams
Senator Mark Furner
Senator Catryna Bilyk
Senator the Hon Helen Coonan

Witnesses

Mental Health Coordinating Council

Ms Jenna Bateman, Chief Executive Officer
Ms Corinne Henderson, Senior Policy Officer

NSW Centre for Rural and Remote Mental Health

Professor Brian Kelly

Wesley Mission

Rev Dr Keith Garner, CEO Wesley Mission
Ms Penny Mayson, Operations Manager, Suicide Prevention Services

The Richmond Fellowship of NSW
Ms Pamela Rutledge Chief Executive Officer
Dr Andrew Campbell, Chair

NSW Consumer Advisory Group – Mental Health Inc

Ms Karen Oakley, Executive Officer
Ms Rebecca Doyle, Senior Policy Officer

Mrs Dianne Gaddin

Mrs Janine Rod

National LGBT Health Alliance

Ms Gabi Rosenstreich, Executive Director
Mr Atari Metcalf (LGBT Member Representative), Evaluation Manager, Inspire Foundation

Australian Men's Shed Association

Mr Mort Shearer, National President

Mrs Kathleen Hawdon

Public Interest Advocacy Centre

Mr Peter Dodd, Solicitor – Health Policy and Advocacy

NSW Health

Assoc. Professor John Allan, Chief Psychiatrist, Mental Health and Drug & Alcohol Programs

Thursday, 4 March 2010
St James Court Conference Centre, West Melbourne

Committee Members in attendance

Senator Rachel Siewert (Chair)
Senator Claire Moore
Senator Sue Boyce
Senator Judith Adams
Senator Mark Furner
Senator Catryna Bilyk

Witnesses

Australian Suicide Prevention Foundation

Clinical Associate Professor David Horgan, Chairman
Mr John Hardy, Chief Executive Officer

Victoria Mental Health Carers Network
Mr Warren Jenkins, Member

beyondblue

Ms Leonie Young, Chief Executive Officer
The Hon Mr Jeff Kennett, Chair

Integrated Primary Mental Health Service of North East Victoria

Ms Jennifer Ahrens, Manager
Ms Laura Parisotto, Early Motherhood Service

National Coroners Information System

Professor Joan Ozanne-Smith, Director
Ms Jessica Pearse, Manager
Associate Professor David Ranson, Deputy Director, Victorian Institute of Forensic Medicine

The Salvation Army

Mr Allan Staines, Director, Suicide Prevention – Bereavement Support Services
Ms Wilma Gallet, Project Manager

Ms Cindy Mills

Royal Australian and New Zealand College of Psychiatrists (RANZCP)

Dr Darryl Watson, Executive Officer
Dr Mirco Kabat, Director

Orygen Youth Health

Professor Patrick McGorry, Executive Officer
Ms Jo Robinson, Research Fellow

Victorian Section of the College of Clinical Psychologists

Professor Nick Allen, Member

Australian Psychological Society

Professor Lyn Littlefield, Executive Director

Wednesday, 24 March 2010
Parliament House, Canberra

Committee Members in attendance

Senator Rachel Siewert (Chair)
Senator Claire Moore
Senator Judith Adams
Senator Gavin Marshall

Witnesses

Australian College of Mental Health Nurses

Ms Kim Ryan, Chief Executive Officer
Ms Anne Buck, Policy Officer

Rural Doctors Association of Australia

Mr Steve Sant, Chief Executive Officer

Australian Institute of Family Studies

Professor Alan Hayes, Director
Ms Elly Robinson, Research Fellow

Council on the Ageing National

Mr Ian Yates, Chief Executive Officer
Ms Jo Root, National Policy Officer

SANE Australia

Ms Barbara Hocking, Executive Director

Thursday, 25 March 2010
Parliament House, Canberra

Committee Members in attendance

Senator Rachel Siewert (Chair)
Senator Claire Moore
Senator Gary Humphries

Witnesses

Mr Jim Snow

Psychotherapy and Counselling Federation of Australia

Associate Professor Ione Lewis, Vice-President

Crisis Support Services

Ms Alyson Miller, Chief Executive Officer
Ms Laura Kennan, General Manager, Clinical Support

ACT Government

Dr Len Lambeth, Chief Psychiatrist
Mr Richard Bromhead, Manager, Mental Health Policy Unit

Peer Support Australia (via teleconference)

Ms Sharlene Chadwick, Training and Development Manager

Australian General Practice Network (AGPN)
Ms Leanne Wells, Executive Director, Policy Development
Ms Katrina Delamothe, Service Manager/Clinical Psychologist, Mental Health Programs, GP Access

Australian Medical Association

Dr Bill Pring, Chair, Public Health Committee

Tuesday, 30 March 2010
Western Australian Parliament, Perth

Committee Members in attendance

Senator Rachel Siewert (Chair)
Senator Claire Moore
Senator Judith Adams
Senator Mark Furner

Witnesses

Aboriginal Health Council of Western Australia

Mr Craig Somerville, Chief Executive Officer

Mission Australia WA

Mr Ross Kyrwood, State Director

The Richmond Fellowship of Western Australia

Mr Joe Calleja, Chief Executive Officer

Hearing Voices Network Australia

Ms Lyn Mahboub, Consultant

Noongar Health Council

Mr Darryl Kickett, Chief Executive Officer

Active Response Bereavement Outreach (ARBOR)

Ms Sharon Hillman, Manager
Ms Josephine Hudson, Chair, ARBOR Reference Group
Mrs Margaret Doust, Volunteer Peer Supporter

Wednesday, 31 March 2010

Western Australian Parliament, Perth

Committee Members in attendance

Senator Rachel Siewert (Chair)
Senator Claire Moore
Senator Judith Adams
Senator Mark Furner

Witnesses

Western Australian Ministerial Council for Suicide Prevention

Professor Robert Donovan, Deputy Chair
Mr Shawn Phillips, Executive Officer

Youth Focus

Ms Jenny Allen, Chief Executive Officer
Ms Nicole Marshall, Acting Youth and Family Services Manager

Ethnic Communities Council of Western Australia

Mr Suresh Rajan, Executive Officer

Indigenous Team of the National Drug Research Institute

Dr Julia Butt, Senior Research Fellow
Ms Anna Stearne, Research Associate

Commission for Children and Young People in Western Australia

Ms Michelle Scott, Commissioner

Coroner's Court of Western Australia

Mr Alastair Hope, State Coroner

Tuesday, 4 May 2010

South Australian Parliament, Adelaide

Committee Members in attendance

Senator Rachel Siewert (Chair)
Senator Claire Moore
Senator Judith Adams
Senator Dana Wortley

Witnesses

Mr Mark Johns, South Australian State Coroner

Freemasons Foundation Centre for Men's Health

Dr Kate Fairweather-Schmidt, Research Fellow

Kentish Regional Clinic

Mr Mark Sheldon-Stemm, Chair/President

Associate Professor James Harrison

Mind Matters

Ms Jill Pearman, National Coordinator
Ms Tracy Zilm, National Training Coordinator
Ms Lindsay Cowper, Assistant Principal, Victor Harbor High School

Professor Ian Webster

Relationships Australia

Ms Claire Ralfs, Director of Services
Ms Mergho Ray, Senior Manager, Primary Health Services, Training and Education

South Australian Government

Dr Tony Sherbon, Chief Executive, SA Health
Dr Margaret Honeyman, Director Mental Health Policy, Chief Advisor in Psychiatry, Mental Health Unit

Monday, 17 May 2010

Northern Territory Legislative Assembly, Darwin

Committee Members in attendance

Senator Rachel Siewert (Chair)
Senator Claire Moore
Senator Judith Adams

Witnesses

Mental Health Association of Central Australia (via teleconference)

Ms Laurencia Grant, Coordinator

Central Australian Aboriginal Congress (via teleconference)

Mr Gerard Waterford, Coordinator

General Practice Network NT

Ms Alison Faigniez, Chief Executive Officer
Ms Sue Korner, Deputy Chief Executive Officer and Manager Health Services (via teleconference)
Ms Kath Harradine, Mental Health Program Manager (North)
Mr Matt Davis, Aboriginal Mental Health Worker Program Team Leader

Northern Territory Government

Ms Bronwyn Hendry, Chair, NT Suicide Prevention Coordinating Committee
Professor Robert Parker, Director of Psychiatry, Top End Mental Health Services
Ms Sarah O'Regan, NT Suicide Prevention Coordinator, Mental Health Program

Tuesday, 18 May 2010

Parliament House, Canberra

Committee Members in attendance

Senator Rachel Siewert (Chair)
Senator Claire Moore
Senator Judith Adams

Witnesses

Australian Bureau of Statistics

Mr Garth Bode, First Assistant Statistician, Social Statistics Group,
Ms Anneke Schmider, Director, Social and Demographic Statistics Branch

Australian Institute for Suicide Research and Prevention

Professor Diego De Leo, Director (Professor of Psychiatry)
Dr Kairi Kõlves, Acting Director (Senior Research Fellow)
Mrs Jacinta Hawgood, Senior Researcher and Course Lecturer

Department of Health and Ageing

Ms Rosemary Huxtable, Deputy Secretary
Ms Georgie Harman, First Assistant Secretary, Mental Health and Chronic Disease Division
Ms Colleen Krestensen, Assistant Secretary, Mental Health and Suicide Prevention Programs Branch
Ms Tarja Saastamoinen, Assistant Secretary, Family Health and Wellbeing Branch, Office of Aboriginal and Torres Strait Islander Health
Dr Andrew Singer, Acting Chief Medical Officer
Ms Virginia Hart, Assistant Secretary, Mental Health Reform Branch

Department of Families, Housing, Community Services and Indigenous Affairs

Ms Deborah Winkler, Branch Manager, Mental Health and Autism

Department of Veterans' Affairs

Mr Shane Carmody, Deputy President, Repatriation Commission
Mr Wayne Penniall, National Manager, Veterans' and Veterans Families' Counselling Service

Professor Robert Goldney (via teleconference)

Mr Michael Barnes, Queensland State Coroner (via teleconference)

Thursday, 20 May 2010

Tasmanian Parliament, Hobart

Committee Members in attendance

Senator Claire Moore (Acting Chair)
Senator Judith Adams
Senator Carol Brown
Senator Catryna Bilyk

Witnesses

Time Out Project – Youth Suicide Action Group

Ms Verity Tunevitsch, President
Mrs Diane Hayes, Coordinator and Committee member

Tasmanian Council for Sexual & Gender Diverse People Inc

Mr Julian Punch, State Coordinator, Coming Out Proud Program
Mr Scott Ryan, State Coordinator for Outright Youth

Mental Health Council of Tasmania

Ms Michelle Swallow, Executive Officer

Lifeline Hobart

Mr Christopher John, Chief Executive Officer
Mr Alan Woodward, General Manager, Social Policy, Innovation, Research and Evaluation

Department of Health & Human Services

Dr John Crawshaw, Chief Executive Officer, Statewide and Mental Health Services