# 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

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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

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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

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

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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

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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

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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

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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

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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

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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.

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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.**