CHAPTER 8

THE NATIONAL SUICIDE PREVENTION STRATEGY

Introduction

8.1 This chapter will address term of reference (h) the effectiveness of the National Suicide Prevention Strategy (NSPS) in achieving its aims and objectives, and any barriers to its progress.

National Suicide Prevention Strategy

8.2 The current NSPS is a program under the COAG National Action Plan for Mental Health 2006-11. The 2006-07 Federal Budget committed the Commonwealth funding which included $62.4 million to expand the NSPP to $127.1 million between 2006-07 and 2011-12.[1] The five year goal of the NSPS is to reduce deaths by suicide across the population and among at risk groups and to reduce suicidal behaviour by:

> Adopting a whole of community approach to suicide prevention to extend and enhance public understanding of suicide and its causes;
>
> Enhancing resilience, resourcefulness and social connectedness in people, families and communities to protect against the risk factors for suicide; and
>
> Increasing support available to people, families and communities affected by suicide or suicidal behaviour.[2]

8.3 DoHA described the current NSPS as having four inter-related components. The first is the LIFE Framework which 'provides national policy for action based on the best available evidence to guide activities aimed at reducing the rate at which people take their own lives'.[3] The second was the National Suicide Prevention Strategy Action Framework which provides a time limited workplan for taking forward suicide prevention and investment. The Action Framework was developed in collaboration with ASPAC and '…will effectively steer the NSPS and NSPP' until 2011. The third, the National Suicide Prevention Program (NSPP), is the Commonwealth funding program for suicide prevention activities which is administered by DoHA. The final component was mechanisms to promote alignment with and enhance state and territory suicide prevention activities, particularly to progress the relevant actions of related national frameworks, such as the COAG

---

1 DoHA, *Submission 202*, p. 27.

2 DoHA, *Submission 202*, p. 25.

3 DoHA, *Living is For Everyone (LIFE): A Framework for Prevention of Suicide in Australia*, 2007, p. 6.

National Action Plan for Mental Health 2006-2011 and the Fourth National Mental Health Plan 2009-14.[4]

Suicide prevention in Australia

Department of Health and Ageing

8.4 DoHA has primary responsibility for suicide prevention at the Commonwealth level but outlined the broad range of services and programs (usually in the area of mental health) which assist those at risk of suicide. They stated:

> Mental health services and programs, broader health initiatives such as indigenous health programs, and drug and alcohol support also comprise an important platform from which DOHA administered programs contribute to efforts to prevent suicide and support people at risk of suicidal behaviour. Other Government portfolios similarly administer a broad range of mainstream programs which contribute to supporting individuals at risk and protecting against factors which may be associated with suicidality.[5]

8.5 In the area of mental health services DoHA highlighted a recent review which indicated expenditure had increased to $1.9 billion in 2007-08. They noted that while only 1 per cent of funding is 'directly contributed to the NSPS, a large amount of funds are provided for programs and services which support suicide prevention efforts'.[6] These included mental health services under the MBS and programs such as ATAPS, training for mental health professionals, mental health promotion (including the National Depression Initiative), mental health programs funded for groups at high risk of suicide (such as indigenous specific mental health programs), early intervention programs (such as headspace) as well as programs for parents (perinatal Depression Initiative) and children (KidsMatter Early Childhood).[7] They also highlighted a range of supported telephone and web based crisis support and self help therapies. The investment in the National Drug and Alcohol Strategy was also highlighted as 'extremely relevant to suicide prevention efforts'.

> Broader investment in Indigenous health programs, including social and emotional wellbeing activities also contributes to suicide prevention efforts targeting Aboriginal people and Torres Strait Islanders.[8]

4 DoHA, *Submission 202*, p. 24.

5 DoHA, *Submission 202*, p. 21.

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

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

8 DoHA, *Submission 202*, p. 23.

Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA)

8.6 The FaHCSIA submission also outlined a range of programs that, while not specifically focused on suicide prevention, also contribute collaterally to the prevention of suicide through promoting resilience and protective factors. They stated:

> FaHCSIA programs play a crucial role in providing early intervention services for individuals and families from high risk vulnerable groups. Many FaHCSIA programs aim to build individual and community resilience, which is core to suicide prevention. Programs also provide services that can ultimately reduce suicide risk and increase protective factors. Research suggests that being part of a cohesive and supportive family unit is an important protective factor for children and young people, helping them to better cope with any stressors or adversity they may encounter.[9]

8.7 In particular FaHCSIA funds Mensline Australia delivered by Crisis Support Services, an initiative which offers a range of services and programs to support men in managing family and relationship difficulties.[10]

Department of Veteran's Affairs (DVA)

8.8 DVA provides training for the peer support of veterans at risk of suicide through Operation Life offering ASIST to veterans or support provided through Family Relationship Centres to help families manage and resolve conflict.[11]

8.9 As part of an election commitment the Commonwealth Government committed to conducting a study that examines the broad issue of suicide in the ex-service community, including a number of specific cases of suicide over the last three years. The Suicide Study report conducted by Professor David Dunt, together with the Government's response, was publicly released on 4 May 2009. The recommendations cover a wide range of matters, including strengthening mental health programs, including suicide prevention, the use of experienced case coordinators for complex cases, and ensuring that administrative processes are more 'user-friendly'.

8.10 The Government allocated $9.5 million over four years to implement the recommendations in order to strengthen and improve the range of mental health services provided, particularly in relation to suicide prevention, to support the veteran community.[12]

---

9 FaHCSIA, *Submission 211*, p. 5.

10 FaHCSIA, *Submission 211*, p. 14.

11 DoHA, *Submission 202*, p. 20.

12 DVA, *Submission 215*, p. 2.

8.11 DVA outlined a number of suicide prevention and mental health projects directed to the veteran community. These included Operation *Life*, a framework for action to prevent suicide and promote mental health and resilience across the veteran community. A major part of this framework included suicide prevention workshops as well as the provision of information on treatment services that are available to the veteran community. Also mentioned was the Veterans and Veterans Families Counselling Service (VVCS), a specialised national service that provides counselling and support to Australian veteran, peacekeepers, their families and eligible Australian Defence Force personnel.[13]

Other

8.12 Other areas noted included the role of the Department of Education, Employment and Workplace Relations (DEEWR) which administers a range of services to assist people with mental illness and those at risk of suicide. Another example was that Centrelink social workers referred 3,463 persons 'as a result of being at risk of suicide' and 30,650 more broadly with 'mental health issues'.[14]

States and Territories

8.13 The State and Territory governments have a range of suicide prevention strategies and programs.

8.14 The Queensland Government stated that it planned to finalise the *Queensland Government Suicide Prevention Action Plan* in 2010 following the previous strategies *Reducing Suicide: the Queensland Government Suicide Prevention Strategy 2003-2008* (QGSPS) and *Queensland Government Youth Suicide Prevention Strategy 1998-2003*. It noted that over the past 12 years the Queensland Government has allocated an annual budget of $2 million directly to cross-government suicide prevention initiatives.[15]

8.15 The NSW Government stated that it is in the process of developing a new NSW whole-of-government 5-year suicide prevention strategy which will follow on from the 1999 NSW Suicide Prevention Strategy: *we can make a difference*.[16]

8.16 The WA Ministerial Council for Suicide Prevention is an advisory body to the WA Minister for Mental Health. The Council has been given a mandate to oversee the implementation of the *WA State Suicide Prevention Strategy 2009-2013* which has been committed $15 million over four years.[17]

---

13 DVA, *Submission 215*, p. 3.

14 DoHA, *Submission 202*, pp 20-21.

15 Queensland Government, *Submission 205*, p. 1.

16 NSW Government, *Submission 136*, p. 3.

17 WA Ministerial Council for Suicide Prevention, *Submission 70*, p. 1.

8.17 The SA Government noted that SA Health is developing a statewide suicide strategy '…that will focus on social justice, coordination, collaboration, partnerships and building on existing programs'.[18] The strategy will be released in late 2010.[19] The SA Government also outlined recent funding for several suicide prevention and support programs including to Beyondblue, SQUARE, Mental Health First Aid (delivered by Relationships Australia SA) and to Centacare Suicide Prevention Program ASCEND.[20]

8.18 The Victorian *Mental Health Reform Strategy 2000-2019 Because mental health matters* states a goal of the strategy is to:

> Renew our suicide prevention plan, *Next Steps: Victoria's suicide prevention action plan*, using the new national framework to strengthen our ability to identify and respond to risk factors and emerging trends in suicide behaviour and suicide prevention.[21]

8.19 In October 2009, the Tasmanian Government released *Building the Foundations for Mental Health and Wellbeing, a Strategic Framework and Action Plan for Implementing Promotion, Prevention and Early Intervention (PPEI) Approaches in Tasmania* (the Framework). A priority under the framework was the development of a Suicide Prevention Strategy for Tasmania. This has been commissioned and is due for completion in June 2010.[22]

8.20 The NT Government noted that the *NT Strategic Framework for Suicide Prevention* commenced in 2003. A NT Suicide Prevention Action Plan 2009 -2011 was launched in March 2009. The Plan provides a whole of Government response to guide directions in suicide prevention over the next three years. New funding of $330 000 has been allocated by the Department of Health and Families from January 2009 to June 2010 to progress a range of new initiatives including '…increased training programs in suicide prevention and self injury and the development of suicide and bereavement support resources'.[23]

8.21 The ACT Government indicated it had recently launched a new suicide prevention strategy *Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009-2014* which '…was strongly aligned to the LIFE Framework'.[24]

---

18 SA Government, *Submission 208*, p. 6.

19 Dr Anthony Sherbon, Department of Health (SA), *Proof Committee Hansard*, 4 May 2010, p. 79.

20 SA Government, *Submission 208*, p. 8.

21 Department of Human Services (Victoria), *Victorian Mental health Strategy 2009-2019: Because mental health matters*, 2009, p. 13

22 Tasmanian Government, *Submission 244*, p. 4.

23 NT Government, *Submission 32*, p. 8.

24 ACT Government, *Submission 44*, p. 1.

Coordination and collaboration.

8.22 A criticism of the NSPS was that it had resulted in fragmented services for those at risk of suicide. The Suicide is Preventable submission argued that 'roles, responsibilities and accountabilities are poorly defined…there is no agency at a national or state/territory level with the mandate to address suicide and suicide prevention'.[25]

8.23 The Suicide is Preventable submission listed how responsibility for suicide was distributed:

- Mortality data collection – this is distributed across an array of organisations.
- Morbidity data – the AIHW and the Injury Surveillance Unit at Flinders University.
- Funding for program initiatives – a person or small group of public servants within health departments in the Commonwealth Government and in some State and Territory governments. These staff are generally located within the Mental Health Branches. They generally provide small scale grants and the few national initiatives receive little funding.
- Research – some health departments program occasional grants for 'research'. Other funds are provided on a competitive basis from the usual national funding sources. Annual funding would be less than $10m, on the available evidence.
- Services – crisis lines, support services, prevention, intervention and bereavement activities are carried out by a range of non-government organisations (NGOs) – many are parties to or supporters of this Submission.
- Advocacy – SPA
- Self-help groups and other support groups – small networks of community groups. [26]

8.24 Similarly, Lifeline Australia stated that despite the significant achievements of the NSPS, the 'execution of the strategy has often been fragmented and lacks a clear vision for how all levels of government, community stakeholders and consumers can work together in a co-ordinated way to think strategically, plan effectively and achieve good outcomes'. Lifeline Australia recommended the vertical integration of the NSPS by engaging all levels of government in strategic development and

25 Suicide is Preventable, *Submission 65*, p. 12.

26 Suicide is Preventable, *Submission 65*, p. 12.

implementation. It also noted the limited processes or structures for developing systematic, cross sector collaboration. They stated:

> While entities like Suicide Prevention Australia do provide forums for sharing of ideas, programs and research, more substantial collaborative structures and mechanisms are needed to work with governments, stakeholders, communities and consumers around planning, developing and implementing suicide prevention strategy.[27]

8.25 Professor John Mendoza also highlighted problems with service coordination between the programs funded by Commonwealth and the States and Territories. He stated:

> We have ridiculous overlaps and duplications of service, and then we have massive gaps. As one consumer that I work with regularly describes it, it is a lucky dip out there if you can get any access to mental health services. It is a really lucky dip if you get access to quality mental health services, ones that actually are effective. In this area, in relation to people experiencing suicide ideation and suicidal behaviour, it is even a greater lucky dip to actually score the sort of service that is going to work.[28]

8.26 Professor Graham Martin highlighted that there was the risk suicide prevention activities could be subsumed into the mental health agenda and '…lost as an issue'. He also commented on Commonwealth-State service provision coordination:

> Several programs in Far North Queensland were funded by the Commonwealth but nobody at the state level seemed to know much about them—what they were doing or how they were working. So there was then duplication, or attempts at duplication.[29]

8.27 DoHA noted that alignment between Commonwealth, State and Territory suicide prevention activities, coordinating investment and activities, was being progressed through the *Fourth National Mental Health Plan*.[30] This includes action to:

> Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them.[31]

8.28 DoHA stated that '…effort has gone into jointly planning Australian Government suicide prevention investment with states and territories, particularly

---

27 Lifeline Australia, *Submission 129*, p. 67.

28 Professor, John Mendoza, *Committee Hansard*, 1 March 2010, p. 103.

29 Professor Graham Martin, *Committee Hansard*, 2 March 2010, p. 81.

30 Ms Georgie Harman, DoHA, *Committee Hansard*, 1 March 2010, p. 65.

31 DOHA, *Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009–2014*, 2009, p. 36

under the COAG National Action Plan for Mental Health 2006-11 and work has begun towards a single national suicide prevention framework'.[32] However they acknowledged that efforts to align '…suicide prevention activity across the Commonwealth and with state and territory government investment in suicide prevention will continue to be both a priority and a challenge'.[33]

Governance and accountability

8.29 The Suicide is Preventable submission argued that the NSPS was not actually a 'national strategy'. They commented:

> It is not a national strategy in the way that other national strategies are formal agreements signed by all Australian governments and, in some cases, by community or industry stakeholders. The current strategy, which carries that name, is the strategy of the Commonwealth Department of Health and Ageing.[34]

8.30 Similarly the Suicide Prevention Taskforce argued the LIFE Framework had served as a proxy for the NSPS. They said:

> The NSPS is not a national policy or strategy endorsed by all governments through COAG. It has never been endorsed by the Australian Health Ministers' Conference or other inter-government forum. Nor is it a whole-of-Commonwealth Government policy or strategy as it does not have the engagement in development or deployment of a whole-of-government strategy. It is a strategy developed by and deployed by the Commonwealth Department of Health and Ageing.[35]

8.31 The ACT Government noted there was confusion within the community concerning the status of the NSPS, specifically around whether or not there is a national strategy. They stated:

> Within the community, some view the Living Is For Everyone: a framework for prevention of suicide in Australia as 'the strategy'. However, the Commonwealth refers to this as a 'supporting resource'… The lack of clarity concerning the content of the National Suicide Prevention Strategy is a significant barrier to its successful implementation[36]

8.32 The ACT Government recommended that the Commonwealth provide greater leadership and guidance surrounding strategies for national suicide prevention by developing a clear strategy document which sets out actions to be implemented, an implementation strategy and mechanisms for consistent data collection.

---

32 DoHA, *Submission 202*, p. 33.

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

34 Suicide is Preventable, *Submission 65*, p.12.

35 Suicide Prevention Taskforce, *Submission 59*, p. 2.

36 ACT Government, *Submission 44*, p. 9.

8.33 Some considered the role of government departments was limiting suicide prevention activities. SPA commented that …previous instability of executive-level staffing arrangements within departments responsible for the oversight of the NSPS has also produced an environment that has not been entirely favourable to the development of a cohesive Australian suicide and suicide prevention research agenda.'[37] Similarly the Suicide Prevention Taskforce argued that 'changes in personnel, machinery of government and policy frameworks have impeded progress and outcomes'. They stated:

> Health Departments have limitations in being able to provide the leadership for a whole-of-government issue like suicide prevention and bring about the structural and broader societal changes necessary to tackle complex issues like suicide and they are limited in their ability to implement whole-of-community programs.[38]

8.34 SPA commented that historically there had been broad support for the NSPS objectives. However they stated:

> In 2008, criticism was expressed by some suicide prevention sector stakeholders towards national suicide prevention policy settings. Feedback from the consultations undertaken as part of the independent evaluation of SPA clearly indicated a growing sense of frustration and malaise with regards to policy formulation and progress in Australia, including what was perceived by some members to be a disregard of the informed advice of experts, the evidence and/or the views of the sector and a continuing marginalisation of the issue of suicide prevention more generally…[39]

8.35 The Suicide Prevention Taskforce submission proposed a new national governance and accountability structure with four key organisations to implement a 'coordinated multi-strategy approach to suicide prevention'. One of the rationales for this approach was that suicide was not only a health issues and there were a number of sectors '… private, public and community - with a stake in suicide and suicide prevention'. In summary these proposed structure would be:

- A new coordinating body which would monitor the performance of subsidiary entities in the new structure and approve strategic priorities for suicide prevention
- A peak advocacy body to advocate on behalf of service providers and those affected by suicide.
- A suicide prevention council and resource centre which would develop information and resources for service providers, develop research strategy, and develop standards and accreditation.

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

38 Suicide Prevention Taskforce, *Submission 59*, p. 7.

39 SPA, *Submission 121*, p. 65.

- A national foundation in suicide prevention which would raise funding from a variety of sources and promote awareness.[40]

8.36 Similarly Lifeline Australia recommended the creation of a national organisation for suicide prevention independent of any specific government department.[41] Professor John Mendoza commented:

> …we have to invest in new structures, new infrastructure and invest in what is truly a national strategy, not one that has got the name 'National Strategy' but a national strategy that engages not only the other eight governments in Australia but the sector, the industries, the stakeholders who really want to see transformation in this area.[42]

8.37 The MHCA also linked better data collection in relation to suicide and attempted suicide with better governance and accountability.

> Robust accountability and transparency means removing the process whereby governments assess their own performances and measures, and giving this role to organisations that can provide genuine oversight and accountability of progress in reducing suicide in Australia.[43]

8.38 Professor Peter Bycroft argued that there were too many vested interests in control of the decision making process, in key positions of policy advice and in co-dependency relationships with DoHA. He recommended that the advisory bodies '… who are instrumental in decisions relating to priorities for policy, service provision and funding should be arms length from the Department and should not be dominated by either the medical/clinical professions or academics/researchers who are major beneficiaries of those funding decisions'.[44]

8.39 Professor Patrick McGorry recommended that an aspirational target should be set for the reduction in the rate of suicide in Australia. He noted this target may not be quick to achieve but it would '…really put pressure on us as a society to significantly reduce the suicide toll as we have been successful in doing in reducing the road toll over the last couple of decades'.[45] This is an approach that has been taken overseas. For example, *Choose Life: the national strategy and action plan to prevent suicide in Scotland* includes a target to reduce suicide by 20 per cent over ten years.[46]

---

40 Suicide Prevention Taskforce, *Submission 59*, pp 9-11.

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

42 Professor John Mendoza, *Committee Hansard*, 1 March 2010, p. 98.

43 MHCA, *Submission 212*, p. 5.

44 Professor Peter Bycroft, *Submission 41*, p. 9.

45 Professor Patrick McGorry, *Committee Hansard*, 4 March 2010, p. 80.

46 Scottish Executive, *Choose life: A national strategy and action plan to prevent suicide in Scotland*, 2002, p. 20.

8.40 Professor Graham Martin's comparison of national suicide prevention strategies noted that some overseas jurisdictions have decided on specific targets for reductions in suicide. He notes that this 'may be a two-edged sword, on one hand leading to criticism of the government for not achieving a goal, but it also may very well help with public perceptions, and the public ownership of, and commitment to, suicide prevention'.[47]

Evaluation of the NSPS

8.41 In 2005 the Commonwealth engaged Urbis Keys Young to conduct an independent evaluation of the NSPS. The evaluation found NSPS was '…widely supported and perceived as an appropriate and necessary strategy that addresses an ongoing community need'. However it also found that 'stronger evidence regarding the impact and outcomes of NSPS funded projects is required'.

8.42 DoHA noted that a full independent evaluation of the NSPS is planned for the 2010-11 financial year '…that will provide guidance on the currency and efficacy of the strategy that will inform the department's advice to government on any changes of direction or amendments to the strategy'. [48] The AISRP argued that evaluating the NSPS was problematic because of the inaccuracy of ABS data on suicides.[49]

Funding issues

8.43 DoHA stated that the Commonwealth has increased its annual allocation of funding for specific suicide prevention programs from $8.7 million in 2005-06 to $22.2 million in 2009-10 and that this forms part of a broader investment in mental health services and programs of $1.9 billion.[50] It stated '…investment by the Australian Government in suicide prevention has increased significantly over the last decade, and that there has been no reduction of effort despite the decline in official data on deaths by suicide'.[51]

47 Graham Martin, *National Suicide Prevention Strategies: A Comparison*, 2009, p.76. Paper prepared for DoHA.

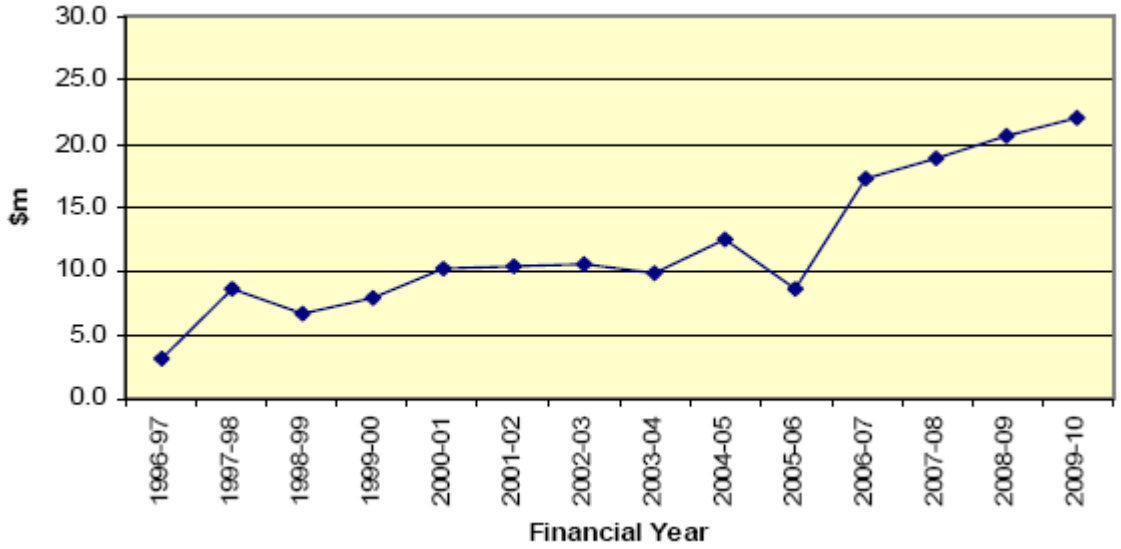
48 Ms Georgie Harman, DoHA, *Committee Hansard*, 1 March 2010, p. 66.

49 AISRP, *Submission 237*, p. 122.

50 DoHA, *Submission 202*, p. 2.

51 DoHA, *Submission 202*, p. 33.

Appropriations by Financial Year for National Youth Suicide Prevention Strategy (1996-97 to 1998-99 and NSPP (1999-00 to 2009-10)[52]



8.44 However the lack of resources available to implement the NSPS was often emphasised during the inquiry. For example Lifeline Australia stated that the 'financial resources allocated to implementing the strategy are meagre in relation to the scope of the problem…'.[53] The funding available for suicide prevention was compared to other issues which received greater levels of public funding such as road safety and cancer. RANZCP recommended that funding allocated to suicide prevention should be equivalent to that spent on events and/or illnesses with a similar mortality rate, for example breast cancer.[54]

8.45 The Suicide is Preventable submission stated there was also a need to '…broaden the funding base from non-government sources – that is, from community, philanthropic, unions and other collectives and business sources – to supplement the contributions made by governments'.[55]

8.46 The approach of the funding projects under the NSPS was also criticised. The Suicide Prevention Taskforce stated that:

52 Extracted from DoHA, *Submission 202*, p. 33.

53 Lifeline Australia, *Submission 129*, p. 66.

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

55 Suicide is Preventable, *Submission 65*, p. 12.

> The NSPS approach to funding small scale projects has been likened to 'spreading confetti across the land'. While this approach of investing through small grants has developed some capacity in communities to respond to suicide, few projects have been sustained and even fewer evaluated.[56]

8.47 SPA recommended the funding priorities should be shifted '… from short-term small scale projects to longer-term investment in projects that derive sustainable outcomes and include a budget for evaluation of interventions as an evidence base against which to measure the ongoing effectiveness of the NSPS'.[57]

8.48 A number of organisations commented that the lack of certainty regarding funding cycles created problems for the organisations in maintaining staff as well as the credibility with clients to whom assistance was being directed. The ACT Government also noted there was a history of mental health programs developed on a pilot basis, where Commonwealth funding is withdrawn after an initial period despite positive evaluations. They noted this can have a significant impact on clients who lose services and for providers who become disillusioned or are unaware of services because of ongoing changes.[58]

8.49 This view was shared by many organisations which operated suicide prevention programs. The Integrated Primary Mental Health Service of North East Victoria emphasised:

> We cannot stress enough the need for long term funding for mental health skilled community workers. Grant funding is inappropriate. Short term projects are regarded cynically, '*How long are you lot going to be around?*'. We have learnt that workers need months to years to successfully be accepted and valued by a community.[59]

8.50 Mr Keith Todd from OzHelp stated:

> We lose good, quality people because they have family themselves. They are probably looking for another job nine months out. They have families to support and they have to take care of their own sustainability.[60]

8.51 Similarly, Ms Kerry Graham from the Inspire Foundation commented:

> … three-year funding contracts, which are set at the beginning, do not allow a great deal of flexibility to be highly responsive; and then, when you are getting to the end of your funding contract, you are putting most of your

56 Suicide Prevention Taskforce, *Submission 59*, p. 3.

57 SPA, *Submission 121*, p. 67.

58 ACT Government, *Submission 44*, p. 6.

59 Integrated Primary Mental Health Service of North East Victoria, *Submission 26*, p. 4.

60 Mr Keith Todd, OzHelp, *Committee Hansard*, 1 March 2010, p. 40.

> efforts into repositioning or demonstrating success, which is very important, as opposed to being as forward-thinking as you can be…[61]

8.52 Centre of Rural and Remote Mental Health Queensland stated:

> Sustainability presents a significant challenge for community based suicide prevention strategies. Pilot and seeding programmes that do not have a strategy for longer-term implementation often raise expectations and needs within communities that are then not met… With short term funding arrangements, many groups struggle to find new resources. Efforts to institutionalise programmes may compete with the time-consuming task of fund-raising during the later stages of projects…There is also a strong likelihood of a loss of momentum and the departure of key project staff.[62]

8.53 The Urbis Keys Young evaluation identified several aspects of the NSPS structure and processes that could be strengthened. This included understanding in the sector of '...funding processes and mechanisms to advise on the progress and outcomes of NSPS activities and projects (including evaluations of these projects)'.[63] During the course of the inquiry the Committee heard from some community organisations who felt their locally-based and long running programs had been excluded from consideration for public funding as they did not have the capacity to write complex competitive tenders.

8.54 DoHA told the Committee that following the open tender process for local community grants in 2006 'there was some concern from smaller organisations who were not as good at writing submissions as bigger organisations… worthwhile small projects felt they could not compete'.[64]

Conclusion

8.55 The Committee understands that work is being undertaken to produce a single national suicide prevention framework and DoHA has indicated that an independent evaluation of the NSPS has been scheduled for financial year 2010-2011.

8.56 In the opinion of the Committee the policy documents around the NSPS (the LIFE Framework resources and the National Suicide Prevention Action Framework) do not assist understanding of suicide prevention activities in Australia, particularly given the different strategies being conducted or developed by the State and Territory governments. There is an opportunity to simplify these policy documents and promote understanding of the NSPS and suicide prevention activities in Australia.

---

61 Ms Kerry Graham, Inspire Foundation, *Committee Hansard*, 1 March 2010, p. 40.

62 Centre of Rural and Remote Mental Health Queensland, *Submission 31*, p. 6.

63 Urbis Keys Young, *Evaluation of the National Suicide Prevention Strategy – Summary Report*, 2006, p. 6.

64 Ms Colleen Krestensen, DoHA, *Proof Committee Hansard*, 18 May 2010, p. 34.

Recommendation 37

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

8.58 The Committee is sympathetic to the views of many organisations and individuals who supported the joint Suicide is Preventable submission and the proposal that a new governance and accountability structure would assist the delivery of suicide prevention programs in Australia. However the Committee is also cautious to support the creation of several interrelated organisations which may divert resources from suicide prevention activities and programs.

8.59 The Committee was interested in the recent changes to responsibility for suicide prevention in WA. In that jurisdiction a Ministerial Council for Suicide Prevention has been charged with overseeing the implementation of the WA State Suicide Prevention Strategy which would be delivered by a non-government organisation.[65] The Committee considers that a greater role could possibly be taken by ASPAC and the various State and Territory Ministerial Councils for suicide prevention in developing policy and programs under the NSPS.

Recommendation 38

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

8.61 The Committee accepts the recommendations made in many submissions that funding for suicide prevention programs, projects and research in Australia be substantially increased. The Committee recognises that many other public programs and welfare expenditure operate to limit or decrease the incidence of suicide and attempted suicide in Australia. In particular, a broad range of mental health services and programs which function to prevent or treat mental illness significantly contribute to reducing suicide and attempted suicide. Similarly many other government services and programs can also be seen as promoting recognised protective factors and limiting risk factors for suicide.

8.62 Nonetheless the funding for programs which could be described as at 'the pointy end' of suicide prevention is relatively limited ($22.2 million in 2009-10) when considered against even some of the lower financial cost estimates of suicide in Australia. Additional public funding directed to effective programs and projects in this area can literally be considered to be lifesaving. It is clear to the Committee that the

65 Mr Shawn Phillips, Ministerial Council for Suicide Prevention, *Committee Hansard*, 31 March 2010, p. 2.

public funding made available for suicide prevention is not proportionate to the personal, social and financial impacts of suicide in Australia.

8.63 The Committee also recognises the need to diversify the funding sources for suicide prevention. In the view of the Committee there is merit in the Suicide Prevention Taskforce proposal to establish a foundation to encourage other sources of funding for strategic priorities in research, advocacy and service provision.

Recommendation 39

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

Recommendation 40

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

8.66 The short term funding of programs and projects is an issue with which the Committee is familiar from previous inquiries. Clearly this approach to funding cycles allows government some flexibility to change priorities. However short term funding cycles can be enormously detrimental to the establishment and ongoing success of projects and programs. Short term funding cycles usually create additional administrative burdens for projects, disruption for clients and uncertainty for project employees.

Recommendation 41

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

8.68 The most important measure of the effectiveness of the NSPS is whether it has reduced the number of suicides in Australia over the period of its operation. Unfortunately this measure has been obscured by changes to data collection and uncertainty regarding the underreporting of suicides. The situation will become clearer as revised data from the ABS is released over the coming years and trends will be identified. The Committee feels that an explicit and ambitious target for the reduction in the annual number of suicides should be included in the NSPS. This target would function to focus the attention and resources of government and the community on suicide prevention initiatives.

Recommendation 42

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