


NATIONAL COALITION FOR SUICIDE PREVENTION

RESPONSE TO WORLD
HEALTH ORGANISATION
WORLD SUICIDE REPORT

'PREVENTING SUICIDE: A GLOBAL IMPERATIVE'

DISCUSSION PAPER
**ONE WORLD CONNECTED:
AN ASSESSMENT OF AUSTRALIA'S PROGRESS
IN SUICIDE PREVENTION**

SEPTEMBER 2014



*We remember those we have lost to suicide
and we acknowledge the suffering that
suicide brings when it touches our lives.*

*Our aim is to ensure that we provide for all
people a future that inspires and empowers
individuals and communities, and is filled
with hope and meaning.*

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FOREWORD

First and foremost, we congratulate the World Health Organisation (WHO) for releasing the first international report on suicide prevention (herein referred to as the WHO Report). Suicide prevention is a global imperative and, while some of this information may be known by those working in the sector, this is the first time a full and transparent picture of global efforts to reduce suicide has been published.

A special thanks to our esteemed colleagues who contributed on behalf of Australia, Professor Diego De Leo, Director of the Australian Institute for Suicide Research and Prevention, a WHO Collaborating Centre for Research and Training in Suicide Prevention, Brisbane, and other expert reviewers from Australia such as Suicide Prevention Australia Board Directors Michael Dudley and Myf Maple.

The National Coalition for Suicide Prevention (members listed in Appendix A), is pleased to offer this perspective on the report, focusing on areas where Australia is leading the way, and where significant work is required to improve outcomes for the community.

The report follows the adoption of the Comprehensive Mental Health Action Plan 2013-2020 by the World Health Assembly, which commits all 194 member states to reducing the suicide rates by 10% by 2020. The National Coalition for Suicide Prevention has sought a further reduction target of 50% in the next ten years. As an ambitious group, we are seeking to achieve a greater reduction and believe this revised goal is appropriate for one of the world's higher income countries with the capacity to implement learning from other countries aspirational target.

We believe Australia needs a clear national suicide prevention strategy that includes specific outcome measures that underpin Government and local efforts. Without clear measurable outcomes we will not know if we are progressing toward our goal – what is working and what may not be working?

We see excellence in suicide prevention throughout Australia but, often in isolation. It is essential that we have a national strategy in place to connect these efforts and to build momentum and encourage creativity. The value of the sum is far greater than that of its parts.

Despite these limitations the beauty of our country is its diversity – a mix of different landscapes, cultures and lifestyles – and our suicide prevention programs must embrace this diversity rather than adopt a 'one size fit all approach'. This is an issue that the WHO Report has reinforced – the need to have a strategy that allows for local and cultural strengths to be recognised in planning and implementation. It is also an area we need to urgently address in Australia, particularly in relation to Australia's Aboriginal and Torres Strait Islander population and immigrants in detention. In this paper we have included a specific section on the disturbingly disproportionate rates of suicide in this group and call for urgent action to be taken to address contributing factors.

The WHO Report mentions Australia's relatively high quality data. While this may be so on a global scale, we do not believe that suicide death and suicide attempt data in Australia is of adequate quality nor is it readily accessible to inform prevention efforts and deliver improvements. We do not have a clear picture of suicide in this country and until we have access to that information we are limited in how we can affect change. This remains one of the National Coalition for Suicide Prevention's top priorities.

Reading the WHO Report has also emphasised that we need to look beyond our borders. What can we learn from other countries? For example, lessons from Indigenous friends in America and Canada, the work the USA has done with the defence forces and veterans, Germany's multicomponent program targeting depressive disorders, the Choose Life strategy in Scotland – just to name a few. The WHO Report is correct: Suicide prevention is a global imperative.

Last but certainly not least, a notable exclusion from the WHO Report is the inclusion of the voices of lived experience in suicide prevention. In this paper we have included some information about how Australia is embedding those whose lives have been touched by suicide in the development of suicide prevention actions. Embracing the constructive voice of lived experience into all of our suicide prevention activities will help us do a better job of helping all Australians lead a contributing life.

Once again, we commend the WHO for putting together an informative, thought provoking and easily digestible World Suicide Report. We appreciate the work done by Australia's leaders in suicide prevention, and look forward to discussing what we, as a country and as a specialist sector, need to do to realise our ambition to reduce suicides by 50% in ten years.



Sue Murray

Convenor, National Coalition for Suicide Prevention
CEO, Suicide Prevention Australia

World Suicide Prevention Day in 2014 is significant because it marks the release by the World Health Organisation (WHO) of the first international suicide report, 'Preventing suicide: A global imperative'.

This WHO World Suicide Report is the most comprehensive, up-to-date record of the current status of suicide prevention internationally. The report:

- Outlines the epidemiology of suicide, presenting the most recent data from countries across the world;
- Discusses major risk and protective factors for suicide, paying particular attention to those which are modifiable. It presents the evidence for key interventions that show promise in reducing suicidal acts;
- Describes the overarching national suicide prevention strategies that have been introduced in a number of countries, highlighting their common features; and
- Then collates this information and makes recommendations about the future direction of suicide prevention activities in different countries and cultures.

The WHO report aims to be an invaluable resource for those working to prevent suicide and has a specific focus on informing stakeholders working in policy development and implementation.

In the report Foreword, Margaret Chan, Director-General World Health Organisation states:

“This report encourages countries to continue the good work where it is already ongoing and to place suicide prevention high on the agenda, regardless of where a country stands currently in terms of suicide rate or suicide prevention activities. With timely and effective evidence-based interventions, treatment and support, both suicides and suicide attempts can be prevented.

The burden of suicide does not weigh solely on the health sector; it has multiple impacts on many sectors and on society as a whole. Thus, to start a successful journey towards the prevention of suicide, countries should employ a multi-sectoral approach that addresses suicide in a comprehensive manner, bringing together the different sectors and stakeholders most relevant to each context.”

In this response paper, the National Coalition for Suicide Prevention looks at the report findings in relation to Australia and suicide prevention, it explores what we are doing well and what we need to do differently.

In the WHO report, the World Health Organisation (WHO) recognises Australia as a high income country and is using national statistics from 2012. This paper assumes WHO Report terminology as set out in Appendix B and on page 12 of the Report. Where Australian terminology is used beyond this, it is defined within or lists an appropriate reference.

FORMAT OF THIS RESPONSE PAPER

This paper offers a brief summary of points of interest from the WHO Report as well as a view on how Australia is performing against some of the criteria set out in this Report as important for a successful national suicide prevention strategy.

For ease of reference, we have used a traffic light system so readers can easily identify where Australia is performing well, where we are heading in the right direction but have work to do; and where serious discussion and action is required.

Please keep in mind that this is a simple reference key to foster discussion on Australian actions needed to better suicide prevention policy and programs. It is by no means a formal evaluation.

REFERENCE KEY



Australia has taken positive strides in this area and has shown demonstrable outcomes/is a leading international example in the sector. The focus now is on continuous improvement.



Australia has undertaken some positive action in this area but has some way to go toward full implementation.



Australia is performing poorly in this area and serious action planning is required.

SNAPSHOT OF AUSTRALIA'S PERFORMANCE

In reviewing the WHO Report, Australia's National Coalition for Suicide Prevention has identified a number of areas that require action. These are summarised below using the traffic light system and discussed in more detail in the subsequent pages of the paper. The National Coalition for Suicide Prevention has drawn out the typical components of national suicide prevention strategies – as set out on page 57 of the WHO Report – to structure its Australia specific rating and commentary.

SUMMARY OF AUSTRALIA'S CURRENT SUICIDE PREVENTION PERFORMANCE

Strategy, oversight and coordination		Creation of a national strategy to prevent suicide. Establish institutions or agencies to promote and coordinate research, training and service delivery in respect of suicidal behaviours. Strengthen health and social system responses to suicidal behaviour.
Data (Surveillance)		Increase quality and timeliness of national data on suicide and suicide attempts. Support the establishment of an integrated data collection system which serves to identify vulnerable groups, individuals and situations.
Means restriction		Reduce the availability, accessibility and attractiveness of the means to suicide (e.g. firearms, high places). Reduce toxicity/lethality of available means.
Media		Promote implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media.
Training and education		Maintain comprehensive training programs for identified gatekeepers (e.g. health workers, educators, police). Improve the competencies of mental health and primary care providers in the recognition and treatment of vulnerable persons.
Access to service		Promote increased access to comprehensive services for those vulnerable to suicidal behaviours. Remove barriers to care.
Treatment		Improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt. Improve research and evaluation of effective interventions.
Crisis intervention		Ensure that communities have the capacity to respond to crises with appropriate interventions and that individuals in a crisis situation have access to emergency mental health care, including through telephone helplines or the internet
Postvention		Improve response to and caring for those affected by suicide and suicide attempts. Provide supportive and rehabilitative services to persons affected by suicide attempts.
Awareness and Stigma reduction		Establish public information campaigns to support the understanding that suicides are preventable. Increase public and professional access to information about all aspects of preventing suicidal behaviour. Promote use of mental health services, and services for the prevention of substance abuse and suicide. Reduce discrimination against people using these services.

SUICIDE DEATHS²

Over the past five years the average number of suicide deaths per year has been 2,415. This equates to approximately seven Australians dying by suicide every day.

In 2012, the most recent data available, 2,535 suicides were reported: This is the highest annual number of suicide deaths over the past decade. *See Chart A*

The age-standardised suicide rate for Australians in 2012 was 11.2 per 100,000. The overall suicide rate has remained relatively steady since 2003 however, as pointed out in the WHO Report, the suicide rate among females has been increasing while the suicide rate among males has been decreasing. *See Chart B.*

Suicide rates vary across sexes and age groups. With the exception of males aged over 85, the highest rates of suicide occur among males in their middle years (i.e. 30-59). *See Chart C*

Suicide accounts for a greater proportion of deaths from all causes within younger age groups compared to older age groups. Suicide is mostly preventable yet it is now the leading cause of death for both Australian males and females aged 15-44 years. *See Chart D.*

CHART A: NUMBER OF SUICIDE DEATHS, 2003-2012

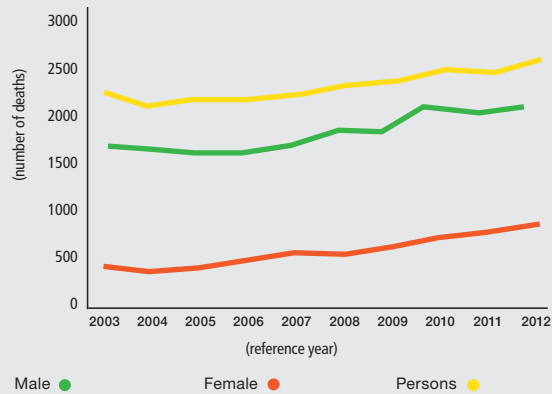


CHART B: SUICIDE RATES BY SEX (ALL AGES), 2003-2012

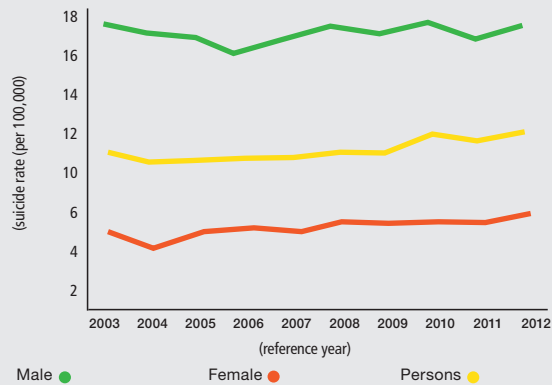
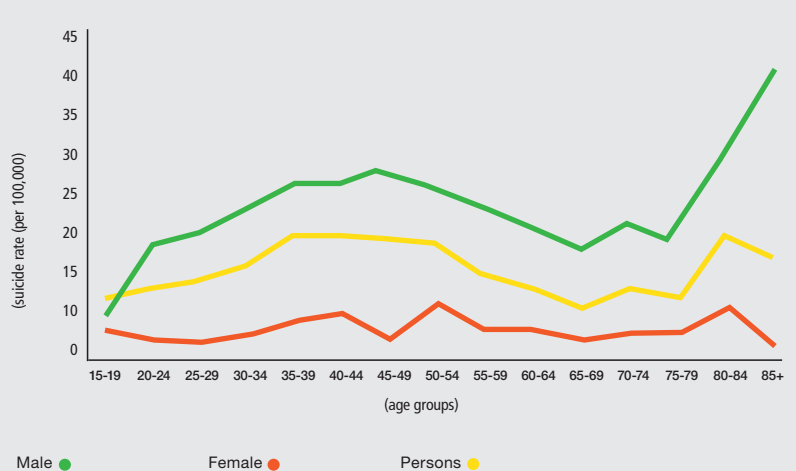


CHART C: SUICIDE RATES BY SEX AND AGE GROUP, 2012



The numbers and rates of suicide vary across the States and Territories. The highest suicide rates occur in the Northern Territory followed by Tasmania and Western Australia. See *Table 1*.

The most common method of suicide in Australia is hanging, strangulation and suffocation (ICD-10 code X70), accounting for 54% of suicides in 2012. Methods do vary between the sexes. See *Chart E*.

Suicide attempts

Limited data is available on the extent of suicide attempts and suicidal ideation in Australia. It is estimated that 370,000 Australians think about ending their life every year, 91,000 make a plan to suicide, and 65,000 suicide attempts occur each and every year.

Suicide bereavement

The tragic impact of suicide extends far and wide. Conservative estimates suggest that for every death by suicide another six people are severely affected by intense grief and that this intense grief can continue for many years. Based on these conservative figures, in 2012 approximately 15,200 individuals were bereavement by suicide: In reality, the number is likely to be much higher.

CHART D: SUICIDE AS A PROPORTION OF ALL DEATHS BY AGE GROUPS, 2012

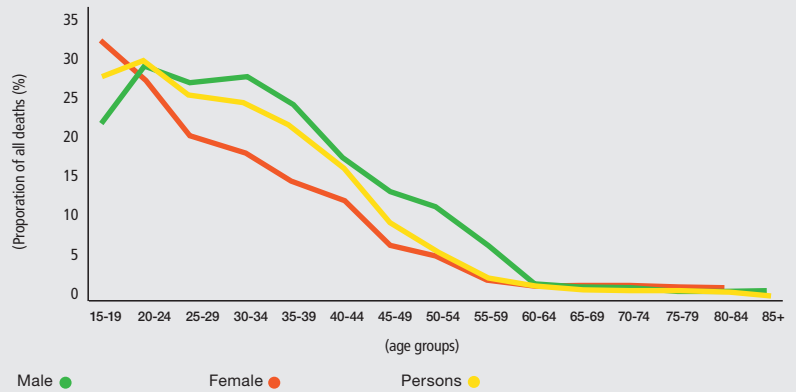
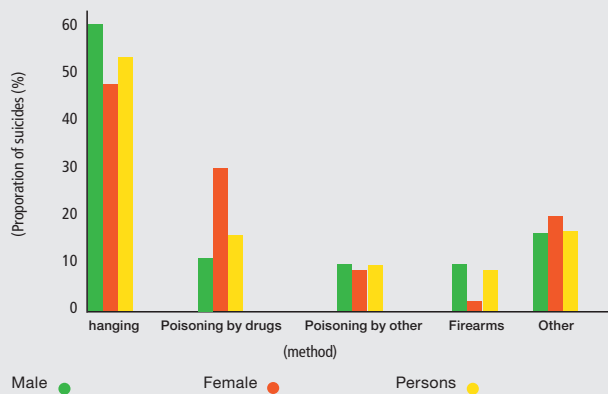


Table 1	No. of deaths 2012	Standardised Death Rate 2008-2012	Rate Ratio 2008-2012
NSW	707	8.9	0.8
Vic.	502	9.7	0.9
Qld	621	13	1.2
SA	197	11.8	1.1
WA	366	13.5	1.3
Tas.	70	14.1	1.3
NT	48	18.1	1.7
ACT	24	9.1	0.8
Australia	2535	10.8	1

CHART E: METHOD OF SUICIDE BY SEX, 2012



LIVED EXPERIENCE

A notable exclusion from the WHO Report is the valuable contribution that those with a lived experience of suicide make to suicide prevention research, policy and practice. We believe it should be recognised that Australia and the United States of America have shown some notable progress in this area.

Suicide Prevention Australia's Lived Experience Committee was established in 2012. The Committee provides Suicide Prevention Australia with advice and guidance on how to incorporate lived experience into our strategy, policy and activities.

The Committee has been instrumental in the development of the first Australian Lived Experience Network Strategy and, at the 2014 National Suicide Prevention Conference, launched the 'draft guiding principles for the inclusion of lived experience in suicide prevention'. These principles will form the core of a draft 'National Statement', a guiding document to assist organisations and individuals to effectively engage those with lived experience of suicide in relevant activities. Consultation to refine the draft National Statement is currently underway.

The draft principles are as follows:

1. People with a lived experience have a valuable, unique and legitimate role in suicide prevention.
2. Lived experience helps change the culture surrounding suicide and to preserve and promote life through compassion and understanding.
3. Inclusion and embracing diversity of individuals, communities and cultures enriches suicide prevention.
4. Empower and support those with lived experience to share their insights and stories with a view to preventing suicide.
5. Utilise our lived experience to educate, promote resilience, inspire others and instil hope.
6. People with lived experience support, advocate for and contribute to research, evidence-based practice and evaluation.
7. All suicide prevention programs, policies, strategies and services will at all levels include genuine meaningful participation from those with lived experience.
8. Encourage and nurture collaboration and partnerships between organisations and stakeholders.

SIX KEY ELEMENTS TO SUPPORT NATIONAL SUICIDE PREVENTION

STRATEGY, OVERSIGHT AND COORDINATION



Creation of a national strategy to prevent suicide. Establish institutions or agencies to promote and coordinate research, training and service delivery in respect of suicidal behaviours. Strengthen health and social system responses to suicidal behaviour.

Australia is recognised as one of the first countries in the world to put in place a strategy to prevent suicide with the instigation of a youth-focused suicide prevention strategy in 1995. Details of current suicide prevention strategy and funding are provided in Appendix C.

"A national strategy indicates a clear commitment of a government to prioritising and dealing with the issue of suicide. It also provides leadership and guidance regarding what the key evidence-based suicide prevention activities are and what should be prioritised. A strategy provides for the transparent identification of stakeholders who are accountable for specific tasks, and outlines ways to coordinate them effectively."
(p. 56, WHO Report)

The WHO Report (p. 58) highlights six key elements to support national suicide prevention strategies. Here, we comment on Australia's performance against these elements.

1. MAKE SUICIDE PREVENTION A MULTISECTORAL PRIORITY, REGARDLESS OF RESOURCES

"The overarching aim of a national suicide prevention strategy is to promote, coordinate and support appropriate intersectoral action plans and programmes for the prevention of suicidal behaviours at national, regional and local levels. Partnerships are required with multiple public sectors (such as health, education, employment, judiciary, housing, social welfare) and other sectors, including the private sector, as appropriate to the country."
(p. 58, WHO Report)

Our strengths:

- The Living is For Everyone (LIFE) Framework¹⁹, the 'linchpin' of the Australian Government's National Suicide Prevention Strategy (NSPS), strives to take a holistic approach to suicide prevention by inclusion of social determinants as well as biomedical determinants of suicidal behaviour.
- States and territory suicide prevention strategies are now aligned with the LIFE Framework, reducing confusion and offering greater potential for coordination and collaboration.
- Suicide prevention is seen as an issue of concern across a number of government portfolios (e.g. defence, veterans, and justice) and industries (e.g. construction, mining) and individual programs to meet the needs of clients and employees are in place.

Where we need to do better:

- In reality, the strategic approach to suicide prevention in Australia is piecemeal, uncoordinated and overly biased on activities falling under the remit of the Department of Health, especially mental health. This must change if we are to significantly reduce the tragedy of suicide. Reducing suicidal behaviour should be seen as a key outcome across a wide range of areas including drug and alcohol, homelessness, domestic violence, family and relationships, justice, employment, veterans and immigration.
- As outlined in the special section outlining current suicide prevention strategy in Australia, there are a wide range of components to the national picture of suicide prevention but no clear responsibility or accountability for coordinating various components or reporting on outcomes.
- There are only isolated strategic plans to prevent suicide at the regional or local level and no mechanism for the alignment and coordination of these strategies. This is despite the LIFE Framework highlighting the importance of equipping communities to respond to suicide.
- There is no clear mechanism or provision for the private sector to become involved in suicide prevention nor responsibility for the provision of up-to-date evidence-based advice for business when stepping out of their core business and into the realm of suicide prevention.
- Despite the significant contribution that NGOs play in the field of suicide prevention (and mental health), coordination and collaboration between these organisations has historically occurred haphazardly and has only just begun to improve: the National Coalition for Suicide Prevention is working to build and focus collaborative effort in suicide prevention
- There is limited shared strategic vision across all sectors to collectively guide investment in activities to make the greatest possible impact on suicide in Australia.



2. TAILOR FOR DIVERSITY

“Although existing national strategies have similar components, no two national strategies are identical, in part because the problem of suicide is different in each country. Suicide depends on a number of factors, and its expression is influenced by social and cultural contexts. While common risk factors have been identified globally, the goals, objectives and interventions must be tailored to the specific context.”
(p. 58, WHO Report)

Our strengths:

- We have a good understanding of the risk factors and protective factors associated with suicidal behaviour in Australia.
- The LIFE Framework identifies the need to ensure activities are appropriate to the social and cultural needs of the groups or populations being served. There is a general agreement within the suicide prevention sector that cultural diversity and cultural appropriateness and safety are important.
- The first *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*²⁰ was released in May 2013 to focus efforts on reducing the devastation occurring in Aboriginal and Torres Strait Islander communities across the country (however, implementation of the strategy has not yet occurred). See special section on Aboriginal and Torres Strait Islander suicide prevention on page 15.

Where we need to do better:

- Despite identification of groups vulnerable to suicide in Australia, activities funded under the NSPS do not adequately provide for the effective targeting of these groups across the country.
- Limited data or poor quality data is available to accurately identify the number of individuals who fall into some vulnerable groups let alone the occurrence of suicidal behaviour among these populations. For example, national data is not centrally and routinely collected on identification as lesbian, gay, bisexual, transgender, intersex and other sexuality and gender diverse (LGBTI) and there are data quality challenges with Aboriginal and Torres Strait Islander deaths data²¹.
- While the LIFE Framework may identify the importance of cultural diversity within suicide prevention activities and a quarter of Australia’s population were born overseas²², the reality is that there are very few suicide prevention activities that specifically target culturally and linguistically diverse groups.
- No funding has been released to support the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*. The disappointment and disillusionment as a result of the now sixteen month wait for funds acts to reinforce historical trauma and may inadvertently add to suicide risk among our Aboriginal and Torres Strait Islander peoples. A powerful call for urgent understanding and action to improve Aboriginal and Torres Strait Islander wellbeing in Australia as documented in *The Elders’ Report into Preventing Indigenous Self-Harm and Youth Suicide*²³, has gone unanswered. See the special section more information on suicide among Aboriginal and Torres Strait Islander people.

ABORIGINAL AND TORRES STRAIT ISLANDER SUICIDE PREVENTION

Suicide in traditional Indigenous communities has emerged as a priority issue of international public concern only in recent decades. Prior to the 1980's suicide was almost non-existent in Aboriginal and Torres Strait Islander communities.

In 2012, suicide was the fifth leading cause of death of Aboriginal and Torres Strait Islander Australians. The age-standardised death rate for suicide was around twice as high in both Aboriginal and Torres Strait Islander males and females than non-Indigenous males and females. (with rates are 4 and 5 times that of non-indigenous males and females respectively)²⁴. Young Indigenous Australians are the most vulnerable.

A complex set of factors contribute to risk of suicidal behaviours among Aboriginal and Torres Strait Islanders. These include history of colonization, cultural dislocation and loss, inter-generational trauma, racism, unemployment, poverty, overcrowding, social marginalisation, and access to drugs and alcohol²⁵.

Despite the prevalence of suicide among Aboriginal and Torres Strait Islander communities, Indigenous understanding and definitions of suicidal behaviours remain under-researched, undervalued and under-utilised.

Our strengths:

Our strength lies in the Aboriginal and Torres Strait Islander communities themselves.

Indigenous community leaders and Elders have made a powerful call for support in helping them heal their young people, by reconnecting them to their culture, and strengthening their sense of identity. Via the Elders' Report into preventing Indigenous self-harm and youth suicide²⁶, Aboriginal and Torres Strait Islander leaders have asked for recognition of the:

'distinct cultural differences between non-Aboriginal and Aboriginal Torres Strait Islander people, and that these differences must be taken into account in the way help is provided... any crisis will not be solved unless partnerships are formed with Aboriginal and Torres Strait Islander people, both in identifying the problem and in delivering the solution' (p. 6).

And made a call for:

*'long-term funding (to) be directed to grassroots, community-based programs that are working on the frontline with at-risk youth, providing vital support, cultural education and on-country healing'*²⁷.

Evidence provided in the WHO Report supports the importance of high levels of local control and involvement of the Indigenous community to ensure that interventions were culturally relevant .

Where we need to do better: Move beyond talk and get to action.

In May 2013 Australia's first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was released. In the foreword the Minister for Mental Health and the Minister for Indigenous Health stated:

'The Strategy demonstrates the Government's commitment to working with other portfolios and across all levels of government to reduce the longer term incidence of suicidal and self-harming behaviour amongst Aboriginal and Torres Strait Islander peoples.'

As of September 2014, **no** funding or activity has occurred under the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. However, recently announced funding by the Australian Government for a national *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project* to review and establish an evidence base of 'what works' in Indigenous suicide prevention is a welcome start and will ensure more effective use of funds when they are released.



3. ESTABLISH BEST PRACTICES

“A closer look at the components of existing national strategies indicates that they are compilations of individual evidence-based interventions and best practices that, taken together, represent a comprehensive approach to addressing a broad range of risk and protective factors that are common to a specific country. Developing, implementing and evaluating pilot projects, targeted programmes and action steps is an essential basis for developing a suicide prevention strategy.”
(p. 58, WHO Report)

Our strengths:

- We have a highly engaged group of professionals, volunteers and individuals with lived experience who specialise in the field of suicidology (i.e. a suicide prevention sector).
- The Australian suicide prevention research community is highly qualified, passionate and produces world class evidence.

Where we need to do better:

- There is no central and transparent process in Australia for identifying activities that meet best practice standards nor is there a central ‘best practice register’ to identify, compare and promote effective activities. These gaps make it difficult to make informed decisions when choosing between activities and represent a missed opportunity to drive continuous improvement in all suicide prevention activities.
- Much of the research evidence that is generated is not translated to policy nor put into practice. We need to make better use of the knowledge already available and focus on testing the effectiveness of evidence-informed or evidence-based interventions. Based on the existing evidence about what works in suicide prevention, the National Coalition for Suicide Prevention is proposing a systems approach to suicide prevention, implementing a set of eight key strategies simultaneously across systems within a local region. *See the box below on the proposed systems approach.*
- We need a clear, accurate and up-to-date mapping of the suicide prevention activities occurring on the ground: At present we simply do not know enough about the quantity, quality or distribution of suicide prevention programs and services. Australia’s federated system makes it difficult to track pathways to care and the siloed approach to suicide prevention between sectors results in gaps and vulnerable individuals falling through the cracks.
- All service delivery should be culturally safe and respectful. To do this, a good understanding of the diversity of the target population is required and best practice principles on culturally safe and respectful practice must be incorporated. This includes, at a minimum, looking at diverse sexual and gender identity, Aboriginal and Torres Strait Islander culture, and ethnicity.

A SYSTEMS APPROACH TO SUICIDE PREVENTION PROPOSED BY THE NATIONAL COALITION FOR SUICIDE PREVENTION*.

We recommend that we implement a systems approach to suicide prevention in Australia. A systems approach has been attempted in Europe, with good results to date.

The key components of the new approach are:

1. Involvement by all medical, health and community agencies responsible for the eight strategies below.
2. Within a local/regional area.
3. At the same time (simultaneously).

The core of the approach is implementation of the following eight strategies locally, simultaneously across these systems.

1. Reducing access to lethal means of suicide
2. Responsible reporting by the media
3. School based peer support and screening
4. Gatekeeper training in schools and in the military
5. Training of front line staff every three years
6. Training of general practitioners in detecting and dealing with risk
7. High quality treatment (CBT and DBT) for those with mental illnesses (including online treatments)
8. Appropriate and continuing care once people leave emergency departments:
 - 24/7 call out emergency teams experienced in child/adolescent suicide prevention.
 - Crisis-call lines and chat services for emergency callers.
 - Assertive outreach for those in the ED and discharged including those hard to engage with.
 - E-health services of web programs through the internet.
 - Many of these interventions are currently used in Australia. Others could be readily implemented through health systems and NGOs. However, no attempt has been made to combine these strategies through communities and health systems in local areas, simultaneously. This really is a case of the whole is greater than the sum of the parts, and this has not been attempted systematically.

*Prepared by the Black Dog Institute, the University of New South Wales for the National Coalition for Suicide Prevention, August 2014

4. ALLOCATION OF RESOURCES (FINANCES, TIME, STAFF)

“In order for a suicide prevention strategy to be coordinated and comprehensive, it should have specified financial and human resources, a time frame for implementation, and short-to-medium and long-term objectives. Developing a national suicide prevention strategy requires having a financially sustainable model in order to accomplish desired goals. A logical framework is one of many programme planning and evaluation tools that can be used to help display the connections between the problem to be addressed, the activities to be implemented and the expected results.” (p. 58, WHO Report)

Our strengths:

- Australia was seen as an innovator in suicide prevention in the mid-1990’s and, with real focus and collaborative effort in relation to resources and funding, saw a successful decline in youth suicide rates as a result of strategic efforts.
- We have plenty of knowledge and expertise available in Australia and can look to international examples where strategic focus has produced significant reductions in suicidal behaviour (for example Scotland).

Where we need to do better:

- An appropriate level of sustainable funding and resourcing is required to match the size and seriousness of the problem.
 - See Appendix C outlining the current suicide prevention strategy in Australia including information on funding under the NSPS.
 - The cost of suicidal behaviour to the Australian economy has been estimated to be in the range of \$1.7 billion²⁹ to \$17.5 billion³⁰ per year, depending on the variables and methodology used in the cost analysis. It was recommended in the report from the 2010 Senate Inquiry into Suicide in Australia 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,³¹” but this has not yet been undertaken.

- Suicide prevention requires a significant and sustained increase in funding from all levels of government to ensure our preventative efforts are appropriately aligned with the burden of disease.
- The private and philanthropic sectors need to understand the priority of suicide prevention in Australia’s public health agenda. A clear and measureable national suicide prevention strategy would help guide these sectors make informed investment decisions.
- Research funding for suicide prevention must be prioritised. A report by Christensen et al. (2011) established that suicide and self-harm research funding per Disability Adjusted Life Year (DALY) for suicide had not increased between 2001 and 2009, and it received the lowest level of investment than any other mental health category³².
- Workforce planning and capacity building must be addressed to ensure we have a highly skilled workforce that is sustainable and meets demand for suicide prevention activities.
- Improvements to the processes for allocating funding is also required.
 - Funding surety and appropriate timeframes (at least 3 years) would assist with recruitment, expansion and sustainability.
 - Funding under the National Suicide Prevention Program (NSPP) has been rolled over twice without an open and transparent tendering process. An open and transparent tendering process would ensure that innovative suicide prevention approaches are supported alongside established programs.
 - Funding arrangements need to promote collaboration rather than competition which dissuades sharing of knowledge and expertise.
 - Opportunities need to be made available for the piloting of programs with clear pathways for upscaling interventions that

demonstrate effectiveness.

- Evaluation of existing suicide prevention activities should include analysis of the cost-effectiveness of suicide prevention approaches in order to inform future investment decisions.
- We need to set clear, specific and measureable targets for the reduction of suicide attempts and suicide deaths over a predetermined period of time.
 - The NSPS does not include such targets.
 - The COAG Expert Reference Group on mental health reform has proposed a reduction in the national suicide rate by 10 per cent in four years and 50 per cent in ten years³³. The National Mental Health Commission supports this ambitious goal³⁴ as does the National Coalition for Suicide Prevention.

5. EFFECTIVE PLANNING AND COLLABORATION

“Regardless of what tools countries choose to employ, their planning and evaluation should be done collaboratively. Creation of a national planning group allows stakeholders to address their underlying assumptions, identify the resources and inputs needed, and plan the activities that will lead to desired outcomes.” (p. 58, WHO Report)

Our strengths:

- The expertise required to undertake collaborative planning and evaluation is available in Australia.
- Plenty of useful information is already available to inform the planning process. What we need now is to harness the expertise we have available to inform the planning and decision making process.
- The suicide prevention sector has matured and is ready to engage in the planning process.



Where we need to do better:

- A national planning group should be established to undertake collaborative planning and set the strategic direction of suicide prevention for Australia.
 - It is essential that this group be accessible and transparent in decision-making. Previous leadership groups, such as the Australian Suicide Prevention Advisory Council (ASPAC) which worked with the Department of Health to provide national leadership in suicide prevention and policy, have not always met these requirements.
- Lived experience representatives must be included in all processes, recognising the valuable contribution they bring. Work currently being undertaken by Suicide Prevention Australia to develop a Lived Experience Network and guidance on how to include lived experience (see special section on page 10) can inform this process.
- Our approach must be whole-of-government and whole-of-community. We must go beyond rhetoric and develop an actionable strategy that provides clear direction and roles for all levels and portfolios of government, business and industry, research, the community sector, the philanthropic sector, community-based groups and passionate individuals.

6. USE OF EVALUATION FINDINGS AND SHARING LESSONS LEARNED

“The suicide prevention strategy and its components should be evaluated, and the findings and lessons learned should be shared with relevant stakeholders. Evaluation findings are likely to be better used if they are tailored to specific audiences with appropriate recommendations. All those involved in the evaluation should receive feedback and should be supported in implementing change after receiving the evaluation results. Dissemination involves sharing the results and lessons learned from the evaluation with relevant audiences in a timely, unbiased and consistent manner. The reporting strategy should consider the intended users and other stakeholders, and the information provided (e.g. style, tone, format) should be appropriate to the audience.”
(p. 58, WHO Report)

Our strengths:

- The skills and capabilities required to undertake research and evaluation and to translate this into practical information to inform on the ground activities is available within Australia.
- The National Suicide Prevention Conference, convened by Suicide Prevention Australia, is an established forum to facilitate sharing of knowledge among those working and volunteering in suicide prevention. The 2014 conference held in Perth attracted close to 400 delegates from across the country.

Where we need to do better:

- The NSPS is not evaluated for effectiveness and no clear measurable outcomes are captured or monitored. We must invest in evaluation—building workforce capacity, allocating resources for evaluation within funding agreements, and prioritising research that fills gaps in our understanding—so we can learn the most effective ways to support individuals find their own contributing life, a life worth living.
- Evaluation is not routinely built into program design or funding agreements. This is an issue across the spectrum of activities from national services to local community activities.
- Funding contracts (for example under the NSPP) typically require data capture and reporting at a process rather than outcome level. Further, there is limited consistency in what data is captured and used to evaluate suicide prevention activities and no mechanism to ensure consistency between datasets. A best practice standard for data collection is required and must be supported in policy and funding arrangements.
- There is a great deal of expertise available within Australia regarding evaluation and social impact measurement. The suicide prevention sector needs to harness this available expertise.
- There is no independent and central access point or distribution mechanism for best practice information and up-to-date evidence about what works in suicide prevention. This creates unnecessary and frustrating barriers when communities, services, businesses, professionals and individuals try to learn how they can effectively contribute to the prevention of suicide.
- Translating research evidence to practice (while maintaining the rigour that underlies quality evidence) requires particular skills such as communication skills. These skills are not always present in the workforce conducting research or delivering services. Specific investment is required to appropriately resource this task for the suicide prevention sector.
- Technology must be harnessed to disseminate information across Australia and in accessible, culturally appropriate formats.

DETAILED REVIEW OF AUSTRALIA'S PERFORMANCE

DATA (SURVEILLANCE)



Increase quality and timeliness of national data on suicide and suicide attempts. Support the establishment of an integrated data collection system which serves to identify vulnerable groups, individuals and situations.

SUICIDE DEATH DATA

Our strengths:

- Suicide death statistics are collected via the National Coronial Information System (NCIS) and publicly reported through the Australia Bureau of Statistics (ABS) on an annual basis.
- Improvements have been made to data quality. Since 2007, the ABS has invested in a revisions program for coronial data and coding practices have been improved. The NCIS works with jurisdictions to improve the timeliness and completeness of information flowing from the Coronial systems to the NCIS database.
- Comprehensive state-based suicide registries exist in Queensland and Victoria and there are indications from other States/Territories to establish registries. These registries allow for in-depth analysis of pathways to suicide which can inform suicide prevention activities.
- The National Committee for Standardised Reporting of Suicide (NCSRS), a multidisciplinary group convened by Suicide Prevention Australia, is working to improve data quality issues across Australia.
- The National Mental Health Commission has identified the need for data surveillance system improvements as an area of national priority³⁵.

Where we need to do better:

- Expansion of suicide data to shed greater light on vulnerable groups, individuals and situations.
 - Suicide Prevention Australia is progressing the development of a National Minimum Data Set via the NCSRS. This will ensure compatibility of core data items between registries and data sources as well as prompt standardised data capture of items such as LGBTI status, Aboriginal and Torres Strait Islander identity, etc.
- Timeliness and accessibility of suicide death data. Delays limit potential to respond to emerging trends with appropriate interventions. Comprehensive, real time data is required.
 - Under the current system there is a delay of two years before suicide death data is made publicly available.
- Data systems require close and expert monitoring to identify, interpret and correct emerging issues that impact data quality and accurate understanding of suicides.
 - For example, recent system improvements employed in the NSW coronial system appear to show a sudden increase in suicide deaths. Close monitoring is needed to see if this is a data quality issue rather than a change in the actual number of suicides³⁶.
- Legislation reform to improve consistency in suicide data across states and territories
 - See recent paper prepared by Coronial Council of Victoria for details³⁷
- A national standardised police form has been developed to improve identification of emerging areas of concern for suspected suicide deaths. Despite COAG acknowledgement and support of this important project rollout across the states and territories has slowed. Political support is required to continue driving this key initiative forward³⁸.
- Stigma impacts data quality.
- There are no clear targets for improvements in suicide data quality set under the National Suicide Prevention Strategy.
- Suicide Prevention Australia currently receives funding under the NSPP to implement the NCSRS. While SPA is well placed as an independent organisation and sector peak body to convene the NCSRS the level of funding received is inadequate to drive national suicide data improvement. Funding uncertainty associated with the NSPP also casts doubt over future data strategies.

SUICIDE ATTEMPT DATA

Our strengths:

- This is an area in which it is difficult to identify any areas of strength.

Where we need to do better:

- There is currently no national or state/territory based surveillance systems that provide quality and timely data on suicide attempts.
 - Our best estimate of the number of suicide attempts that occur in our

community—approximately 65,000 suicide attempts annually—is taken from the 2007 National Survey of Mental Health and Wellbeing³⁹.

- While some states/territories or regions publish statistics on presentations at emergency department for self-injury, there is limited confidence in quality or consistency in data capture at source.
- The National Mental Health Commission has called for action on improvements to surveillance of suicide attempts⁴⁰.

Cautionary note: As we improve data quality it is not unreasonable to expect that we will see an increase in the rate and number of suicide deaths. Expert interpretation of suicide data that takes into account contextual changes is critical to protect the community from unhelpful and sensational interpretation of statistics.



MEANS RESTRICTION



Reduce the availability, accessibility and attractiveness of the means to suicide (e.g. firearms, high places). Reduce toxicity/lethality of available means.

Our strengths:

- Australia has a history of significant reforms (e.g. firearms legislation) that restricted access to means of suicide and had a significant and protective impact on suicide rates.
- Research expertise in the area of means restriction and the identification of 'suicide hotspots'⁴¹.
- Experience in implementation of multidisciplinary intervention at a suicide hotspot via the Gap Park Self-Harm Minimisation Masterplan project⁴².

Where we need to do better:

- Ongoing monitoring of emerging trends in suicide method, supported by timely availability of suicide death and suicide attempt data, so rapid action can be taken to restrict access to means wherever possible.
 - A number of submissions to the Senate Inquiry into Suicide in Australia identified areas where regulatory controls could be implemented to limit access to certain means of suicide⁴³. These recommendations have not been addressed.
- Restriction of access to means of suicide must be coordinated and consistently implemented across local government authorities and by all those with responsibility for infrastructure development. Requisite funding and training and education programs are required to support this.
- Community education is needed to build understanding of suicide prevention and to improve acceptance of means restriction activities such as barriers on bridges.
- Replicate successes found in existing project work in other identified hotspots.

MEDIA



Promote implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media.

Our strengths:

- Improvements in the quality and quantity of media reporting of suicide through the implementation of a national media initiative and complementary guidelines.
- Evidence-informed resources to guide conversations about suicide.
- Australia is a leader in the research and use of mental health platforms with social media tools such as forums offering mental health interventions.
- Collaborative relationships established between social media providers and suicide prevention organisations or research bodies
- Emerging agreement between national suicide prevention and mental health organisations about key suicide prevention messages to be delivered through media and social media via the Communications Charter prepared by the National Mental Health Commission.

- Organisations within the National Coalition for Suicide Prevention as well as other national and state/territory bodies have been engaged in the development and distribution of shared messaging for World Suicide Prevention Day in 2013 and 2014.

Where we need to do better:

- There is an extensive amount of unhelpful information available on the internet and distributed via social media. We need to remain vigilant and look at how we measure and evaluate success of social media programs.
- Further research is necessary to understand the role of bullying, both online and offline, as a risk factor for suicide.
- Robust and sustainable evaluation needed.

TRAINING AND EDUCATION



Maintain comprehensive training programs for identified gatekeepers (e.g. health workers, educators, police). Improve the competencies of mental health and primary care providers in the recognition and treatment of vulnerable persons.

Our strengths:

- Comprehensive workplace gatekeeper programs supported by clear pathways to care exist in some industries.
- Increasing support and training is being provided to employers to assist them to meet their obligations in mental health via organisations and businesses.
- There are a wide range of local training providers who deliver suicide intervention training.

Where we need to do better:

- A quality standard for suicide prevention training programs is required to assist individuals and organisations make an informed choice between training service providers.
- Strategically target gatekeepers in the community and provide them with training and support.
- There is no national minimum competency level required for health workers (e.g. general practitioners, emergency department nurses), mental health workers (e.g. psychologists, psychiatrists, mental health nurses) or other occupational groups that interact with groups known to be vulnerable to suicidal behaviours (e.g. social workers, youth workers, high school teachers, police, ambulance, prison officers, Centrelink workers).

- Training and education need to be built into pre-service training and education programs (i.e. taught during university or TAFE study) rather than waiting for on-the-job training.

ACCESS TO SERVICES



Promote increased access to comprehensive services for those vulnerable to suicidal behaviours. Remove barriers to care.

Our strengths:

- Specific youth and school-based support programs are implemented across Australia.
- Some Government departments outside of Health Programs have implemented pathways to care for vulnerable groups (for example, Defence Force personnel and veterans and their families).
- Expertise in both developing and researching mental health and wellbeing programs.

Where we need to do better:

- Many vulnerable groups experience significant barriers to care including a lack of culturally safe and effective services, exacerbating their risk of suicidal behaviour. This includes:
 - Aboriginal and Torres Strait Islanders
 - Men
 - Older Australians
 - LGBTI population
 - Rural and remote population
 - Culturally and linguistically diverse populations
- Where programs are in place to support vulnerable groups, for example national mental health promotion programs for secondary schools (MindMatters), evaluation is required to assess the effectiveness and efficiency.
- Prevention efforts need to extend beyond the health system. Access to services that assist individuals navigate life stressors such as financial hardship,

relationship breakdown, child custody issues and unemployment are required.

- Remove barriers to accessing primary care (including the proposed General Practitioner co-payment) which hit the vulnerable members of our community the hardest.
- The stigma associated with suicidal behaviour and mental illness inhibit help-seeking behaviour. We must educate the community about the preventability of suicide. Stories from those with lived experience of suicide that emphasise hope and recovery play a key role in breaking down stigma.
- Policies around immigration detention need urgent attention. Refugees and asylum seekers are often highly vulnerable to suicidal behaviour, having experienced trauma and had their social support networks disabled. There is clear evidence that detention in closed environments for longer than six months has a significant, negative impact on mental health⁴⁴.



TREATMENT



Improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt. Improve research and evaluation of effective interventions.

Our strengths:

- Specialist centres such as the Life Promotion Clinic at the Australian Institute for Suicide Research and Prevention, Griffith University⁴⁵, or the Green Card Clinic at St Vincent's Hospital, Sydney⁴⁶, offer specialised treatment for suicidal behaviour while generating research evidence to continuously improve clinical treatments.

Where we need to do better:

- Tragically, the level of care an individual receives when experiencing a suicidal crisis comes down to chance. This is not good enough.
 - There is a lack of consistency in risk assessment processes in our health care settings. Indeed, some practices can be harmful.
 - Suicide 'safe houses' (or alternative care accommodation) that offer stepped care models for those in suicidal crisis should be available in every capital city and regional centre.
 - Mental health services, including step up and step down care, need to be available and accessible in the community to reduce incidences of suicidality and also to provide appropriate sites of crisis care for people who become suicidal. The coordination and interagency collaboration of mainstream, mental and allied health services are essential for the provision of effective and accessible care.
 - We need more mental health professionals, GPs and first responders to have specialist skills in managing suicidal crisis.
 - There is limited evidence on the types of interventions that work in suicide prevention. We need increased and sustained investment in research to identify what works in suicide prevention.
- Services delivering frontline suicide interventions on the ground require funding continuity to retain trained staff and guarantee service availability.
 - The future of the Access to Allied Psychological Services (ATAPS) Suicide Prevention Program is uncertain. This program was found to deliver positive consumer outcomes⁴⁷.
 - Current uncertainty associated with the Government's planned changes to Medicare Locals (which currently deliver the ATAPS program) and establishment of Primary Healthcare Networks mean that the provision of these services after 30 June 2015 is unknown.
 - Staff in emergency departments require training in suicide prevention to reduce stigma and help foster supportive care for those in suicidal crisis.
 - Services must provide culturally safe and respectful practice to all clients. Education and training, supported by robust policies, are required to ensure staff do not discriminate against any client on the basis of past suicidal behaviour, mental illness, race, sexual or gender identity, Aboriginal and Torres Strait Islander status or any other characteristic.

CRISIS INTERVENTION



Ensure that communities have the capacity to respond to crises with appropriate interventions and that individuals in a crisis situation have access to emergency mental health care, including through telephone helplines or the internet.

Our strengths:

- Established crisis support services that provide free support via telephone or internet to individuals in crisis situations.
- Early adoption of emerging technology, enabling services to be provided to geographically isolated communities.
- Partial integration of telephone helplines with national treatment initiatives (ATAPS Suicide Prevention Program).

Where we need to do better:

- There is no specific policy or program recognition of the place of crisis lines and crisis support services in the Australian national suicide prevention strategy: These crisis support services must be acknowledged as essential, core suicide prevention infrastructure and funded at levels and with the continuity that will allow them to meet demand for services.
- The evaluation of crisis intervention services should incorporate the effectiveness of pathways that link crisis intervention with other treatment strategies determined.
- Currently no national protocols, or state/territory arrangements, exist to establish linkages between crisis lines and crisis support services with the mainstream hospital and health services, and with mental health professional services. This severely limits the opportunities for crisis support services to operate collaboratively with other services, and create effective pathways for suicidal persons and their carers. These protocols must be established to ensure individuals in crisis receive seamless, quality support.
- The establishment of personal support services in emergency departments and hospitals and during transitions between care should be considered. These services would work alongside mental health and medical care, ensuring suicidal patients receive emotional support and are not left alone. Established crisis services are well positioned to administer this type of service.
- Broaden the scope of telephone crisis support services to provide meaningful ongoing support to those unable or unwilling to access other services.
- Develop service responses that better address the needs of those members of the community who frequently and solely rely on crisis services.
- Technology-based crisis support services (including telephone helplines, online chat services and mobile app resources) need

to be recognised as key components of the national E-Mental Health Strategy and related funded programs, reflecting their status as essential help-seeking channels for individuals in crisis.

- Emergency services such as Triple Zero operators, police, ambulance and emergency departments should be recognised as service providers in suicide prevention on the basis of their involvement in interventions to uphold personal safety, and should accordingly operate within national protocols to define the intersection of emergency services and other suicide crisis support services.
- As they are exposed to high risk, stressful and challenging situations, first responders need to be trained and supported to manage their own needs as well as the needs of those they respond to.



POSTVENTION



Improve response to and caring for those affected by suicide and suicide attempts. Provide supportive and rehabilitative services to persons affected by suicide attempts.

Postvention includes both support after a suicide attempt for the individual and their family and friends, as well as bereavement support for those who have lost a loved one by suicide.

BEREAVEMENT SUPPORT

Our strengths:

- Australia is leading the way globally with suicide bereavement services that not only provide tailored support for individuals but are evidence-generating.
- There is emerging evidence that bereavement support is not only cost effective but reduces suicide risk in the long-term⁴⁸.
- Suicide bereavement support groups are available in many communities across Australia

Where we need to do better:

- There is no reliable and valid measure of the number of individuals exposed to or bereaved by suicide in Australia: This data is simply not collected. Given the existing research evidence suggests that those bereaved by suicide are at elevated risk of suicidal behaviour, the collection of national data on exposure to suicide is a priority.
- Suicide bereavement support is a relatively new area of suicide prevention and requires investment in research to determine the best way to target effective interventions to those at risk.

SUPPORT AFTER SUICIDE ATTEMPT

Our strengths:

- Growing voice of lived experience is shedding greater light on the needs of those impacted by suicide attempt including the individual and those providing support. (See box pg. 10)
- Localised examples of effective and evidence-based programs that provide care, contact and referral pathways post-discharge from hospital after suicide attempt demonstrate that risk of future suicidal behaviour can be reduced via simple⁴⁹ or complex interventions⁵⁰.
- Momentum within the suicide prevention sector to better support the needs of those post-suicide attempt.

Where we need to do better:

- Follow up care after discharge from hospital is relatively rare. This must be improved. Models to coordinate care post-discharge must be developed and evaluated.
- Suicide 'safe houses' (or alternative care accommodation) that offer stepped care models for those in suicidal crisis should be available in every capital city and regional centre.
- We must listen to the stories and recommendations of those who have lived through suicide attempt. Those with lived experience have a vital role to play in developing responses that compassionately and effectively help those in suicidal crisis find a life worth living.

"If someone has attempted suicide, we know there is a big risk factor for another suicide attempt and the first three months are critical in their recovery. More than half of people who have tried to kill themselves leave hospital and don't get any support or follow-up treatment and, disturbingly, between 15 and 25 per cent will attempt suicide again." Mr Jeff Kennett

AWARENESS AND STIGMA REDUCTION



Establish public information campaigns to support the understanding that suicides are preventable. Increase public and professional access to information about all aspects of preventing suicidal behaviour. Promote use of mental health services, and services for the prevention of substance abuse and suicide. Reduce discrimination against people using these services.

“Awareness campaigns aim to reduce the stigma related to mental disorders and help-seeking for suicide, and to increase access to care. There is little evidence linking awareness campaigns to a reduction in suicide, but they have had a positive impact on community attitudes, thus increasing the opportunity for public dialogue on these issues.”
(p. 35, WHO Report)

Our strengths:

- Australia has expertise in health promotion and social marketing campaigns as demonstrated campaigns such as anti-smoking, HIV/AIDS and road trauma.
- Significant improvements have been made in community awareness of and attitudes towards depression as a result of government investment.
- Community has accepted and engages with campaigns that promote conversations and social connections.
- Targeted awareness building activities for some vulnerable groups have been implemented (e.g. LGBTI, veterans, ex-serving personnel and their families).

Where we need to do better:

- There is a general lack of community awareness that suicide is preventable. Many individuals (health professionals included) assume suicide to be (only) a medical problem; more often than not, a response to mental illness. This association obviously and detrimentally ignores the social determinants of suicide.
 - We need to build community understanding of the preventability of suicide and awareness of appropriate support in times of suicidal crisis.
 - Targeted awareness campaigns are required to educate professionals who are likely to come into contact with individuals during suicidal crisis.



APPENDIX A: NATIONAL COALITION FOR SUICIDE PREVENTION MEMBERS

Current members of the National Coalition for Suicide Prevention are: (listed in alphabetical order)

ARAFMI

Australian Women's Health Network

beyondblue

Black Dog Institute

Community Mental Health Australia

Curtin University

Headspace

Hunter Institute of Mental Health

Lifeline Australia

Mates in Construction

Mental Health Australia

Mental Illness Fellowship of Australia

Mental Health First Aid

Mental Health in Multicultural Australia

National LGBTI Health Alliance

On the Line

Orygen Youth Health

OzHelp Foundation

Relationships Australia

R U OK? Day Foundation

ReachOut.com by Inspire Foundation

SANE Australia

SuperFriend

The Butterfly Foundation

Suicide Prevention Australia

United Synergies (National StandBy Response Service)

Wesley LifeForce

Young and Well Cooperative Research Centre

The National Mental Health Commission and NSW Mental Health Commission also kindly offer their support in principle to the National Coalition for Suicide Prevention.

Ref: <http://suicidepreventionaust.org/project/national-coalition-for-suicide-prevention/>

APPENDIX B: TERMINOLOGY

This paper assumes WHO Report terminology as set out below and on page 15 of the Report. Where Australian terminology is used beyond this list, it is defined within or references an appropriate definition.

"It is important to acknowledge that during the process of putting together this report, much discussion took place with regard to definitions, with ultimate agreement on the terms below. This by no means negates the ongoing evolution of terms in this field and the use of different terms for very good reasons elsewhere in this sector. It is beyond the scope of this report to resolve issues of terminology and definitions of suicidal behaviour conclusively.

For the purpose of this report, suicide is the act of deliberately killing oneself.

For the purpose of this report, suicide attempt is used to mean any non-fatal suicidal behaviour and refers to intentional self-inflicted poisoning, injury or self-harm which may or may not have a fatal intent or outcome.

It is important to acknowledge the implications and complexities of including self-harm in the definition of "suicide attempt". This means that non-fatal self-harm without suicidal intent is included under this term, which is problematic due to the possible variations in related interventions. However, suicide intent can be difficult to assess as it may be surrounded by ambivalence or even concealment.

In addition, cases of deaths as a result of self-harm without suicidal intent, or suicide attempts with initial suicidal intent where a person no longer wishes to die but has become terminal, may be included in data on suicide deaths.

Distinguishing between the two is difficult, so it is not possible to ascertain what proportions of cases are attributable to self-harm with or without suicidal intent.

Suicidal behaviour refers to a range of behaviours that include thinking about suicide (or ideation), planning for suicide, attempting suicide and suicide itself. The inclusion of ideation in suicidal behaviour is a complex issue about which there is meaningful ongoing academic dialogue. The decision to include ideation in suicidal

behaviour was made for the purpose of simplicity since the diversity of research sources included in this report are not consistent in their positions on ideation."

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³The WHO Report, Annex 1, p. 80

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- ³⁸Response of the Council of Australian Governments to "A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention" - a report by the National Mental Health Commission <http://www.mentalhealthcommission.gov.au/media/95942/COAG%20Response%20to%20Report%20Card.pdf>
- ³⁹Dept of Health, The Mental health of Australians 2: report on the 2007 national survey of mental health and wellbeing, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-haust2> (accessed 25 Aug 2014)
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- ⁴⁷<http://www.health.gov.au/internet/publications/publishing.nsf/Content/suicide-prevention-activities-evaluation~positioning-the-nssp-ataps>
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- ⁴⁹For example, Carter GL, Clover K, Whyte IM, Dawson AH, D'Este C. (2013). Postcards from the EDge: 5-year outcomes of a randomised controlled trial for hospital-treated self-poisoning. British Journal Psychiatry, 202, pp. 372-380.
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APPENDIX C: CURRENT SUICIDE PREVENTION STRATEGY IN AUSTRALIA

The current National Suicide Prevention Strategy (NSPS) is described by the Department of Health, the custodian of the NSPS, as providing “the platform for Australia’s national policy on suicide prevention with an emphasis on promotion, prevention and early intervention”¹⁰.

The main objectives of the NSPS are to¹¹:

- Build individual resilience and the capacity for self help
- Improve community strength, resilience and capacity in suicide prevention
- Provide targeted suicide prevention activities
- Implement standards and quality in suicide prevention
- Take a coordinated approach to suicide prevention
- Improve the evidence base and understanding of suicide prevention

The National Suicide Prevention Strategy has four key inter-related components:

1. *Living Is For Everyone (LIFE) Framework* which sets an overarching evidence based strategic policy framework for suicide prevention in Australia. Published in 2007, the main objectives of the NSPS align with the six action areas of the LIFE Framework, guides Australia’s National Suicide Prevention Strategy (NSPS) and sets out priority target audiences, settings and interventions.
2. *National Suicide Prevention Strategy Action Framework developed* by Australian Suicide Prevention Advisory Council (ASPAC) in collaboration with the (formerly named) Department of Health and Ageing. The action framework provides a work plan to provide national leadership in suicide prevention and policy. The last published action framework focused on the period 2009-10 to 2010-11¹².
3. *National Suicide Prevention Program (NSPP)*, representing the Australian Government funding program dedicated to suicide prevention activities. There are currently 49 projects funded under the NSPP.
4. *Mechanisms to promote alignment with and enhance state and territory suicide prevention activities*. These mechanisms particularly progress the relevant actions of related national frameworks, such as the Fourth National Mental Health Plan 2009-14¹³.

In addition to the NSPS, Australia’s first *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*¹⁴ was released in May 2013. The strategy highlights the importance of cultural continuity as protective against suicide risk and emphasizes Aboriginal and Torres Strait Islander peoples’ holistic view of mental health, physical, cultural and spiritual health and focuses on ‘upstream’ prevention efforts that build community, family and individual resilience. The strategy includes six action areas that are aligned with the six action areas under the LIFE Framework.

In response to recommendations made by the Senate *The Commonwealth Response to The Hidden Toll: Suicide in Australia* was tabled on 24 November 2010 and included details of the Taking Action to Tackle Suicide (TATS) package. The TATS package provides further support for suicide prevention through universal and population-wide approaches and through community led responses. The TATS package was comprised of the following four areas:

1. More frontline services and support for those at greatest risk of suicide:
 - More community-based psychology services (through expansion of ATAPS Suicide Prevention Program)
2. More services to prevent suicide and boost crisis intervention services: Boost capacity of crisis lines:
 - Mental Health First Aid training for frontline community workers
 - Infrastructure for suicide hotspots
 - Community prevention activities for high-risk groups (including Aboriginal and Torres Strait Islander people; men; lesbian, gay, bisexual, transgender and intersex (LGBTI) people; and families bereaved by suicide)
 - Outreach teams to schools through the headspace School Support program
3. Target men who are at greatest risk of suicide:

Expansion of the National Workplace Program delivered by *beyondblue*

 - Increased helpline capacity
 - Targeted campaigns on depression and reducing stigma
4. Programs to promote good mental health and resilience in young people:
 - Expansion of the KidsMatter primary school program
 - Additional services for at-risk children through the ATAPS child mental health service
 - Online mental health and counselling services.

A recent evaluation report, commissioned by the Department of Health and Ageing and prepared by Australian Healthcare Associates (AHA), looked at activities funded under the NSPP and selected elements of the TATS package over the seven-year period from 2006-07 to 2012-13. Within this report a range of other key national initiatives that impact suicide prevention were identified and are presented in the box below.

Taken from *Evaluation of suicide prevention activities: Final report January 2014* prepared by AHA, Table 11-1: Selected key national initiatives

- NSPP and TATS-funded projects
- MindMatters and KidsMatter
- Aboriginal and Torres Strait Islander Suicide Prevention activity
- Development of the Aboriginal and Torres Strait Islander Suicide Prevention Strategy
- Renewal of the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing (in development)
- Research bodies and related funding, including the Black Dog Institute, the Australian Institute for Suicide Research and Prevention, the Hunter Institute for Mental Health and *beyondblue's* research program
- Acute, sub-acute and community mental health services
- ATAPS, the Better Access initiative, and other programs offered through Medicare Locals
- Initiatives under the National Drug Strategy
- Aged care programs
- Initiatives under A Stronger, Fairer Australia – Australia's social inclusion policy, including a range of strategies that address unemployment, homelessness, disability and other key forms of disadvantage, all of which are risk factors for suicide
- Initiatives run by headspace – Australia's National Youth Mental Health Foundation – including headspace centres, headspace school support and headspace online counselling
- *beyondblue* services
- Helplines, including Lifeline, Kids Helpline and MensLine Australia
- Initiatives that support GPs (and other primary care health professionals) including GP Psych Support, Primary Mental Health Care, the Royal Australian College of General Practitioners (RACGP) mental health page and Suicide Questions, Answers and Resources (SQUARE)
- Online counselling and self-help services, such as the MoodGYM program established by the Centre for Mental Health Research at Australian National University
- Programs delivered through the Department of Veterans Affairs, such as Operation Life
- Aboriginal and Torres Strait Islander initiatives and mental health programs delivered through Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), such as Personal Helpers and Mentors Services (PHaMS)

Suicide prevention strategies have also been developed at the state/territory level. More recent versions of these strategies have aligned with the six action areas of the LIFE Framework.

Funding

At the current time, funding for projects covered by the NSPS ends effective 30 June 2015.

Funding, amounting to \$292.4 million for the period 2011-12 to 2015-16, for projects under the TATS package ends effective 30 June 2016.

Despite the Australian Government investing \$127.1M in the NSPS between 2006–2012¹⁵, concerns have been raised that this has been ineffective in preventing suicide^{16,17}.

Determining future investment

On 4 February 2014, the terms of reference for the Mental Health Review, to be conducted by the NMHC, were announced by the Minister for Health¹⁸. This review will examine existing mental health services and programs across the government, private and non-government sectors. Programs and services which focus on suicide prevention are to be included in the review. The NMHC is due to report on the review by the end of November 2014.

It is expected that decisions about future government investment in suicide prevention activities, programs and services will be made after the review has been completed.



LISTED BELOW IS A SUMMARY OF KEY CRISIS SUPPORT SERVICES AVAILABLE ACROSS AUSTRALIA.

Service	Who?	Telephone counselling	Online crisis counselling	Other details
Lifeline Phone: 13 11 14 www.lifeline.org.au	Anyone experiencing a personal crisis or thinking about suicide	Available 24/7	Available at set times - see website for details	
Suicide Call Back Service Phone: 1300 659 467 www.suicidecallbackservice.org.au	Anyone aged 15+ yrs who is suicidal, caring for someone who is suicidal, bereaved by suicide, or a health professional supporting a suicidal individual	Available 24/7	Available at set times - see website for details	Access up to 6 x 1 hr telephone counselling sessions
Kids Helpline Phone: 1800 55 1800 www.kidshelp.com.au	Young people aged 5-25 yrs	Available 24/7	Web and email counselling	
MensLine Australia Phone: 1300 78 99 78 www.menslineaus.org.au	Men, all ages	Available 24/7	Online and video counselling at set times - see website for details	Access up to 6 x 1 hr telephone counselling sessions. Services also available in Arabic

IF LIFE IS IN DANGER CALL 000.